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HEALTH ECONOMICS, POLICY and LAW

PERSPECTIVE

What's the ideal World Health Organization (WHO)?

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Abstract

The World Health Organization (WHO) is tasked with the 'attainment by all peoples of the highest possible level of health', yet, it is widely struggling to meet this mandate, and COVID-19 has revealed significant limitations of the organisation. Despite clear guidance provided by the institution as to how best to respond to the pathogen, many governments departed from WHO's guidance in their response efforts. Is this a new crisis for WHO? Does WHO need to restore its legitimacy in the eyes of the global community? As renewed calls for changes to WHO emerge, in this perspective we lay out the obstacles WHO face to become the WHO 'we' need. The assumption is that UN member states need an empowered and well-funded organisation. Yet, many years of discussion of reform of WHO have failed to lead to meaningful change, and glaring challenges remain in its financing, governance and politics, which are considered in turn. The reality may be that we have the WHO that UN member states need – one that can provide guidance and advice, but also take criticism for health governance failures when states want to avoid blame or responsibility. We discuss this, by analysing three key areas of WHO'S challenges: mandate and scope; structure, governance and money and domestic vs international.

Keywords: Global health governance; global health policy; WHO reform; World Health Organization

1. Introduction

We have the World Health Organization (WHO) that we deserve (Gostin, 2020). With a recent history of the institution being side-lined politically with increased involvement of multiple other actors in the global health arena, combined with a reduction of funding awarded, has significantly reduced the power and capacity of the institution to manage the range of health activities in operation. Fundamentally, WHO could warn states on how to respond to COVID-19, but had little power to assist states or compel states to heed their advice, resulting in considerable criticism of WHO since 2020.

The WHO is the UN's specialist agency tasked with 'the attainment by all peoples of the highest possible level of health' (World Health Organization, 1946). Within this broad mandate and vision of social medicine, the WHO works to respond to health emergencies, but simultaneously has long-term initiatives focused on tackling HIV/AIDS, malaria, tuberculosis, antimicrobial resistance, non-communicable diseases, improving road safety, working to better prevent mental health issues and beyond. The WHO's work has also been at the centre of the health-related goals of the sustainable development goals (SDGs) and the attainment of universal health coverage (UHC).

However, there is a gap between what the WHO was created to do – offer technical guidance and best practice for a range of health concerns in 'routine' times and health emergencies – and

what it is able to secure states to do in practice (Wenham, 2017). The COVID-19 pandemic reveals an exemplary paradox that WHO finds itself in more broadly: in this example, the WHO has argued that free and universal access to vaccine technology is essential to end this pandemic; meanwhile, WHO depends upon funding from the very states that are preventing universal access and use of this technology. As a result, the WHO has to invest time and people in creating new programmes and initiatives that donor states are willing to fund to deliver (limited) vaccine access. As is so often the case, WHO is in the midst of a political operation as well as a technical operation. It is possible that no reform can fix the structural problem that WHO faces as a technical international organisation: the tension between the best public health approach and the most politically salient offering. To meet its technical and mandated function – to provide advice to states in the interests of public health and health for all – reforms are required. We lay out below provocative ideas for reforming WHO's own ideals of what it can achieve in the area of global health, and indeed call for the organisation to embrace the political status it has as a UN organisation. This is a radical step: it is not an argument for WHO to have more but possibly for WHO to do less to enable it to excel as the lead international organisation for health. States have designed 'natural' limitations around WHO in areas such as funding and governance; and there is little evidence that states desire to change these conditions to empower WHO. It is possible, we contend in this piece, to make the case for WHO to maintain its status of an authoritative public health figure that is finite in its capacity and political reach. As always, WHO will have to be what states want it to be. We address these suggestions to those with responsibility in the WHO Secretariat at headquarters especially, but also the regional offices.

We stress that there are some key strengths to WHO, which should be lauded, and which should not be lost in reform activity. Indeed, WHO needs to embrace its strengths and let go of its weaknesses. The strength of WHO is the organisation's convening power as the lead international health authority: the WHO, unlike any other organisations in global health, can bring states to the table and can create meaningful agendas and work plans – ranging from mental health to tobacco control, UHC, SDGs to clinical trial guidance and assistance. Whilst governments of the Global North may show waning trust or commitment to the WHO, they still participate in the Executive Board, the World Health Assembly (WHA), and care about the leadership of WHO (Director-General). The WHO technical prestige in many countries has not diminished: WHO Emergency Use listing for the COVID-19 vaccines was as important to the high-income countries process for vaccine approval as it was for low-income countries. WHO's coordinating role of technical health advice and as the forum for international health standards is fundamental to WHO, as is currently being seen in the discussion on the development of the Pandemic Treaty under WHO auspices. The gaps that WHO cannot overcome through reform are in implementation, funding and securing government commitment to WHO standards. We suggest that rather than seek powers that states do not wish to give it and see it fail, WHO should audit and enhance the governance areas that achieve greatest state compliance. Below, we detail what this reform would entail in the areas of mandate and scope; structure, governance and money and the tensions between domestic and international measures.

2. Mandate and scope

For the WHO to provide guidance and advice for the range of health issues that fall under the mandate of WHO, as well as provide operational readiness to support states response to a global health emergency, the governments must commit to a renewed system-wide reform. There have been dramatic changes to low-, middle- and high-income status, shifts in geopolitical power, as well as regional shifts in economy and technology since the last significant reform effort (under former WHO Director Dr Gro Bundtland's leadership in late 1990s) (Robbins, 1999).

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A dedicated review of WHO's structure and mandate should be accompanied by a renewed commitment to assessed contributions to the organisation. The review, led by states, should establish whether WHO's future is to rely on ever diminishing assessed contributions or abandon its reliance on the high-profile voluntary contribution work it has increasingly taken over the last 30 years (see Section 3).

The second step towards this mandate reform would be for states to agree to alignment between the WHO budget and the Programme of Work developed by the WHA. Currently the WHO Programme of Work is focused on 'One billion more people to benefit from universal health coverage (UHC); one billion more people better protected from health emergencies; one billion more people enjoying better health and well-being' (World Health Organization, 2019). Yet, under the current budget, only 78% of funding required has been provided for UHC, 49% for protecting people from health emergencies and 50% for enjoying better health and wellbeing. At the same time, voluntary funds enjoy greater capitalisation, with funding earmarked for polio eradication (26% of total budget), increase access to essential health and nutrition services (12% of budget) and vaccine preventable disease (8% of budget) (World Health Organization, 2020*a*). Thus, it appears that the 2-year budget cycles agreed at WHA and Executive Board (EB) and 5-year programmes of work are out of sync and must be brought into greater alignment.

This is the challenge that may create discomfort for WHO advocates: not more funding but more alignment between states expectations of WHO and WHO compliance pull and expertise. The problem with a call for increased financing is that much of what WHO could be financed for might be better spent investing in health at the domestic level. For example, funding for UHC is best placed to be invested in strengthening health systems directly, rather than strengthening a global organisation to in turn champion health system strengthening and the roll out of UHC. Importantly, the question of funding must be considered alongside the mandate of the WHO, which is to be the norm setting agency for global health activity, rather than an operationalised delivery unit. Our point is that either the funding model designed in the 1940s is no longer fit for purpose for an increasingly operational body, or the activities of the organisation need to be reduced to fit the financing model.

Whilst much recent focus has been on the WHO's role in health emergencies and the legitimacy states attach to WHO's advice in this role, this is only part of the work that WHO does. WHO manages programmes across the whole spectrum of health and wellbeing issues. WHO provides a key role as arbiter of best practice for a range of health concerns, such as list of essential medicines, diagnostic tests, for clinical and public health guidance. For many states, national best practice for maternal health, non-communicable diseases, antimicrobial resistance, etc. are sourced from the WHO. Without the WHO setting standards and guidelines there would be significantly worse health outcomes for vast swathes of the world. Over the past decade, there have been growing concerns that the WHO is trying to do too much given its limited budget, and that instead of trying to manage all health issues it should simply focus on epidemics or those which pose international risks (Clift, 2014). This has been suggested either as a separate agency, just focused on health emergencies, such as how UNAIDS became a separate institution out of WHO; or to further bring to prominence the WHO Health Emergencies Programme (HEP) to act with its own budget line and governance structure separate to that of the WHO. After that report, there were at least seven further reports examining WHO reform in response to health emergencies (prior to the outbreak of COVID-19) published between 2015 and 2017 (Moon *et al.*, 2017). Our concern with contemporary WHO reform focus on the question of health emergency management is twofold.

First, separating health emergencies from WHO may lead to a prioritisation of funding for pandemic preparedness but where will governance lie? One of the successful structural components of WHO has been its engagement with Ministers for Health through World Health Assemblies and technical programmes. One lesson from COVID-19 is that health systems

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need to have ongoing capacity, reach and global means of communication. WHO's technical work on advising and supporting health system capacity and response is persuasive at the ministerial level, across regions and politics (Davies, 2019). Moreover, states have shown no interest in decoupling WHO from health emergency operations. Creating a new institution requires new rules, new commitments, new staff and new funding.

Second, creating a new institution wouldn't tackle WHO's scope problem. WHO was able to create the Global Outbreak Alert and Response Network (GOARN) and emergency medical teams, both of which have played crucial roles in responding to Ebola, Zika and COVID-19, because of their activity in non-emergency situations like dengue, anti-microbial resistance (AMR) and polio. WHO's presence in 'peace time' benefits its response in 'war time'. There is no evidence that states would adhere more or less to WHO's recommendations because of a single focus for the organisation, and indeed, COVID-19 has showed the opposite to be true (Eccleston-Turner and Wenham, 2021). The question is what role should WHO be mandated to do for its 194 member states, which includes a prominent role for health emergency prevention and response? Do states want to limit WHO's voluntary contributions or increase its core budget in this programme? Either way, this would be a significant departure from the current position of WHO that seeks to expand its mandate to 'the highest attainable standard of health', to imagine itself as a smaller, tighter outfit.

The mandate of WHO is as a technical and normative organisation, tasked to act as the directing and coordinating authority on international health work, and to furnish appropriate technical assistance to eradicate epidemic, endemic and other diseases (World Health Organization, 1946). What it is not is an operational body. It does not implement programmes or have a cadre of health workforce that can be 'boots on the ground' in health activities. This is often presented as a key tension within the WHO, but perhaps we need to reframe the problem. The question is not what should WHO become but what WHO can do well?

One solution to both challenges would be for WHO to work better with its mandate within the international UN system. WHO should remain at the centre as the technical lead on health advice across emergencies, conflict, development and human rights; but it may have to outsource operational activities to UN partners. This will have budget consequences for WHO but it is possible that existing institutions could better implement programmes that WHO coordinates. For example, the UNICEF and UNFPA is mandated to deliver treatment, training, medical supplies and immunisation to support maternal and child health, UNOCHA was depended upon by WHO to provide humanitarian support in health emergencies including Ebola outbreaks in West Africa and cholera outbreak in Yemen (Harman and Wenham, 2018). Beyond the UN system, the World Bank would also be able to implement (or at least fund) operationalisation of many WHO projects, as proposed with the new Pandemic Fund. In such an arrangement, the WHO should remain in a standard setting and coordinating role for global health but leave the implementation and delivery to national health systems, other international organisations and civil society. There are key examples of learning through tri-partite working on AMR/One Health (with OIE and FAO) to harmonise expertise and communication in shared areas of concern and effort (OIE, 2013). To achieve this greater trust building needs to continue in 'peace time'. WHO has a role to play but it is, as a technical agency, a limited one in operations. Indeed, it is important to note that WHO's lack of operational experience may have contributed to the organisation being found culpable for the largest incident of sexual exploitation and abuse investigated in UN history, in the Democratic Republic of Congo (DRC) in 2019, during its 10th Ebola outbreak (Reis, 2021). As noted above, the risk of such a hub and spokes model for WHO would be significantly reduced funding if donors chose to fund implementation directly to the delivery organisations. It would not be popular within WHO but the benefit for WHO is that this may be the most strategic way forward to improve mandate, legitimacy, service delivery, and protection in the system.

3. Structure, governance and money

The WHO is governed through the WHA, comprised of 194 member states, which meets annually and makes decisions as to the overall strategic direction of the institutions and an Executive Board (EB) which aims to operationalise decisions made at WHA, comprised of 34 state health officials on a rolling term, which meets twice a year. The WHO Secretariat in Geneva is to implement the will of the WHA and EB, headed by the Director General (DG), alongside six regional offices with a country office in member states who request representation (approximately 120 member states have country office representation).

The regional offices are a result of the historical legacies of League of Nations Health Office, Pan-American Sanitary Bureau and Office International d'Hygiene Publique. As these structures already existed, the mechanisms to bring them together as the WHO necessitated a semi-federal structure (Hanrieder, 2015). If you were to re-design the WHO today, it is not clear states would create the same structure but then, states have never sought to undo the WHO regional structure despite efforts, especially DG Gro Harlem Brundtland, to 'streamline' the WHO. This economic opportunity to streamline WHO and reduce regional offices was not grasped by states. This indicates that states still see purpose in the regional structure. Regional offices of WHO create donor competition for budgets with Headquarters (HQ), competing work streams and confusion at time of crisis (Lee, 2008). Regional offices are, theoretically, more likely to bend to political pressure. The African regional office, AFRO, was blamed for the delayed reporting of Ebola cases from West Africa, especially in the early months in 2014. But regional offices also create avenues for members to pursue diplomatic objectives closer to home. A counter-argument to regional offices hampering HQ organisation is that HQ have failed to support regional initiatives that they did not design (Davies, 2019).

The result, nevertheless, is a structure with internal friction and duplication, with competing mandates, budget lines and ways of working (Graham, 2014). Efforts have been made to streamline the organisation, such as by Brundtland, some of which were vetoed by regional block coalitions voting against such actions to protect regionalism (Hanrieder, 2015). DG Tedros has taken a different route and sought to heighten cooperation and interaction between the three levels (country office, regional and HQ) of the institution through personnel rotation between levels, mirroring the UNICEF and UN (New York) rotation policy (UNICEF, 2013). It is unclear, due to the impact of the COVID-19 pandemic, to ascertain if this one WHO voice has worked. A nuclear option would be to dissolve regional offices of WHO, leading to a central and more powerful HQ and increased resources to the country offices. This presumes states would agree to it, and channel the money to the WHO HQ. There is no evidence this would happen. Another option, less drastic but equally unlikely, would be to change power structures within WHO and give more authority to HQ – perhaps the WHO EB – to determine the representation of regional directors and the agenda of regional assemblies. This would not be popular, and there is a legitimate argument that the public health agenda and priorities of states belonging to the AFRO (African region) may not be the same as WPRO (the Western Pacific office), for example. Again, there is no evidence that this 'freeing up of expenditure' would be handed over by states to the WHO Secretariat in Geneva. A final path could see a reduced role for a slimline HQ, with most activity redirected to strengthened regional WHO offices. That way greater ownership could be developed at regional levels. This would likely be more politically attractive to governments if the institution is perceived to be responding to their direct needs and understanding local concerns. In such a model, HQ could be retained simply for issues which meaningfully transcend international borders, such as global health emergencies, and coordination between regions. Our point is that the presumption that WHO regional offices should reform to suit the agenda of the WHO Headquarters is not politically straightforward and, crucially, it is not desired by the majority of member states.

A second concern with the structure and membership of the WHO is the role of the WHA and EB. The WHA comprises Ministry of Health representatives from each member state (plus

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broader advisory delegates) that set the agenda for each year. The WHA is governed by the principle of one state one vote, similar to the UN General Assembly, giving all states the same power as each other, regardless of size or financial contribution, formally, if not in practice. There is no question that WHA should remain as the central governance mechanism. In reality, decisions are often made prior to WHA, at the EB, or in (virtual) corridors and in this context, it is those states with the most technical knowledge, funding and/or human capacity who can drive agendas (Lee, 2008). The WHA is now a 5-day affair. This is a great strain to low- and middle-incomes countries (LMICs) that have to pay premium prices for representation in Geneva and it gives some states an unfair advantage. This points to the need to seriously streamline the breadth of WHO work (above). It also points to the need for WHO to consider, perhaps, loosening the representation requirements for WHA and EB physical attendance.

The EB is made up of technical health experts who meet twice a year to support implementation of what was agreed at the WHA. However there is often little difference between these two executive groupings, with the EB acting as a mini WHA in practice. An alternative option would be to make the EB a member-state body with an elected 2-year rotation that determines the direction and focus of WHO programmes in cooperation with the WHO DG similar to that of the UN Human Rights Council, something which many states are doing in practice already.

Structurally, there must be a place for civil society organisations (CSOs) (and to a lesser extent the private sector) to have more of a prominent role in the institution and even within the WHA. At present, the WHA membership is reserved for states. There is no dedicated forum, board or assembly for CSO participation and contribution. This is fundamentally at odds with other UN institutions which permit non-state actor participation and observation. Consider, for example, the annual UN Commission on the Status of Women in New York and the right of CSOs to contribute to the UN Human Rights Council process. The reality of global health is its dependence on CSOs, whereby multiple non-state actors perform pivotal roles in designing agendas, but perhaps most importantly in delivering and implementing programmes in the global health arena. This lack of representation works the other way in terms of transparency. The Bill and Melinda Gates Foundation (BMGF) is the largest donor of voluntary assistance to the WHO, and has no process by which it has to account for its investments in the WHO to the EB or the WHA. This raises significant concerns about the influence of non-state actors, and the power that some have to influence the democratic decision-making process from outside of the WHA. One option would be to formally include all philanthropic agencies and NGOs in the WHA process, but not provide them with a vote. Whilst this would undeniably be complex, lessons can be learned from global health institutions which already have civil society participation in meetings and arrangements, including UNAIDS, GAVI and The Global Fund. Indeed, a reformed EB would be the perfect venue for civil society to have a forum for representation on particular agenda item for DG and EB consideration (similar to the women-led CSO reporting mechanism attached to the Women, Peace and Security agenda in the UN Security Council).

The question is why states would agree to this but the sad reality is few WHO reformers advocated for more meaningful civil society participation until the advent of COVID-19 (Moon *et al.*, 2017). There may be untapped potential here for WHO governance reform. There will be states who will oppose greater CSO participation but states who support and work with CSOs could take leadership in this arena within WHO.

A further key problem for WHO's programmes is its lack of funding and the limited control of its budget that it has due to the financing structure of the organisation. In an ideal world, a future empowered WHO would be fully financed, not just to respond to health emergencies, but to lead research and respond to all public health-focused activities it undertakes. Current biennial budget for WHO is $5.8bn (representing a $1.4bn increase from previous cycle, owing to COVID-19) – annually this represents about how much it costs to run the NHS across England for 6 days (The Kings Fund, 2019). However, the WHO was never designed to carry out the functions of a national public health system. WHO was designed under the

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1948 Constitution to have the capacity for technical operations – support and advice to states through WHO country offices – and normative functions – guidelines, standard setting, data collection and dissemination, coordination of trade and travel measures in the event of an infectious disease outbreak; notably absent is operational activities. If WHO was intended to conduct humanitarian operations, deliver relief and support national health systems, then its budget would be wholly incommensurate. As noted above, we are not convinced an operational WHO is what states want or WHO HQ has the capacity to achieve. It is not clear why the organisation requires an enlarged budget to provide advice to states on an impending health crisis. Indeed, a leaner WHO more focused on its initial mandate could, arguably, issue advice without fear of favour or rancour.

The WHO's funding model is derived from *assessed contributions* which governments pay on an annual basis, dependent on the size of their GDP. Currently, 17% of the overall WHO budget is linked to assessed contributions. Yet, these assessed contributions have not increased in real terms since payment was frozen in 1980s (this was first limited to zero real growth, then latterly limited to zero nominal growth). Moreover, analysis of the actual contributions that states pay, despite what they are required to pay, and the funding shortfall that exists as a consequence is further evidence of state's calculations of the value of the international organisation. In 2022, Germany led a financing working group to agree to increase assessed contributions to be over 50% of total funding to the institution by 2029, an annual increase of $600m to core funding. This is a substantial commitment on the part of member states, but as yet, we do not yet know whether this will become a reality.

The remaining 80% of WHO's budget is comprised of *voluntary contributions* that state and non-state actors contribute directly for programmes which they wish to support. This is the key phrase: which they wish to support. Not necessarily what WHO should be doing under its mandate. This underlines the value that states assign to WHO's budget: directing the spend. Of course, these voluntary contributions are approved by the WHA, so whether the programme reflects the 1948 Constitutional terms is less important in political terms. However, there is the argument that WHO is being instructed to do more outside of its core functions and more voluntary programmes. WHO's pathology, like any international organisation (Barnett and Finnemore, 2004), is to say yes to more money and higher profile roles. This donor shift demonstrates the value attached to WHO in real terms: voluntary over assessed contributions allows stakeholders to align their funds alongside manifesto pledges or political/strategic priorities, which may or may not be technical priorities. Whilst a small percentage of voluntary funds are made available as 'flexible funds' over which the WHO has discretionary use, 90% of voluntary funds are earmarked by donors.

For example, take the role of the Global Polio Eradication Initiative, hosted by WHO, and which is almost exclusively voluntary funded by donors. Almost ¼ of all WHO employee salaries are funded by this scheme, and they work on polio efforts. If polio becomes eradicated (which hopefully it will) then there are serious sustainability concerns for many programmes within WHO that have relied on this money for cross subsidisation. Under this scheme, WHO is always at risk of not doing enough in core programmes or not doing programmes to the satisfaction of different communities that can't fund the programmes they need, for example, neglected tropical diseases.

Addressing the funding shortfall through more voluntary funds or assessed contributions, for it is clear the WHO can't have both, is a vital question for WHO and its members states to consider. The argument for more funding is tempting; but why states should fund WHO requires answering first – what do member states want from WHO?

4. Domestic vs international

If the WHO wants to lead meaningful change for global health then and demonstrate its authority in the global health architecture, it needs to better mediate the path between domestic

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responsibilities and international activities. One key area of tension for WHO is that their technical expertise, normative agenda and best practice guidance are only as pertinent as the extent to which governments engage and embed recommendations into their national policies and practice.

One notable example of this is the International Health Regulations (IHR), the international law that member states have ratified to prevent, detect and respond to infectious disease threats. We will discuss this example at some length in this final section in order to reveal the importance of states collectively leading the WHO reform agenda we have outlined above. The IHR was originally designed to straddle the domestic vs international impulses of states, with significant powers given to WHO to act as global epidemic coordinator in the case of an outbreak of infectious disease (Kamradt-Scott, 2011), and yet the actions required to bring about the end of an epidemic require implementation by national governments. Whilst this tension between global and domestic is nothing new, the future of collective response to health emergencies need an instrument which is viable in its implementation under existing global health architecture. When do states trust, and mostly comply with, WHO's guidance?

Under Article 6 of IHR governments shall notify WHO of any emerging pathogens within their territories which may constitute a public health emergency of international concern. There has been considerable analysis showing the differences in considerations of incentives to do this (Davies, 2012), and despite IHR seeking to remove the disincentive through revisions to an all-risk approach, with an offer to mobilise international assistance and by seeking to limit travel or trade restrictions within the broader mandate of the IHR, this still remains an issue. However, there are the few countries that evade reporting, and then there are those that simply do not know about outbreaks for many weeks/months due to poor infrastructure. These require different solutions. Looking to elsewhere in the international system, ensuring compliance is implemented either through carrot or stick. Whilst one option would be to apply a sanctions-based model, such as that used within WTO, or some form of removal of voting rights at WHA for failure to comply, the risk is that this would disproportionately affect those who need WHO the most and those which may have the biggest gaps in health security, not to mention the fact that WHA as a forum carries considerable less influence of that of the WTO, and thus non-participation may not work as an incentivisation mechanism. From a governance perspective, the WHO has no capacity to gather states together to meet quickly to propose and vote on such actions. Interestingly, the Austrian government proposed such a function under the EB and it was approved in 2022. This attempt to try and reform WHO governance will not be tested until the next emergency, but this state-led response to emergencies is an interesting proposal, and its outcome is pending further state discussion and deliberation at time of publication. The proposal does point to however, the need to conceptualise alternative incentives for compliance and reporting with IHR in real time, something echoed by the IHR Review Committee on the functioning of the regulations during COVID-19, and to meaningfully understand what states actually want.

One option could be available financing for health emergencies at point of notification to be able to support the response efforts, potentially through a new health emergencies insurance fund with World Bank through public–private partnerships, through a new budget line within WHO, or through special drawing rights within the IMF (2021). This would create a two-tiered system though where states in need of financing comply with reporting (and suffer the economic harm) whilst states less depending on international financing do not report. A second option would be to assume greater powers within WHO because of good behaviour. This could be through appointments to committees etc. or nominations to the Emergency Committee of the IHR.

Recent suggestions have focused on the creation of new pandemic early warning system that can 'outpace' states reporting compliance, but this already exists within the combination of the WHO EWARS (state only), GOARN, Pro-MED Mail and Health Map. However, we conceptualise that the problem isn't the detection of these emerging pathogens, as much as it is the

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'what happens next': do governments confirm the outbreak, do neighbouring governments take these warning seriously, how do they interpret the alerts, etc. In other words, what happens at the domestic level in response to an international level alert? Article 9 of the IHR allows for non-governmental reporting to WHO, which is how most outbreak rumours are detected. This remains the crux of the problem: it is not whether we know about outbreaks sooner at the global level, or how they are reported to WHO, but what efforts are taken once these outbreaks are known about to mitigate national, regional or global transmission. This is true both of the WHO, and of member states. For example, we know that ProMed first detected COVID-19 on 31st December 2019, and yet it took 11 days for WHO to receive a meaningful response from China. What's more, many states did not start to act on the reports until the end of January, and then only repatriating nationals from China and imposing travel restrictions. Very few had built up meaningful response mechanisms domestically until March 2020 when the WHO Director General had raised the taxonomy to that of a pandemic (with some notable exceptions such as Taiwan, Singapore, Hong Kong, South Korea, Australia and New Zealand). One key development must be states hold each other accountable for a failure to report and comply.

Do states want to commit each other to this requirement? Do states want WHO to have oversight of their commitment? For long-term activities, under Article 5 of IHR, states are required to build core capacities to be able to prevent, detect and respond to outbreaks promptly, through improvements to surveillance, laboratory capacity, health workforce development, access to tates self-reported IHR compliance, and to what extent they had met these core capacities domestically each year. Of course, a gap remained between what states told WHO and what had actually been achieved, as well as many gaps remaining in global health security systems. In the wake of Ebola in West Africa, the compliance requirement was updated to encourage countries to participate in a joint external evaluation, a peer evaluation process monitoring compliance. This was voluntary, but many countries took part (over 90 before the COVID-19 pandemic), wanting to appear compliant with IHR (Davies, 2019). This example reveals states' willingness to participate in compliance and capacity building processes. However, this process can be significantly improved to improve incentive mechanisms within global health.

Learning from other forms of surveillance within the global system such as within the IMF can offer many lessons. Macro-economic surveillance under Article 4 of IMF Articles of Agreement is conducted annually in each country. This is mandatory, and it is undertaken by IMF staff, rather than peers: it is thought almost a third of staff within IMF is involved in this function. Whilst this is resource heavy, it does allow an incredibly detailed picture of the current context and landscape to be able to pre-identify any causes for concern. If this model were applied to WHO to current capacities under Article 13 of IHR – mapping out of how countries have sought to improve their capacity to prevent, detect and respond to crises (or indeed under any other article of IHR) – this would lead to increased awareness of capacity globally, allowing WHO and/or domestic governments to mitigate weaknesses in health emergency preparedness. This should be undertaken in line with National Action Plans for Health Security (NAPHS) – all governments are supposed to develop a NAPHS post inspection – so that there is clear country ownership for implementation for preparedness efforts. In this way, such a process could neatly straddle the global vs domestic tension, with global processes being combined with national action plans with clear context-specific steps for implementation. The cost would be colossal, requiring a multiple fold increase in assessed contributions to be able to employ the staff to carry these out on a regular annual basis similar to the IMF review mechanism. However, if broader WHO reforms have occurred this is not an impossible task. More ambitiously, such an approach could be incorporated into the Universal Health Periodic Review (UHPR) that WHO is currently exploring: mapping out and assessing not only a country's capacity to respond to a health emergency (and thus on a narrow series of indicators linked to emerging pathogen and response) but a much more comprehensive review of UHC and broader health system indicators (World Health Organization, 2020*b*). The likelihood of states agreeing to such a comprehensive review based

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on contemporary geopolitics remains unlikely. The point is that there is an established practice, for over a decade, of WHO providing a review feedback process that assists states with building biosecurity capacity which supports health system strengthening.

The next complication under this proposed reform package is what happens if holes are discovered in preparedness efforts? States are responsible to fund these holes but there needs to be a capacity building financing mechanism available. One option would be to engage in a GAVI style model for financing and building capacity for the IHR where gaps are identified. Once thorough surveillance had been undertaken (as above), any gaps in capacity could be identified, and key criteria to be met to achieve this capacity (this would be like that of the recommendations attached to IMF surveillance reports). Under the GAVI model, states struggling to implement necessary development in the health system to support annual immunisation coverage are eligible for financing to improve on indicators identified. A similar mechanism could be implemented for IHR and help to finance capacities to ensure compliance with IHR. As capacity improves (and alongside additional criteria such as economic performance to ensure sustainability of core capacities for IHR) countries' external financing would be moved into a transition phase (GAVI, 2018), until such point as governments are able to self-finance and self-sustain IHR capacity going forward. The key here is that the financing model may initially start at the global level, but over time it moves to the domestic to try and ensure country ownership and to avoid prolonging the global to domestic tensions. This proposal is an example of the way in which WHO's technical and normative mandate could evolve to support states build the health capacity they need. We acknowledge that under the current WHO budget and structure this is less possible, which points to the need for substantive mandate, governance and financing reform (above).

The final question is whether states want the WHO to have the power to intervene during a crisis and supersede national sovereign prerogatives as to support a national health crisis to the benefit of the global community if governments failed to do so. Understanding what power states want WHO to have, both at the global and the domestic level is pivotal to the future plans for a pandemic treaty. The Intergovernmental Negotiating Body (INB) is now empowered to negotiate a pandemic treaty to complement the IHR to bring political commitment to the public health goals instilled within the current governance framework, under the auspices of WHO. However, the key tension remains as to how a pandemic treaty can led to domestic course changes at a time of crisis. Governments may sign up to something at peace time, but as COVID-19 has shown us, at time of crisis domestic priorities are not the same across the world. Fundamentally, we need to understand what the purpose of this treaty would be – and greater consideration must be made as to how this will address the failures of the IHR thus far to overcome failures of, government compliance with international law: why would governments be likely to comply with a treaty, when they have failed to do so under the IHR thus far? A starting point for future negotiations must be to address why governments comply or don't comply and put this at the centre. Notably, not all states have welcomed this treaty proposal, with several LMIC governments highlighting that those very states which are wishing to implement such mechanism have failed to demonstrate commitment to global norms of collaboration, cooperation and solidarity during COVID-19. This example serves to show that WHO operations come from member states who do not always agree on what their commitments to the organisation and each other should be. Therefore, it is no surprise WHO's functions will continue to be hampered by this political reality. Yet, WHO continues to be the institution that states turn to for guidance.

5. Concluding thoughts

It is important to note that the WHO, however ideal we might envision it as an institution for realising the right to health, is not a panacea, and at times of crisis these institutions will fail. No institutional model is perfect, but the WHO can be significantly improved – but to do so

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this will require considerable political and financial support from states. It requires the institution to audit and radically revise its mandate, scope, financing and relationship to states.

Strong health systems, and universal health care coverage more broadly, is a rare example of a global public good. States clearly have opted to invest financially and normatively in the WHO to achieve the goal of health for all. However, not all states agree with how to get to this goal. The differences in investment between assessed and voluntary contributions reveal different political and technical understandings of how to reach this goal. WHO headquarters pursuit of a pandemic treaty when compliance with the IHR is far from secure created an unnecessary political distraction. The starting point for WHO reform must be to assess what states want and seek from the WHO and to work to create that vision of the organisation, rather than continue with the mismatch between expectation and achievement which creates broader normative challenges in the perceived success or role of the institution.

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