BRIEFING

European Parliament

World Health Organization

Is it fit for purpose?

SUMMARY

The World Health Organization (WHO) declared Covid-19, the disease resulting from the novel coronavirus SARS-COV2, a pandemic on 11 March 2020, putting the United Nations (UN) agency in the global spotlight. The WHO is coordinating international efforts to fight the virus, for example by issuing guidelines on preventing and treating the disease, and coordinating research into testing and vaccines.

Critics argue that the WHO was overly accommodating of China, and as a result failed to handle the pandemic effectively in its early stages. According to them, the WHO too readily accepted Chinese reassurances that there was no evidence of human-to-human transmission. The WHO also failed to hold China to account for its initial cover-up, and even praised its transparency.

Even before coronavirus, the WHO already had a mixed track record, including, on the one hand, successful eradication of smallpox, and on the other, a delayed response to the West African Ebola epidemic of 2014, which may have cost thousands of lives. Its failures, both in the Covid-19 pandemic and in previous health crises, highlight long-standing problems: the agency is weak, underfunded, and its complex organisational structure can get in the way of effective action. Underlying such weaknesses is the fact that the WHO is entirely dependent on cooperation from its member states and can only act within the limits set by them.

While Covid-19 has highlighted many of the WHO's weaknesses, it is also a reminder that diseases respect no borders, and that the organisation's task of global coordination has become more necessary than ever.

Headquarters of the World Health Organization in Geneva.

In this Briefing

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Background

History, membership and governance

A series of International Sanitary Conferences, launched in 1851 in order to harmonise quarantine requirements for infectious diseases, was the first step towards international cooperation on health. In the early 20th century, the Pan-American Sanitary Bureau, the Office international d'Hygiène publique, and the Health Organisation of the League of Nations were established. In 1948, these three bodies were merged into the World Health Organization (WHO), a UN agency based in Geneva.

The WHO is headed by a Director-General, since 2017 Dr Tedros Adhanom Ghebreyesus. Directors-General serve a five-year term, renewable once. Their work is overseen by the World Health Assembly, which meets once a year, usually in May, and comprises delegations from the 194 member states. Among other things, the Assembly determines WHO policies, appoints the Director-General, and reviews and approves the budget. It can also vote to admit non-UN countries to the WHO, as it did for Niue and the Cook Islands (but not Taiwan). The Vatican and Palestine participate in the Assembly as observers, as do several dozen UN agencies, international organisations (including the EU) and foundations. The work of the World Health Assembly is organised by a 34-member Executive Board.

The WHO is represented on the ground by 149 field offices. These in turn are coordinated by six autonomous regional offices, covering Africa, the Americas, South-east Asia, Europe, the Eastern Mediterranean and the Western Pacific.

Priorities and tasks

According to its constitution, the WHO directs and coordinates international health work. In 2017, the current Director-General made universal health coverage his top priority. He also set three 'billion' targets for the next five years, based on the UN Sustainable Development Goals: universal health coverage for one billion more people, better protection from health emergencies for one billion people, and one billion more people enjoying better health and well-being.

To achieve these goals, the WHO coordinates, and in some cases directly finances, vaccination programmes to eliminate infectious diseases such as polio. It also leads the international response to crises such as Covid-19.

WHO activities cover the entire range of health issues – not only infections, but also non-communicable diseases and health threats such as smoking and road accidents. The WHO issues international guidelines on diagnosis and treatment, sets conditions for certifying internationally traded medicines, collates statistics on health trends, provides policy advice and technical assistance, in particular to governments, and implements projects aimed at improving healthcare in developing countries.

Public Health Emergencies of International Concern (PHEICs)

Under the 2005 International Health Regulations, the WHO has the power to declare international health emergencies. It has done six times so far: for swine flu (April 2009); polio (May 2014); Ebola (August 2014; July 2019); Zika virus (February 2016); Covid-19 (30 January 2020).

Although WHO recommendations in the context of a PHEIC are non-binding, they help to mobilise resources and stimulate research activity.

WHO achievements: A mixed track record

Fighting infectious diseases

One of the WHO's biggest achievements was in eradicating **smallpox**: in 1980, 21 years after launching an international vaccination campaign, it was finally able to declare the world free of the

disease. In 1988, the WHO declared a target of similarly eliminating **polio** by the end of the millennium. That target was missed, and the stubborn persistence of infections prompted the WHO to declare a PHEIC in 2014. Nevertheless, considerable progress has been made, with the number of cases falling by 99 % over the past three decades. Unfortunately, **tuberculosis** is very far from disappearing; however, the WHO's Global Drug Facility has enabled millions of patients in developing countries to access high-quality anti-TB medicines, both through collective purchasing mechanisms that bring the cost of drugs down, and through grants that help the poorest countries to buy such medicines. The WHO has also been praised for its leadership during the 2003 **SARS** epidemic; within just four months, the disease had been contained.

In 2009, fears that the **swine flu** virus could mutate into a more lethal form prompted the WHO to declare its first ever Public Health Emergency of International Concern (PHEIC – see Box). Governments rushed to stockpile vaccines, most of which were never used, as the epidemic turned out to be milder than expected. This 'disproportionate' response, as it was described in a 2011 European Parliament resolution, was blamed for wasting millions of euros of public money on unnecessary vaccines. Some critics even alleged that WHO decisions had been swayed by the interests of the pharmaceutical sector. An internal enquiry exonerated the WHO from most of these accusations, arguing that, in view of the evidence available at the time, it would not have been possible to predict the course of the epidemic, while also acknowledging that the situation could have been handled more transparently.

Whereas the WHO was accused of over-reacting to swine flu, its response to the 2014 West African **Ebola** outbreak came too late to prevent tens of thousands of deaths. In what international health experts described as an 'egregious failure', the WHO waited months before declaring a PHEIC, despite warnings, including from its own staff, that the epidemic was out of control. The organisation's lumbering bureaucratic response contrasted unfavourably with more agile interventions by non-governmental bodies such as Médecins Sans Frontières. On the other hand, in 2018 efforts to contain a second outbreak of Ebola in the Democratic Republic of the Congo were more successful, with just 33 deaths in total; for some observers, the organisation's quick response, which included the release of emergency funding just hours after the start of the outbreak and a personal visit to Kinshasa by Director-General Tedros a few days later, suggested that it had learned lessons from its 2014 failures. Ebola remains a serious threat in West Africa; a subsequent outbreak triggered another PHEIC, and killed over 2 000.

Non-communicable diseases and other health threats

While media attention tends to focus on emergencies caused by infectious diseases, non-communicable diseases such as **cancer** cost far more lives. However, the WHO's track record in this respect is, again, a mixed one. For example, many recommendations issued by the International Agency for Research on Cancer, a semi-autonomous branch of the WHO, are scientifically sound; however, critics allege that the body does not do enough to prevent conflicts of interest that might influence expert assessments on which its recommendations are based, nor is it very successful at communicating its conclusions with the public.

On **smoking**, described by the WHO as a 'global epidemic', the main instrument is the 2003 Framework Convention on Tobacco Control, the first ever international treaty adopted within the WHO framework. The measures it envisages have played a key role in shaping national tobacco control policies, including in developing countries. Implementation is still patchy, but gradually improving: as of 2018, 12 % of the 181 countries which are parties to the Convention were failing to ensure protection from passive smoking (e.g. bans on smoking in public places), 23 % were not applying packaging and labelling requirements (such as health warnings on cigarette packets), 29 % did not have awareness-raising and educational measures in place, while 30 % were not restricting tobacco sales to and by minors. Tobacco still kills over 8 million people every year, most of them in developing countries, and consumption is only declining slowly.

Obesity is another global health scourge that the WHO has taken on. For example, in 2016 it endorsed taxes on soft drinks as an effective means of reducing sugar consumption. However, it has run into resistance from the beverages industry, and the US government, which in 2018 blocked a WHO panel from issuing a global recommendation on sugar taxes.

In developing countries, the high cost of medicines is often a barrier to effective treatment. Improving **access to medicines** has long been a priority for the WHO. The interests of producers, which are protected by patents, have to be balanced against patients' need for affordable treatment. However, WHO work in this area has been blocked by disagreements between countries which argue that intellectual property is not part of the organisation's remit – typically pharmaceutical exporters, such as the United States (US) – and others, including developing countries, which feel that it should be.

WHO response to the Covid-19 pandemic

Leading the global response

As in previous epidemics, the WHO has played a key role in coordinating the global response. On 30 January 2020, it declared a PHEIC, and on 11 March it went a step further by labelling the outbreak as a pandemic, i.e. an epidemic of global proportions. While the WHO's declaration of a pandemic had no legal effect beyond the PHEIC in place since January, it emphasised the global nature of the threat and urged governments to do more to contain it. Just hours after this wake-up call, Italy became the first of many European countries to introduce a wide-ranging lockdown.

The WHO is leading the communication effort, with daily reports and regular press conferences. Its recommendations guide doctors and decision-makers. WHO advisors have been dispatched across the world to help governments prepare their response. The organisation also facilitates networks enabling researchers and medical practitioners from different countries to share information, thus supporting international efforts to develop vaccines, tests and treatments.

Criticisms of the WHO's response

In January 2020, Director-General Tedros claimed that China was 'setting a new standard for outbreak response', and lauded its 'commitment to transparency'. Such fulsome praise – which prompted accusations of 'parroting Chinese propaganda' – could at least be justified by the WHO's need to persuade Beijing to allow its observers into the coronavirus hotspot of Hubei province. On the other hand, it is harder to understand why the organisation was so willing to accept initial Chinese reassurances that the disease could not spread from one human being to another. On 10 January, it was already considering the possibility of human-to-human transmission, yet just four days later, it uncritically shared a Chinese study denying the evidence to that effect.

The WHO's response to the 2003 SARS epidemic had been very different; suspecting a cover-up, it forced China to reveal the extent of the outbreak, enabling prompt and effective action. However, despite this experience, this time the WHO did not challenge China, which only finally acknowledged that humans could also spread the disease on 20 January. By that time, the epidemic had already spread beyond its region of origin.

Taiwan, which is not a member state of the WHO nor, since its new president openly challenged Beijing's One China policy in 2016, even an observer, claims that it had already warned the WHO of human-to-human infections as early as December 2019. Assuming this claim is true, it provides further evidence of how the organisation's approach to China got in the way of an effective response to the initial outbreak. Taiwan's almost complete exclusion from the organisation is a hindrance to information-sharing. Although the WHO communicates with the Taiwanese authorities, for example through a national contact point on health threats, dialogue on coronavirus seems to have broken down. Taiwan claims that it is not receiving all of the WHO's alerts, and also that it is unable to share data with the rest of the world – not least on its own response to the virus, which has been one of

the most successful in the world (and, contrary to WHO advice, included a travel ban from China from the start). Awkward relations with Taipei were apparent in March 2020, during an interview with a senior WHO official who refused to answer questions on the island's status. Tensions were further highlighted in April 2020, when Tedros accused the Taiwanese government of condoning racist attacks against him originating from the island

The WHO's recommendations on how to handle Covid-19 have also been widely criticised. Most countries have chosen to ignore its February 2020 warning that travel restrictions would only increase 'fear and stigma, with little public health benefit'. On 6 April, WHO guidelines stated that 'the wide use of masks by healthy people in the community setting is not supported by current evidence'; nevertheless, the US, China, Poland, Belgium and Germany are among over 50 countries which are either recommending or requiring face masks in public spaces. It remains to be seen how many will follow the WHO's advice not to lift lockdowns until six conditions have been met, including 'the ability to quickly detect, test, isolate and treat new cases as well as to trace close contacts'.

Some of the most virulent criticisms have come from Donald Trump, who has accused the 'China-centric' WHO of 'really blowing it' and missing a chance to contain the spread of what he regularly describes as 'the Chinese virus'. On 14 April, he announced that the US would suspend funding for the WHO budget, pending an investigation into the organisation's role in the pandemic; his administration has since threatened to pull out of the WHO altogether, and perhaps look into setting up an alternative body. Trump's announcement was widely condemned, including by UN Secretary-General António Guterres and EU High Representative Josep Borrell, who both argued that during a pandemic was not the right time to cut WHO funding.

With regard to accusations that the WHO's complacency during the early stages of the pandemic cost thousands of lives, it should also be pointed out that, on 23 January, the organisation was already warning that 'all countries should be prepared for containment'. Given that Covid-19 did not start spreading in most parts of the world until more than a month later, the worst affected countries – including the US – still had plenty of time to prepare at that point. For opponents of Donald Trump, he has used the WHO as a convenient scapegoat to divert criticisms of his administration's mishandling of the situation.

Strengths and weaknesses of the WHO

The WHO has unique assets

The WHO's mixed track record, including on Covid-19, reflect long-standing issues. On the one hand, despite current accusations of a pro-China bias, as a UN agency it has a neutral status that enables it to work with governments around the world. Given that environmental, trade and other factors also have health implications, its capacity to work with other UN agencies and international organisations is a key asset. For example, cooperation with the UN's Food and Agriculture Organization is crucial in the context of tackling infectious diseases, since many of them (such as SARS and Covid-19) are of animal origin. The WHO has the prestige to attract highly qualified technical staff. In developing countries, the organisation is a trusted source of policy advice, and it is at the forefront of efforts to bring better healthcare to the world's poorest people. The agency has developed unparalleled networks with governments, researchers, NGOs and other health actors; such networks play an essential role in facilitating global cooperation, including on Covid-19.

Organisational weaknesses hamper the WHO's work

However, critics point to organisational weaknesses. Building consensus between member states and coordinating multiple departments with overlapping tasks can slow down decision-making. With a strong bias towards recruiting staff from medical backgrounds, the organisation does not have enough economists or lawyers – a weakness, given the cross-cutting nature of health issues.

The World Health Assembly, and in particular its Executive Board, are responsible for overseeing the organisation's work; however, effective scrutiny is hindered by the fact that Board members' responsibilities in their own countries often do not leave them enough time to carry out this task.

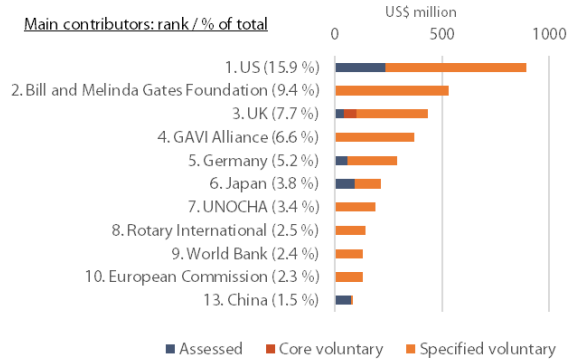
The extensive autonomy enjoyed by the WHO's regional offices can also cause problems. The WHO's constitution envisages that directors of regional offices are appointed by the Executive Board 'in agreement with the regional committee'. However, in practice, the Board invariably acquiesces to the candidate chosen by representatives of regional governments. As a result, regional directors tend to listen to the governments that appointed them rather than Geneva. It is sometimes claimed that the WHO functions not as a single organisation but as seven separate ones – the six regional offices along with headquarters. This becomes a problem when regional offices put national interests first, as in the Ebola crisis, where the WHO's delayed response may have reflected West African fears over the economic costs of declaring an international health emergency, given the likely impact on trade and travel. It has also made some offices 'parking places' for friends and relatives of regional politicians, attracted by generous WHO pay and conditions. The WHO's multi-level structure is not only a bureaucratic nightmare, but also adds significantly to administrative costs, which eat up nearly one-third of the organisation's budget.

Has the WHO lost its focus?

According to its constitution, the WHO's objective is 'the attainment by all peoples of the highest possible level of health'. Taking advantage of this broad mandate, the organisation has steadily expanded the range of its activities. At the same time, the field of international health has become increasingly crowded, with over 200 players according to one study. These include international organisations such as the World Bank, which branched out into funding health projects in the 1980s, public–private partnerships such as the GAVI Vaccine Alliance, private foundations such as the Bill and Melinda Gates Foundation, and NGOs such as Médecins Sans Frontières. Even at United Nations level, the WHO does not have the field to itself; alongside Unicef and its Children's and Population Funds, which have taken on some health tasks, the UN also has a dedicated agency on HIV/AIDS; perhaps reflecting a lack of confidence in the WHO's capacity to tackle the disease, UNAIDS was set up in 1994 on an adjacent but separate site in Geneva. The plethora of global health players, and the WHO's tendency to spread limited resources across a broad range of tasks, have led to calls for it to focus on areas where it can most clearly offer added value, such as setting international standards and coordinating responses to global health emergencies.

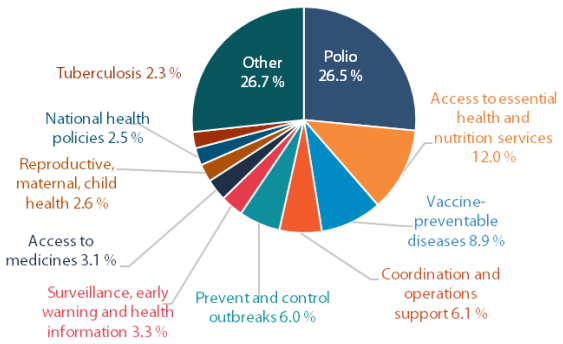
WHO financing – Not enough of it, and not the right kind

Figure 1 – Main contributors to WHO, 2018-2019



Data: World Health Organization.

Figure 2 – Spending by programme area



For the 2020-2021 period, the WHO envisages spending US$4.8 billion, compared to US$4.4 billion for 2018-2019. This is a modest amount, given that WHO activities span the entire globe – in the US, there are individual hospitals with larger budgets.

Another problem for the WHO is the nature of its funding. Seventeen per cent comes from 'assessed contributions', paid by the member states on the basis of their wealth and population. However, these mandatory payments have not kept pace with the organisation's needs, and it has become increasingly reliant on donations – from states, international organisations and private foundations. Voluntary contributions are of two types: 'core' and 'specified'. The WHO can spend assessed and core voluntary contributions (3 % of total contributions) flexibly; it therefore has full control over one-fifth of its revenue. The remaining four-fifths comes from specified voluntary contributions, which as their name suggests, are to a greater or lesser extent earmarked by donors for specific purposes. Pre-allocated funding constrains the WHO's capacity to set its own priorities and allocate resources where they are needed most. On top of this, dealing with funding that comes not in large chunks but in many small, separately managed grants – over 3 000 of them in 2018 – is an administrative headache. Given that the US provides around one-sixth of the budget, if it follows through on its April 2020 threat to suspend contributions, the WHO's financial position will become even more precarious.

Reforms to make the WHO more efficient and effective

Successive Directors-General have tried to address the WHO's organisational weaknesses and adapt it to changing global health challenges. For example, in 2011, Margaret Chan, who led the organisation from 2006 to 2017, promised reforms, but the organisation's dysfunctional response to the 2014 Ebola crisis came on her watch.

The election of Tedros Adhanom Ghebreyesus as her successor raised high hopes of a change for the better. Praised by Bill Clinton as 'one of the ablest public servants I ever worked with', Tedros is a media-savvy diplomat with a background in medical research – solid grounding for a post which requires him to engage with multiple stakeholders on health matters. In Ethiopia, deaths from AIDS, malaria, and tuberculosis were more than halved during the seven years he served as health minister (although he was also criticised for covering up cholera epidemics). As the first ever African to lead the WHO, and the first developing country representative to do so since 1973, it was hoped that he would do more to improve healthcare in the world's poorest countries. Indeed, this is reflected in his 'triple billion' priorities (see above).

Like his predecessors, Tedros has also made changes. In 2019, the WHO announced several administrative reforms, including compulsory rotation of staff between headquarters, regional and country offices, more frequent staff appraisals, and a new pay scale for scientists allowing them to earn the same as managers. Staff rotation should help to bridge the disconnect between headquarters and field offices, helping to ensure that Geneva-based officials are more in touch with what happens on the ground. Appraisals are intended to address the problem of under-performing staff, while more attractive career prospects for scientists will make it easier for the organisation to hold on to highly qualified specialists.

The WHO's fundamental weaknesses cannot be easily addressed

Although such measures are a step in the right direction, Covid-19 has highlighted the organisation's fundamental flaw: its dependence on member states, something that cannot be overcome by internal reforms. Whereas the WHO constitution states that the organisation 'shall not seek or receive instructions from any government … [each member state] undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them', in practice this requirement is not respected.

Critics of the WHO's accommodating stance towards China note that Beijing was a key backer in Tedros' 2017 election, and is also increasingly influential in his home country. In any case, the organisation is entirely dependent on cooperation from member states: it has no legal powers to impose binding measures, and with 3 600 staff (out of 8 000 WHO employees) dispersed around nearly 150 field offices, very little capacity to make things happen on the ground. Without Beijing's approval, the WHO could not even have sent observers to the Chinese regions affected by the virus.

The same problem underlies many of the weaknesses described in the previous sections. Financing is of course almost entirely dependent on member state goodwill. Control over regional offices cannot be easily addressed, if member states insist on their prerogative to appoint their representatives as directors and office staff. So long as it remains weak and underfunded, the WHO will continue delivering suboptimal responses to international health crises such as Covid-19 and Ebola. However, Covid-19 is also a reminder that diseases respect no borders, and that the WHO's task of global coordination has become more necessary than ever.

The EU and the WHO

EU-WHO cooperation takes place at several levels: with the individual EU Member States, the European Centre for Disease Prevention and Control, which is an EU agency, and the European Commission. All EU countries send delegations to the World Health Assembly, and five are currently represented on the WHO's Executive Board. The European Commission participates in the work of both bodies as an observer, but does not have full membership, as this is only open to states. Together with the European External Action Service, it works with EU countries to build common positions.

The EU and its Member States played a leading role in the negotiations that led to the WHO's 2003 Framework Convention on Tobacco Control and 2005 International Health Regulations. In terms of financial support, three EU Member States (Germany, Sweden and France) together with the European Commission are among the WHO's top 20 contributors. Sweden, the Netherlands, Belgium and Denmark are among the top 10 providers of core voluntary contributions, which have the advantage for the WHO that they can be spent flexibly.

In 2018-2019, the European Commission contributed US$131 million to the WHO. Among other things, this will help the WHO reach its goal of universal health coverage in African, Caribbean and Pacific (ACP) countries. In 2020, the EU allocated €25 million from the European Development Fund and €30 million from the ECHO (humanitarian aid) budget reserves, to help the WHO response to the Covid-19 pandemic; again, this funding will be used in ACP countries.

EU institutions and Member States remain supportive of the WHO, in the face of US threats to withdraw funding. For example, the European Parliament (in its resolution of April 2020 on EU coordinated action to combat the Covid-19 pandemic) and German foreign minister Heiko Maas have emphasised that international cooperation on health is more necessary than ever, and called for a stronger WHO.

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