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Short Communication

Global health challenges facing bureaucracy: democratization or revolution?

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This year marked the 67th World Health Assembly, the annual meeting of the World Health Organization's (WHO) 194 member states. Between 19th and 24th May 2014, more than 3500 participants met at the Palais des Nations, Geneva, Switzerland to discuss and agree new WHO policies and its programme budget. Coincidentally, Public Health published a paper by Van de Pas and van Schaik calling for a democratization of WHO.[1] This opinion contrasts with reports in medical journals which lavished praise on the meeting. For example, the British Medical Journal provided three pieces about the meeting which, some would argue, were unbalanced, characterized by self-satisfaction, and even claiming victimization: ‘Perhaps WHO is a victim’.[2]

Given these differing views it is appropriate to ask what are the reasons to question WHO policies or results and why should the proposed changes be needed? To answer these questions one can look at the way in which WHO fulfils it role in: ‘*...providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends*’. (*see:* http://www.who.int/about/en/). In other words, how well is it developing evidence-based policies and its level of professionalism (integrity and transparency).

Firstly, with regard to developing evidence-based policies, between 2007 and 2013, it has been argued that WHO clinical practice guidelines have been characterized by strong recommendations based on low or very low confidence estimates for evidence.[3] For example, in 2013, the WHO continued to recommend rapid fluid resuscitation for children in shock, despite the evidence from the only large controlled trial of fluid expansion as a supportive treatment (published in 2011), finding that it increased the risk of death in African children.[4]

Secondly, even when recommendations are well evidence-based and there is a mechanism for the enforcement of tobacco control policies, WHO has continually failed to act in seeking to ensure better compliance with the Convention for Tobacco Control (CTC).[5,6] Admittedly, CTC is ‘soft’ legislation and not a mandatory regulation. As such the 'soft-diplomacy' function of the WHO is a complex task as it must keep members ‘on board’ rather than ‘naming and shaming’ them for their shortcomings. Where countries have very limited resources this might be to some extent understandable; elsewhere however, as in Europe, it is less so. Belgium, for example, is one of many member states that have failed to provide the required 2012 annual report, without any threat to their membership of the Convention. WHO also accepts repeated and obvious violations of article 5.3 of the Convention, which requires member states to protect public health policies from the influence of the tobacco industry.[5] Having a ‘soft diplomacy’ approach must not become an excuse for complacency or for unintended complicity. Facts must not be ignored: from 1980 to 2004 the annual decrease in the prevalence of daily smoking was on a fast track, reaching 2% in 2004, the year of the Convention. Since then it has leveled off and the 2012 annualized rate of change in prevalence of daily smoking is now almost null (6, see Fig. 1b).

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Thirdly, WHO exhibits inconsistency in its leadership for health. Take alcohol as an example, the WHO Director General recently stated: '*In the view of WHO, the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests*'.[7] However WHO's status report on the progress of alcohol control in Europe highlighted France's 2009 law on 'Hospital, Patients, Health and Territories' that the bans on the sale of refrigerated alcoholic beverages in petrol stations and to young people aged under 18 years would improve alcohol control.[8] However, as there is no mechanism for enforcing these bans, the law is – arguably – futile. It is also only part of the story, as this law also specifically authorized the marketing of alcohol on the internet.[9] The previous legislation from 1991, called Evin's law after Claude Evin, a Minister of Health, who designed the first comprehensive legal framework in France to combat the tobacco and alcohol burdens, banned such marketing.[9] This suggests that WHO does not understand when the interests of the alcohol industry are being served and when population health is actually being protected?

Lastly, WHO has not created a credible means of dealing and reporting on potential conflicts of interest amongst those professionals who contribute to its work as expert advisors. A fact which was reinforced in the aftermath of the 2009 H1N1 flu pandemic in the context of the WHO's resolution calling for an unprecedented campaign of mass vaccination against flu and stockpiling of antiviral drugs.[10] WHO has a long history of such concerns; a case from 1994 relating to the WHO gave a definition of normal bone density which classified half of all women over 50 as suffering from osteoporosis and osteopenia,[11] also the 1996 WHO view that 'depression' would be a worldwide epidemic that within twenty years will be second only to cardiovascular disease as the world's most debilitating disease.[12]

Expertise, independence, transparency are mandatory prerequisites for global health. The distribution of health risks worldwide remains extremely and unacceptably uneven. There seems to be less and less concern and room for the disadvantaged people in the 'Palais des Nations' ('United Nations Palace'), in a country with one of the highest per capita and standards of living in the world.

Van de Pas and van Schaik[1] are right: WHO must change, but can they? Current proposals seem to focus on new developments not addressing the existing problems. For example, WHO is considering engagement with non-state actors beyond its member states.[13] Is this what is needed? Adding public debate is needed at the very least and Van de Pas and van Schaik's proposal could only be icing on the cake. Those who have created the problems are often not the best to fix them, as Albert Einstein noted: '*Insanity: doing the same thing over and over again and expecting different results*'.

Happily, there are concrete initiatives such as the Oslo Commission on Global Governance for Health.[14] This young independent academic commission comprises 18 renowned researchers and policy makers selected by the University of Oslo according to criteria of bringing diverse geographical, disciplinary and personal perspectives to the table. WHO could do worse than follow this work with interest.

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