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The WHO's 75th anniversary: WHO at a pivotal moment in history

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ABSTRACT

The World Health Organisation (WHO) was inaugurated in 1948 to bring the world together to ensure the highest attainable standard of health for all. Establishing health governance under the United Nations (UN), WHO was seen as the preeminent leader in public health, promoting a healthier world following the destruction of World War II and ensuring global solidarity to prevent disease and promote health. Its constitutional function would be 'to act as the directing and coordinating authority on international health work'. Yet today, as the world commemorates WHO's 75th anniversary, it faces a historic global health crisis, with governments presenting challenges to its institutional legitimacy and authority amid the ongoing COVID-19 pandemic. WHO governance in the coming years will define the future of the Organisation and, crucially, the health and well-being of billions of people across the globe. At this pivotal moment, WHO must learn critical lessons from its past and make fundamental reforms to become the Organisation it was meant to be. We propose reforms in WHO financing, governance, norms, human rights and equity that will lay a foundation for the next generation of global governance for health.

SUMMARY BOX

⇒ WHO was inaugurated in 1948 as the pre-eminent leader in public health, promoting global solidarity to prevent disease and promote health; however, WHO has faced political challenges over the past 75 years in advancing global governance for health.

⇒ The COVID-19 pandemic has revealed continuing governance challenges in global health, with WHO leading an unprecedented pandemic response while facing new political limitations, and the coming years will bring sweeping reforms that could transform global health governance.

⇒ Learning from WHO's history, ongoing reforms amid the COVID-19 response provide a path to respond to future challenges through sustainable financing, amendments to the International Health Regulations and a pandemic accord.

⇒ As it commemorates its 75th anniversary, WHO finds itself at an inflection point, with ongoing reforms at this critical juncture presenting new opportunities to reshape WHO financing, governance, norms, human rights and equity to create a WHO fit for purpose.

"We have a lot to be proud of over the past seventy-five years, but it's not the last seventy-five years that matters – it's the next seventy-five. We learn the lessons of the past so we can apply them in the future." Tedros Adhanom Ghebreyesus (2023)

INTRODUCTION

Seventy-five years ago, the World Health Organisation (WHO) was established as the first United Nations specialised agency, with its constitution entering into force on 7 April 1948. The preamble of WHO's constitution boldly declares that the highest attainable standard of health is a fundamental right of every human being. Today, as we commemorate WHO's 75th anniversary, it faces a historic global health crisis, the COVID-19 pandemic. The world has turned to WHO for leadership and guidance, yet never before has the Organisation faced such challenges to its institutional legitimacy and authority.

WHO stands at a critical juncture that will define the Organisation's next 75 years and, crucially, the health and well-being of billions of people across the globe. At this pivotal moment, WHO must learn from its past and use its governance tools for a healthier and more secure future. Learning lessons from enduring challenges and rising threats, WHO must shore up its core functions, including technical guidance, country support, normative standards and operational emergency response. States must equip WHO to create a future in which every individual can achieve the highest attainable standard of health.

POSTWAR BIRTH OF GLOBAL GOVERNANCE FOR HEALTH

The roots of WHO trace back to the creation of the Office International d'Hygiène

Box 1 UN Charter

Article 13

1. The General Assembly shall initiate studies and make recommendations for the purpose of…b. promoting international cooperation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 55

With a view to the creation of conditions of stability and wellbeing which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote…

b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Article 57

1. The various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and related fields, shall be brought into relationship with the United Nations…
2. Such agencies thus brought into relationship with the United Nations are hereinafter referred to as specialized agencies.

Publique (OIHP) in 1907, following European Sanitary Conferences dating back to 1851. OIHP operated until 1950, when WHO subsumed its responsibilities. Meanwhile, after World War I, the League of Nations Health Organization (LNHO) was created to provide epidemiological analysis, develop technical standards and support countries.[1] OIHP adopted a series of International Sanitary Conventions (ISC) from 1892 to 1933, while LNHO worked on disease standardisation. At its birth in 1948, WHO adopted both the ISC and the International Classification of Diseases. The International Sanitary Bureau (now the Pan American Health Organization (PAHO)), created in 1902,[2] became WHO's Regional Office for the Americas.

World War II revealed the brutality of a fractured world, raising a postwar imperative to bring nations together in a new world order. The Allied States meeting in Dumbarton Oaks in 1944 proposed a new international organisation to replace the League of Nations, what would become the United Nations.[3] At the 1945 San Francisco Conference on International Organisation, the Brazilian and Chinese delegations jointly proposed 'health' as a major aim of the UN Charter, advocating for a new international health organisation[4–6] (see box 1). In the following months, the UN Economic and Social Council jointly convened an International Health Conference to establish WHO.

WHO Constitution (1948)

During the 1946 International Health Conference, state delegates adopted the WHO Constitution under articles 55 and 57 of the UN Charter, establishing an interim commission to subsume within WHO all the responsibilities of predecessor organisations: OIHP, LNHO and the UN Relief and Rehabilitation Administration's Health Division.[7] The WHO Constitution established three governing organs: the World Health Assembly (WHA), the policy-making body comprising all member states, each with a single vote; the executive board, an executive programme-developing subset of WHO members; and the secretariat, carrying out the decisions of the Assembly and board through an elected director–general and appointed staff.[8] Sixty-one states signed the WHO Constitution on 11 July 1946, after which came into force on 7 April 1948.

Recognising a pressing postwar imperative to facilitate international cooperation,[9] WHO's first stated constitutional function would be 'to act as the directing and coordinating authority on international health work'.[10] The constitution granted the WHA unparalleled normative authorities to adopt international health standards: recommendations (article 23) as well as legally binding conventions (article 19) and regulations (article 21). The constitution extended the Organisation's policy leadership and technical assistance to all manner of disease prevention and health promotion activities, laying the foundation for 75 years of global health governance (see figure 1).

CHALLENGES IN THE COLD WAR AND BEYOND

In spite of WHO's active exercise of international legal authorities in its early years—through binding International Sanitary Regulations, regulations on the nomenclature of diseases and death and regulations on the purity of drugs in international trade—WHO pulled back from using its normative authorities during the Cold War. The Cold War would irreconcilably divide national foreign policies into two opposing ideological camps—Western capitalist democracies and Soviet-aligned states—impacting a wide range of vital global governance, including human rights and public health. As an early WHO leader described,

> The World Health Organization came into being just at the time (1948) when the political honeymoon which the United Nations had enjoyed for a short period after the Second World War had definitely come to an end, and the "cold war" had started. It was of course a most unfortunate political climate for a newcomer which was supposed to act non-politically in the field of international health, but which was built and run by member governments.[11]

While the first meetings of the WHA would avoid issues perceived to be 'political', Cold War debates on social reforms and national health services would soon lay bare WHO's claims to be apolitical, limiting efforts to address underlying determinants of health and paralysing WHO's actions to advance 'social medicine'. By the early 1950s, the Soviet Union and Eastern European states were withdrawing from the Organisation.[12] The Soviet bloc's withdrawal cut at the heart of WHO's mission, denying social

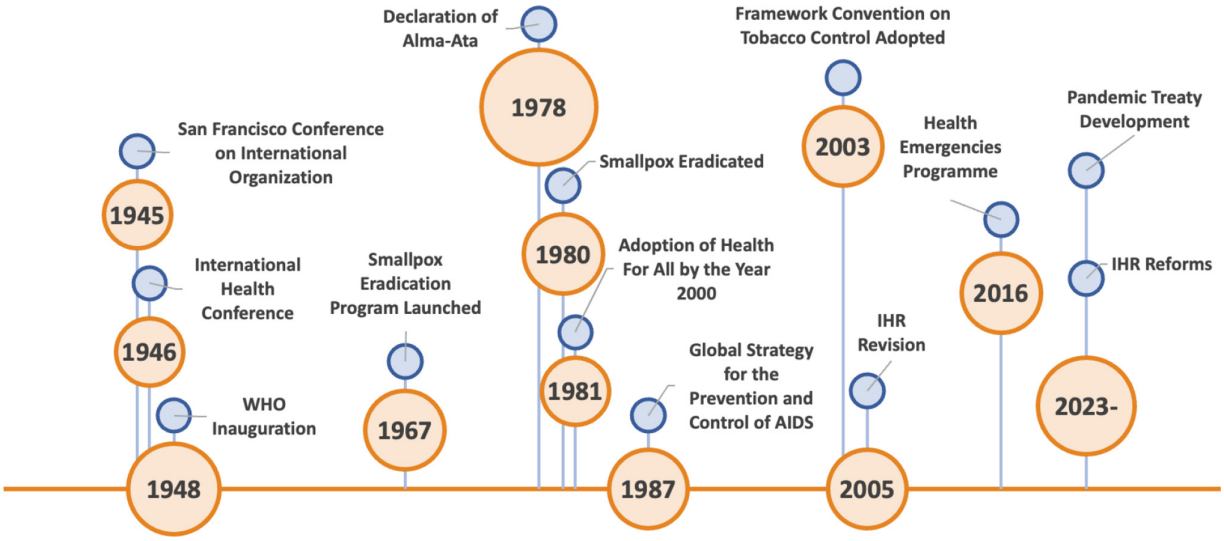

Figure 1 Seventy-five years of global governance under WHO: select milestones. IHR, International Health Regulations.

medicine a voice in WHA debates and preordaining a Western-driven medicalisation of health.

Shifting from global norms to pursue a technical agenda

While WHO was born as a normative organisation with robust treaty making powers under its constitution, it had by the 1960s all but abandoned international lawmaking as a tool to advance the right to health. WHO's chief legal officer rationalised:

> The limited degree to which WHO has entered into the field of international legislation is due to a considerable extent to the difficulty of drawing up and maintaining up-to-date international conventions, agreements or regulations on technical questions as well as to the differences in the scientific and technical development within its Member States.[13]

Other UN specialised agencies were producing copious international regulations and multilateral conventions to govern substantive issues within their respective purview;[14] however, WHO—while holding authority over the ISC, soon to be renamed the International Health Regulations (IHR)—long avoided such policymaking, looking to technical consensus on biomedical advances as a central focus of its early governance.

WHO remained averse to negotiating multilateral normative agreements, focusing instead on technical guidance and country assistance. Without new global standards to codify public health consensus, WHO shifted to address health issues through direct action in the absence of policy guidance. The Organisation's vision narrowed, with the then director-general viewing WHO personnel simply as 'catalysts who, working on projects, pass on to their national counterparts the skill and knowledge needed to attack a specific health problem'.[15] Turning its attention to purely technical enterprises, which it approached through a medical lens, WHO adopted a vertical, disease-specific approach to health. Its technical agenda focused largely (1) at the international level on communicable disease elimination or eradication, including most prominently malaria, tuberculosis, plague, cholera, yellow fever and smallpox; and (2) at the domestic level on country assistance through medical training and technical support, often delegating country assistance to its six regional offices.[16]

Decolonisation and a new international economic order

WHO's Secretariat has always been mindful of maintaining and expanding its membership. To this end, it created a legal fiction by categorising the withdrawn states as merely 'inactive members', ushering in the eventual return of Soviet Socialist Republics to full membership in the late 1950s and early 1960s. With the return of these states and the rise of decolonised nations—especially in sub-Saharan Africa—WHO would be pressed anew to consider social medicine and government health systems to realise the right to health.[17]

As decolonisation progressed and the UN rapidly expanded, nascent member states pushed for a 'new international economic order' to moderate the inequitable effects of the international economic system.[18] 'Healthy development' would become a watchword within WHO. By voting in concert in the WHA and enlarging the executive board, developing states pushed WHO to advance health equity through medical technology transfers and public health systems.[19] WHO would come to emphasise maldistributions of wealth, focusing on health equity to create a 'new international health order'.[20] With the election of Halfdan Mahler as director-general in 1973, WHO would come to champion primary care and social determinants of health.[21] Together, these developments marked a pivotal moment in WHO's history as it shifted towards promoting equitable healthcare systems worldwide.

Figure 2 International Conference on Primary Health Care, September 1978 (WHO).

Declaration of Alma-Ata

For WHO, health was not just the absence of disease but also a state of complete physical, mental and social well-being that resonated with broader goals of healthy development. In the 1970s, WHO made significant strides towards advancing primary healthcare, culminating in the historic Declaration of Alma-Ata. WHO developed a 'health-for-all' strategy to attain 'by all citizens of the world by the year 2000 of a level of health that would permit them to lead socially and economically productive lives'.[22] Grounded in norms of health equity and human rights, this focus on health for all became an integral part of national development, moving away from vertical hospital-based technologies towards horizontal public health systems.[23] This marked a moment of great hope, as WHO officials proclaimed 'the onset of the health revolution'.[24] The pinnacle of this revolution was the International Conference on Primary Healthcare, held in Alma-Ata, USSR (now Almaty, Kazakhstan) in 1978 (see figure 2). The Conference adopted the groundbreaking Declaration on Primary Healthcare, which came to be known as the Declaration of Alma-Ata.[25]

WHO was again seen as the principal leader in global health governance, as nations throughout the world looked to WHO in promoting primary healthcare under the Declaration of Alma-Ata. With increasing international cooperation in health, WHO in 1980 achieved a vertical, disease-specific achievement that became WHO's crowning achievement: the eradication of smallpox.[26] Yet, the commitments made in Alma-Ata were never fully realised. The rise of neoliberal economic agendas and the promotion of low-cost, results-driven health interventions pushed WHO away from the Declaration of Alma-Ata and towards a narrower focus on 'selective' primary healthcare, which centred on disease-specific technological interventions rather than comprehensive strategies to advance public health.[27] In this pushback against WHO's health for all strategy, high-income nations steadily reduced financial contributions to the WHO budget just as the Organisation faced a novel threat in the HIV/AIDS response.

The global AIDS response

Since its first reported cases in 1981, the HIV/AIDS pandemic has changed the world. The AIDS community mobilised and demanded fundamental reforms from the ground up. People living with AIDS demanded robust research funding, expedited regulatory approvals and affordable access to treatment. They fiercely opposed traditional disease control policies, including compulsory testing, named reporting, travel restrictions and isolation or quarantine. Advocates saw coercive measures as violations of human rights and personal liberty, and pushed for a rights-based approach to health.

The upheaval caused by the HIV/AIDS pandemic profoundly changed WHO. In the early period of burgeoning fear, stigma and discrimination, WHO established the Global Programme on AIDS (GPA), led by Jonathan Mann. Mann saw the pandemic through a human rights lens, advancing the idea that public health and human rights were not in tension but synergistic.[28–30] Conceptualising human rights violations as a key driver of HIV, the GPA operationalised human rights in WHO programming.[31]

WHO's 1987 Global Strategy for the Prevention and Control of AIDS solidified human rights principles,

including non-discrimination and equitable access to care, in WHO governance.[32] The UN General Assembly underscored WHO's human rights leadership, resolving to ensure 'a coordinated response by the United Nations system to the AIDS pandemic'.[33] The GPA became the largest programme in WHO's history but came under fire by then director-general Hiroshi Nakajima, whose efforts to rein in GPA's independent advocacy led to Mann's resignation—stymieing WHO's human rights advocacy and leaving WHO's AIDS programming in disarray.[34 35]

Proliferation of global health actors

The global health and development landscape expanded rapidly in the late 20th century, with WHO struggling to maintain its institutional authority. Conservative donor states pushed a 'neoliberal' agenda for international development, shifting funds away from WHO and towards vertical initiatives with more narrow mandates.[36] With this neoliberal approach driving increasing World Bank investment in the health sector, low-income countries were pushed to privatise health systems and introduce user fees, which were thought to be more economically efficient but led to harmful consequences for national health systems and patients.[37] These shifts weakened WHO's leadership further, limiting its institutional impact and sowing doubts about its constitutional role as the directing and coordinating authority on international health.[38]

A dizzying array of new actors arose to tackle the most consequential global health issues—from HIV/AIDS, tuberculosis and malaria to vaccines and scientific innovations. As the AIDS pandemic grew, states in 1994 created a new governance institution, the Joint United Nations Programme on HIV/AIDS.[39] AIDS would become a dominant theme in other global initiatives in the early 21st century, notably the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund) in 2002 and Unitaid in 2006. The President's Emergency Plan for AIDS Relief in 2003 became the largest aid programme in American history. WHO was no longer the driving force in the global response to the greatest health challenges of the era, as WHO sought to reorient itself to maintain its authority among rising global health partnerships.

The early 21st century saw a multilevel proliferation of global health partnerships, bringing together international institutions and national governments with philanthropic organisations, civil society and transnational corporations.[40] Global public-private partnerships (GPPPs) emerged, often with innovative financing and governance.[41] Beyond the Global Fund and Unitaid, two vital GPPPs were formed to expand scientific innovations and equitable allocation of vaccines and other life-saving products: Gavi, the Vaccine Alliance in 2000 and the Coalition for Epidemic Preparedness Innovations (CEPI) in 2017. These GPPPs were financed and governed by a broad array of public/private actors, with WHO as only one among many partners.

The 21st century also brought a major expansion of global health funding and influence from the Bill and Melinda Gates Foundation. Established in 2000, the Gates Foundation is a major partner in an array of initiatives and GPPPs, including the Global Polio Eradication Initiative, the Global Fund, Gavi and CEPI. Yet, despite this array of new actors, WHO continued to possess unique advantages that set it apart, including a constitutional mandate to lead and coordinate global action, promote international cooperation and adopt international standards.

GLOBALISED CHALLENGES THROUGH GLOBAL HEALTH LAW

From geopolitical divides to unprecedented pandemics, WHO has faced a complex and ever-evolving landscape of global health challenges. The WHA has significant law-making authorities to empower the Organisation to face these challenges through a united normative vision. Despite the Assembly's historical reluctance to use its normative powers, there have arisen significant advances in both 'hard' and 'soft' global health law.[42 43]

Framework Convention on Tobacco Control (FCTC)

With Gro Harlem Brundtland's appointment in 1998, WHO had a director–general with stature and ambition. Although WHO had never before drafted a binding international treaty, Brundtland took on the powerful tobacco industry and succeeded in achieving WHO's first, and to this day only, treaty: the FCTC.[44] The FCTC's bold aim is to protect present and future generations from the devastating consequences of tobacco consumption and exposure to tobacco smoke. Following extensive drafting and negotiation by an intergovernmental negotiating body, the WHA unanimously adopted the FCTC in May 2003. The 'framework convention–protocol' model employed in the FCTC has allowed WHO to achieve wide acceptance of the Convention, and then for the FCTC governing body, the Conference of the Parties, to develop more specific tobacco control obligations over time.[45]

International Health Regulations (2005)

The IHR serve as the primary instrument for the prevention, detection and response to potential public health emergencies of international concern. Following longstanding calls for their reform, the IHR were significantly revised in 2005 following the SARS outbreak.[46] The 2005 revision solidified WHO's legal authority 'to prevent, protect against, control and provide a public health response to the international spread of disease'[47] while avoiding unnecessary interference with international traffic and trade and safeguarding human rights in the public health response. Looking beyond specific infectious diseases, the IHR (2005) adopted an 'all-hazards' approach, addressing 'any illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans'.[48] The Regulations required governments to build and maintain core health system capacities[49] while also urging high-income states

Table 1 WHO soft law

Resolutions	Declarations	Recommendations
► WHA 64.5: Pandemic Influenza Preparedness Framework (2011). ► WHA 72 Global Action on Patient Safety (2019).	► Declaration of Alma-Ata on Primary Health Care (1978). ► Declaration of Astana on Primary Health Care (2018).	► WHO recommendations on maternal and newborn care (2022). ► WHO recommendations for routine immunisation (first issued 1984).
Strategies and action plans	**Guidelines and codes**	**Global compacts**
► WHO Global Strategy on health, environment, and climate change (2020). ► WHO Global Strategy for food safety (2022–2030). ► Comprehensive Mental Health Action Plan (2013–2030). ► WHO Global Action Plan to Promote the Health of Refugees and Migrants (2019–2023).	► International Code of Marketing of Breast-milk Substitutes (1981). ► WHO Guidelines for Malaria (first issued 2021). ► WHO Guidelines on the Management of Chronic Pain in Children (2021). ► WHO Consolidated Guidelines on Tuberculosis (first issued 2011). ► WHO Global Code of Practice on the International Recruitment of Health Personnel (2010).	► Global Noncommunicable Disease Compact (2020–2030). ► WHO Global Diabetes Compact (2021). ► Global Health and Care Worker Compact (2022).

to collaborate and assist low-income states.[50] Yet, despite these evolving obligations to support public health capacities and meet IHR responsibilities, many states failed to develop core capacities, and international assistance remained insufficient.

Soft law

Beyond hard law, WHO has adopted an array of soft instruments, including WHA resolutions, guidelines, global strategies, global compacts and declarations (see table 1). While soft law does not create binding obligations under international law, it can nevertheless be politically persuasive and normatively authoritative.[51] WHO often opts for soft law, as it is generally faster and easier to negotiate than hard law. Moreover, soft law can sometimes set the stage for hard law treaties, as seen in the FCTC.[52]

Soft law instruments have come to incorporate binding elements and significantly influence both WHO programmes and national policies. The 2011 Pandemic Influenza Preparedness (PIP) framework reflects a new bargain in global health, with countries agreeing to share influenza viruses with human pandemic potential (needed for surveillance and development of medical countermeasures), and in return, assuring that low- and middle-income countries gain equitable access to the fruits of scientific sharing.[53] Beyond WHO, soft law instruments have proven influential in binding the world together to advance sustainable development, with a 2015 UN General Assembly resolution establishing the 2030 Agenda for Sustainable Development, which now guide a host of global priorities under 17 ambitious Sustainable Development Goals.[54]

THE COVID-19 PANDEMIC: ONGOING REFORMS TO STRENGTHEN WHO

Despite these governance advancements, the COVID-19 pandemic has caused untold human suffering, vividly revealing a global system rife with unconscionable health disparities. SARS-CoV-2 circumnavigated the globe within weeks, exposing the fragility of the international legal order. Borders closed; businesses shuttered; education was disrupted; and daily life was brought to a standstill.[55] Human rights were systematically violated.[56] WHO was thought to be prepared, reflecting fundamental reforms undertaken after its widely criticised response to the West African Ebola epidemic.[57] For the first time in its history, WHO developed operational capabilities through its new Health Emergencies Programme in 2016.

Yet the COVID-19 pandemic exposed gaps in global health law, revealing the limitations of WHO governance under the IHR in (1) state reporting of public health risks, (2) WHO coordination of national responses and (3) global solidarity in a common response. States failed to report public health risks rapidly to WHO, particularly China's initial reporting delays, hampering WHO's ability to understand the scope of the threat and coordinate the international response. Once WHO declared an emergency, states imposed overwhelming restrictions on international traffic, individual rights and global commerce, contravening WHO recommendations and undermining global solidarity.[58]

Governance gaps in social protection resulted in widening inequalities both within and among countries. The Access to COVID-19 Tools Accelerator (ACT-A) became the signature initiative to promote equitable access to medical resources. In this initiative, WHO was only one of many partners governing ACT-A, ranging from CEPI, FIND, Gavi, the Global Fund and Unitaid to the World Bank, Wellcome, and the Gates Foundation. Following the ACT-A launch, UNICEF and PAHO became delivery partners for COVAX, the vaccines pillar.

Nationalist policies undermined ACT-A, which limited its ability to deliver on its pledge to reduce inequitable access to medical resources. Geopolitical tensions undermined WHO, with populist governments undermining

global solidarity, as the United States of America gave notice of withdrawal from the Organisation.[59] Despite WHO's formation of a Scientific Advisory Group on the Origins of Novel Pathogens,[60] bitter disputes endure about how SARS-CoV-2 started in Wuhan.[61] Just when WHO leadership was needed most, the world experienced staggering humanitarian upheaval, economic instability and health insecurity.

The COVID-19 pandemic thus magnified WHO's challenges in serving as a unifying and effective leader amid a changed global health landscape—and against the type of threats that globalisation amplifies. With the pandemic bringing concerted government attention to global health reforms, WHO has arrived at a critical juncture. Will the world have the political resolve needed for true pandemic preparedness and response?[62] WHO is undertaking fundamental reforms, including sustainable financing, IHR amendments and a pandemic accord.[63 64] Both instruments would be binding under international law and are set for presentation to the WHA in May 2024.[63 64] Harmonisation between these legal instruments and enhancing compliance will be essential to their success.[65] These reforms demonstrate the Organisation's commitment to new norms in the COVID-19 era. With political will and concerted action, the world could be better equipped to confront future public health emergencies.

WHO sustainable financing

WHO funding is wholly incommensurate with its constitutional mission to act as the leader and coordinator in global health, with its budget less than the size of a single large teaching hospital in the United States of America. WHO is funded through (1) assessed contributions (ACs), 'membership fees' provided by member states based on the UN principle of 'ability to contribute' and (2) voluntary contributions (VCs) from donors.[66] Forty years ago, ACs comprised 80% of the agency's revenue, but by 2022, that portion had shrunk to 16%. While ACs are predictable and flexible, most VCs are specific and targeted, limiting the Secretariat's ability to use the funds outside of the goals set by donors. With this imbalance significantly impairing WHO's ability to set the global health agenda, the WHA resolved in 2022 to incrementally increase ACs to 50% over the following 8 years.[67]

Amending the IHR

Seeking to codify the lessons learnt from the COVID-19 pandemic, 16 WHO member states proposed 309 amendments to the IHR. With many proposals made on behalf of regions, over 90 member states expressed their dissatisfaction with IHR governance.[68] In its final report to the director-general, the review committee regarding amendments to the IHR (2005) endorsed several values to underpin proposed amendments: equity, solidarity and international cooperation; trust and transparency; and sovereignty.[69] The Working Group on Amendments to the IHR is currently negotiating a final text.[70] As the Regulations are the only near-universal instrument for global health security, states must ensure bold and effective IHR amendments, coordinating these amendments with parallel negotiations on a new pandemic accord.

A pandemic accord

At the height of the pandemic, 25 heads of government and international organisations jointly advocated in March 2021 for a new WHO treaty to galvanise high-level political action.[71] Shortly thereafter, the WHA, in its second-ever special session, launched a global process to draft and negotiate a pandemic accord to strengthen pandemic prevention, preparedness, response and recovery.[72] This pandemic accord will most likely be negotiated as a framework convention, becoming only the second use of WHO's article 19 treaty-making authority in its 75-year history. The pandemic accord's zero draft contains 38 articles, with the most consequential relating to equity, health systems, coordination and cooperation and sustainable financing.[73] The 2021 WHA Special Session established an intergovernmental negotiating body to draft and negotiate the treaty.[74] Like the FCTC, a conference of the parties would oversee the new pandemic accord, with the power to negotiate binding protocols on crucial issues such as equity, financing and accountability.

THE NEXT 75 YEARS: A WHO FIT FOR PURPOSE

There is no substitute for WHO, with an unmatched global membership, democratic legitimacy and constitutional mandate. The world needs a global health leader that has the resources, authority, institutional credibility and evidence-based policies to effectively carry out its normative, technical and operational functions. It needs a global health leader that can catalyse and support domestic and global action to reduce the burdens of disease and to protect populations, from ancient scourges to potentially catastrophic emerging threats like climate change and novel diseases. Moreover, the world needs a global health leader that, in all of its work, fosters national and global systems for health that are inclusive, equitable and unwavering in their commitment to human rights. Creating such a robust WHO fit for purpose for its next 75 years requires at least five major reforms in finance, governance, norms, human rights and equity.

Finance

The WHA resolution to gradually raise ACs to 50% of the WHO base budget—based on 2022–2023 levels—by 2030 represents a modest advance. Even if political leaders fulfil their pledge, it leaves two major governance deficits. First, WHO's overall budget would not increase appreciably. 'Pockets of poverty' would prevail, as seen in inadequate funding for non-communicable diseases (NCDs) and mental health. Second, WHO would be beholden to high-income donors for more than half its budget. The unpredictability of VCs impairs WHO's long-horizon planning and hiring. There is a significant

mismatch between the world's expectations of WHO and its willingness to politically support and sustainably fund the Organisation.

Governance

WHO governance is member state driven, leaving out key stakeholders, and is far less inclusive than modern GPPPs. The Framework of Engagement with Non-State Actors, adopted in 2016,[75] indiscriminately lumps together highly disparate non-state stakeholders, including civil society organisations (CSOs), transnational corporations, philanthropic foundations and academic institutions. To gain even limited voice in the Organisation, non-governmental actors must be in 'official relations' with WHO, a privilege that the executive board selectively grants to large national and regional actors.[76] Consequently, WHO governance rarely reflects the views of affected communities. In turn, CSOs are tepid in their support for WHO, robbing the Organisation of vital advocates in national parliaments.

Norms

While WHO has formidable law-making powers, it has rarely developed robust norms beyond health emergencies and tobacco control. Its twin global health law reforms are bold, but the IHR amendments and a pandemic accord focus solely on health security. WHO has been reticent to codify binding norms on major global health threats. It has never negotiated binding instruments for its health for all strategy—allowing the Alma-Alta Declaration to all but wither. The development of normative standards and innovative financing could accelerate universal health coverage and support the creation of new norms in long-neglected areas, such as NCDs, mental health and injuries.

Human rights

WHO has not vigorously implemented its constitution's proclamation on the right to health or mainstreamed human rights in global health governance. WHO has no formal relationship with the UN Special Rapporteur on the Right to Health, and despite a budding partnership with the Office of the UN High Commissioner for Human Rights, WHO has never operationalised it to advance human rights in global health. There are concrete steps WHO could take to mainstream human rights into its policies and programmes. Gender, equity and human rights were recently elevated to a WHO department but should be elevated to the assistant director level. WHO could develop a right to health action plan to integrate human rights at all levels of the Organisation.

Equity

WHO has a responsibility to address the structural drivers of inequities within and among countries—beginning with disaggregated data—so governments have detailed understandings of who is left behind and why. Equity mechanisms at the global level have been inadequate. ACT-A was unable to deliver equitable resource allocation during the pandemic. WHO has convened a consultation on a new medical countermeasure platform,[77] but its design and financing remain unclear. The pandemic accord zero draft would establish a PIP framework model of access and benefit sharing (ABS), while also seeking greater flexibilities in intellectual property protection. The era where ABS relies on charitable donations should end, replaced by sharing technology and diversification of manufacturing, centred on low-income and middle-income countries.

An inflection point

WHO has had remarkable successes in its first 75 years, from the eradication of smallpox to the advancment of normative instruments on tobacco control and global health security. At its 75th anniversary, WHO is at an inflection point. If WHO can transform its financing, governance and norms; if it can advance the right to health and human rights; if it can create a healthier, fairer world through effective equity mechanisms and partnerships; if it can do all these things and more, WHO could fulfil the vision of the United Nations and its own constitution—becoming the organisation it was always meant to be.

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