

## **E1 | World Health Organization**

The strategic importance of the WHO as the UN's specialist health agency, its many influential programmes and policies at global, regional and national and community levels, and perhaps above all, its humanitarian mission, earn it worldwide authority and guarantee it a central place in this report.

While it may be seen as the leading global health organization, it does not have the greatest impact on health. As many sections of this report illustrate, transnational corporations and other global institutions – particularly the World Bank and International Monetary Fund – have a growing influence on population health that outweighs WHO's. Furthermore, some of these institutions, the Bank in particular, now operate in direct competition with WHO as the leading influence on health sector policy. The rise of neoliberal economics and the accompanying attacks on multilateralism led by the US have created a new, difficult context for WHO's work to which the organization, starved of resources and sometimes poorly led and managed, is failing to find an effective response.

The purpose of this chapter is to explore this decline in WHO's fortunes from the perspective of a critical friend, and suggest how it might begin to be reversed. The problems of global health and global health governance are beyond the reach of any entity working in isolation, requiring WHO leaders and staff, governments, health professionals and civil society to work together in new alliances. A new shared vision of WHO for the 21st century must draw on its strengths, but be reshaped for the modern world, as part of a broader vision of global governance. And then we have to make it reality. The Health for All movement partly succeeded in moving from vision to action: this time round, as inequalities widen and the health of many of the world's poorest people worsens, we have to do even better, because failure will be catastrophic.

### **A complex organization**

Entering the Geneva headquarters of WHO is an awe-inspiring, even intimidating experience. Having made your way there past a series of imposing buildings occupied by a range of famous organizations, including the United Nations and the International Red Cross, and admiring the distant views of the Swiss Alps, you finally reach a huge 1960s block set in a grassy campus. Its interior, gleaming with glass and marble, seems designed to impress rather



**20 Health ministers gather at the World Health Assembly.**

than befriend. Besuited bureaucrats and smart secretaries rub shoulders with visitors from every corner of the globe, and the enormous restaurant offers an exotic menu to match. Upstairs, rather less smart corridors of small cubicles house hundreds of health professionals from all over the world.

The calm, hushed atmosphere is a far cry from the simple bush hut where WHO consultants are encouraging midwives to help new mothers feed their babies from the breast rather than a bottle. It is a long way from the WHO office in a country in conflict where staff operate under conditions of physical danger. Yet all these settings are part of the same organization, the UN's specialized agency for health and the world's leading health body. The immense range of what WHO does and where it does it, the complexity and regional differences in its structures, and the infinite variety of people who work for it and with it, make generalizations about it both difficult and dangerous. Inevitably, too, such a large and diffuse organization provokes strong feelings, from optimism and inspiration to frustration, anger and despair.

This chapter cannot do justice to the full range of WHO activity and the many criticisms and reform proposals. Issues of global health policy are discussed elsewhere in this report. Rather, it will present a brief report card on WHO as an institution. In reviewing recent major criticisms and reforms, it is noted that the critics are long on description but short on solutions. The final part of the chapter therefore focuses on three major drivers of WHO performance – resources, the internal environment of WHO, and the attitudes of member states – and how they need to change.

The sources consulted worldwide in making this assessment include literature written by academics, development agencies, policy analysts, present and former WHO staff members and health journalists. The official views of some member states were reviewed selectively in literature from individual countries and major donor networks. Interviews were conducted with past and present WHO staff members, consultants and advisers, and other observers. The staff members included people working at global, regional and country levels in a range of specialties and fields, at different levels of seniority and from different national backgrounds, some newly arrived in the organization, others long-serving. Many WHO informants felt anxious about speaking openly, and all were interviewed on the basis that they would not be identifiable. The views described here represent an aggregate rather than those of any individual.

### **Some background**

WHO came into formal existence in 1948 as the UN specialist agency for health, incorporating several existing organizations that represented a long history of international health cooperation. WHO's objective is the attainment by all peoples of the highest possible level of health, defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Its constitution also asserts that health is a fundamental human right and that governments are responsible for the health of their peoples – bold statements treated warily by governments who equated social equity and socialized medicine with 'the Communist threat' (Lee 1998). Thus politics and health were inseparable even at WHO's birth.

The importance of health to the global political agenda of the day was reflected in the decision to give WHO its own funding system and a governing body of all member states that is still unique among UN specialist agencies. Its basic composition and overall organizational structure have changed little since 1948. Like other UN non-subsidiary specialist agencies its governing body makes its own decisions, but reports annually to the UN. All UN member states and others may join it. Through the World Health Assembly, its 192 member states approve the programme of work and budget and decide major policy. A 32-strong executive board with rotating membership, selected on the basis of personal expertise rather than country representation (although a geographical balance is maintained), oversees implementation of assembly decisions (WHO global website, 2005). Its accountability to its annual global and regional assemblies of delegations from all member states is unique in the UN system, and offers developing countries unparalleled opportunities to exert influence.

The Secretariat is the administrative and technical organ responsible for

implementing the activities. It has around 3500 staff on fixed-term or career-service appointments, and several thousand more on short-term contracts and secondments, working either at headquarters, in the six regional offices and their outposts and specialist centres, or in WHO offices in around 140 countries. The balance of power and resources between these three main operational levels has been a matter of debate and disagreement since 1948.

A third of the staff are 'professional', among whom the vast majority are medical doctors and two thirds are men, with the proportion of women decreasing at senior levels. The other two thirds are 'general' staff, ie working in administrative and support services, with women disproportionately over-represented. A quota system is meant to ensure a fair distribution of staff from all regions, but in practice is often ignored to recruit a favoured candidate, especially when a very specialized set of skills/experience is required.

As well as these directly appointed staff, a huge variety and number of people worldwide work on projects or in centres funded or supported by WHO. Many different institutions have evolved in partnership with WHO to meet particular needs, with an infinite variety of funding and governance arrangements. Hundreds of designated WHO Collaborating Centres conduct jointly agreed programmes of work, sometimes strongly supported with funds and secondments from member states. No organogram could successfully capture the range and complexity of the WHO family, a fact that highlights the many challenges of achieving good overall governance.

*Milestones* A look at some of WHO's major historical milestones (Lee 1998) illustrates the magnitude of its challenges, the complexity of the environment in which it operates, and some of its successes. It also shows the longevity of its leadership, with only six directors-general (DG) in nearly 60 years. Each has led or at least presided over significant change. Best remembered is Dr Halfdan Mahler, DG from 1973–1988, whose term of office is often spoken of as a golden age of WHO and perhaps of global health in general. He established WHO as a global 'health conscience', challenging the commercial practices of transnational corporations in the pharmaceutical and food industries. He initiated or endorsed such key initiatives as the expanded programme on immunization, the model list of essential drugs, the international code on breast milk substitutes, and – the jewel in the crown – the Alma Ata declaration (discussed in detail in part B, chapter 1).

Mahler's visionary and inspirational leadership was always going to be a hard act to follow. It was the misfortune of his successor Dr Hiroshi Nakajima not only to lack those qualities but also to take office at a time when neoliberal

*Box E1.1 Milestones in WHO history*

- 1948 WHO established as the UN's specialist agency for health. April 7, when its constitution approved, becomes World Health Day. First World Health Assembly (WHA) attended by 53 member states. Mass treatment programmes begun for syphilis.
  - 1951 WHO member states adopt the International Sanitary Regulations (later renamed the International Health Regulations, they are the only binding rules governing international health).
  - 1955 Intensified malaria eradication programme launched.
  - 1959 WHA commits to global eradication of smallpox (lack of funds means programme not started till 1967). First *World health situation report*.
  - 1964 WHA withdraws South Africa's voting rights in protest against apartheid. South Africa leaves WHO.
  - 1965 WHO puts forward the basic health services model.
  - 1973–88 Dr Halfdan Mahler is third director-general.
  - 1974 Expanded programme on immunization created.
  - 1977 WHA proposes Health for All by the Year 2000. Publishes model list of essential drugs. Last natural case of smallpox identified.
  - 1978 Alma Ata declaration on primary health care signed by 134 countries.
  - 1981 WHA adopts international code on the marketing of breast-milk substitutes.
  - 1982 Consultative meeting on AIDS in Geneva.
  - 1986 Ottawa charter for health promotion signed.
  - 1988–98 Dr Hiroshi Nakajima is fourth DG.
  - 1995 First WHO *World health report* published.
  - 1998–2003 Dr Gro Harlem Brundtland is fifth DG.
  - 2000 Commission on Macroeconomics and Health established; *World Health Report* on health systems.
  - 2003 Dr Lee Jong-wook is sixth DG. Launches 3 by 5 initiative. WHO Framework Convention on Tobacco Control.
  - 2005 Commission on Social Determinants of Health established.
- (Source: most data drawn from Lee 1998)

health policies were beginning to supersede the social justice model of health for all. The backdrop was a global ideological shift to the right, accompanied by economic recession, oil crises and rising debt. WHO's core funding remained

static while new actors entered the health field and challenged its leadership role. Even those who did not much like what the World Bank said about the route to better health nevertheless felt obliged to accept its large loans conditional on implementing market-oriented health sector reforms.

At the same time, new health threats demanded urgent responses – arising from AIDS and other newly emerging diseases, from complex emergencies combining armed conflict with human or natural disasters and social disintegration, and from demographic and social shifts (Lee 1998, Buse and Walt 2002). Nakajima struggled and ultimately failed to come up with convincing responses to these challenges, also alienating WHO staff and partners through his management style, high-profile disagreements and communication failures. Few lamented his departure.

The election in 1998 of Dr Gro Harlem Brundtland, who combined a medical background with national and international political experience, was widely welcomed. She set about pushing health higher up the international development agenda, through initiatives like the Commission on Macroeconomics and Health that explored the relationship between economic growth and health. Her most acclaimed achievements included putting health on the agenda at the summit where the UN Millennium Development Goals were agreed, and persuading all member states to endorse the 2003 WHO Framework Convention on Tobacco Control, the world's first public health treaty (see part E, chapter 4). There are mixed views about her tenure, during which WHO also strengthened its organizational and ideological relationship with the World Bank and encouraged and pursued controversial public-private partnership initiatives (Buse and Walt 2002).

Meanwhile Brundtland introduced sweeping internal reforms aiming to make WHO more businesslike and results-oriented. New top managers were appointed and large numbers of staff redeployed in a major restructuring that gradually eroded the internal optimism generated by her appointment (Lerer and Matzopoulos 2001). Many staff felt that it was just change for change's sake, or for the sake of promoting people who were in favour not necessarily for the right reasons, and the organizational climate was uncomfortable. At the end of her five-year term WHO remained centralized and top-heavy, still dominated by white men from developed countries (Yamey 2002).

The appointment of her successor Dr Lee Jong-wook was likewise initially greeted enthusiastically by many staff who felt that an insider would handle internal matters more sensitively – he has worked in WHO since 1983 – though others were concerned that his experience was too strongly rooted in vertical programmes, and that he was susceptible to US influence. Hopes were further

raised by his attempts to revitalize WHO's commitment to Health for All, in contrast to Brundtland's more neoliberal focus.

After 18 months in post (at the time of writing) it is too early to pass definitive judgement. Lee's flagship initiative to treat three million people with AIDS with antiretroviral therapy by the year 2005 (known as 3 by 5) demonstrates a passionate, high-risk approach that has divided staff and partners, arousing both support and opposition. The influence of private foundations (e.g. Gates) and public-private partnerships (e.g. GFATM, GAVI) continues to grow and the question of WHO's place in this emerging configuration is still unresolved. Meanwhile the new Commission on Social Determinants of Health could represent an important advance.

Many of these shifts in WHO policy and management over the decades were reflected in the six WHO regional offices, though their locally elected regional directors (RDs) exercise considerable autonomy from headquarters. The changes gradually filter down through the regional offices to the WHO country offices they administer, although these too may enjoy much independence from a distant regional centre that sometimes has only limited knowledge of what is going on in the field. Seen by many as the most important focus of WHO activity, and promised a stronger role in the Lee reforms, most of the country offices remain attached to low-prestige ministries of health, and are weak and inadequately resourced in comparison with the country-based offices of other international organizations and government development agencies.

### **Current context: recent successes**

Even the harshest critics admit that WHO can claim many important achievements since 1948. Many are highlighted elsewhere in this report. In disease prevention and control WHO led the global eradication of smallpox. It is making good progress towards eradication of poliomyelitis, leprosy and dracunculiasis, and ongoing efforts to tackle malaria, cholera, tuberculosis and HIV/AIDS (albeit inadequately funded and unlikely to reach the desired targets). Its leadership role in collecting, analyzing and disseminating health evidence is unrivalled. It is the leading global authority preparing guidelines and standards on numerous issues, and the foremost source of scientific and technical knowledge in health.

In many countries it remains the best trusted source of objective, evidence-based, ethically sound guidance and support on health. Since Lee's appointment as DG it has regained some of its reputation as the world's health conscience, and facilitation of an effective global response to the severe acute respiratory syndrome (SARS) outbreak has underlined its critical public health

role. 'It is for all (this) work that the world recognises the need for WHO as a cornerstone of international relations' (Lee 1998).

Many formal and informal evaluations and commentaries on WHO mention its traditional strengths (for example Godlee 1997, Lee 1998, Lerer and Matzopoulos 2001, Wibulpolprasert and Tangcharoensathien 2001, Buse and Walt 2002, DFID 2002, Minelli 2003, Selbervik and Jerve 2003, Kickbusch 2004, Murray et al. 2004, interviews and personal communications). These include:

- advocacy for marginalized population groups such as the poor, people with AIDS and people with mental illness;
- performing important global communicable disease surveillance and control functions, as with SARS;
- production of authoritative guidelines and standards that support excellent practice;
- global, regional and national health reports and cross-country studies providing an evidence base for policy, practice and advocacy;
- excellent staff whose technical expertise and international health experience are unsurpassed;
- provision of effective technical support in some countries, within tight resource constraints;
- promotion of agendas that are value-based, knowledge-based and support health, rather than ideologically driven or politically motivated;
- innovative intersectoral programmes such as Healthy Cities.

There is also praise for recent work, some of which builds on these traditional strengths, and some of which is taking WHO into new areas of work:

- returning health to the international development agenda;
- good practical and analytical work on key areas such as violence and health and complex emergencies;
- the gradual renaissance of primary health care and health promotion, including challenges to commercial interests that damage health;
- interagency alliances such as the Partnership for Safe Motherhood and Newborn Health;
- active support for a greater investment in relevant and applied health systems research;
- emerging innovative approaches to knowledge management using new technology;
- more active and transparent engagement in WHO reform processes with some influential member states, such as the Multilateral Organizations Performance Assessment Network of eight leading donor countries;



- stronger internal focus on performance management and results;
- better training of WHO staff, for example on human rights;
- effective advocacy for global tobacco control and access to medicines.

A controversial review of its partnership with WHO by the UK Department for International Development pronounced it ‘an improving organization’ (DFID 2002), while others note how WHO has begun to ‘refashion and reposition itself as the coordinator, strategic planner, and leader of “global health” initiatives’ (Brown et al. 2004). Much of this praise, however, has a ritual air, run through rapidly as an appetiser to the main dish – strong criticism.

### **Current context: major criticisms**

The often contradictory accusations and criticisms of WHO reflect the existence of a wide range of critics, with different agendas. A number of criticisms emanate from interests that want to weaken WHO’s mandate and capacity to tackle urgent global health problems, especially poverty, or to challenge the hazard merchants (commercial enterprises profiting from products that damage health). Other criticisms reflect frustration over WHO’s lack of political will and strength to tackle the drivers of poverty and health inequity, and its inefficiencies. Of the latter group, the following bullet points represent a selection of the more common criticisms:

- WHO’s ‘vertical’, single-focus disease control programmes, reflecting the continued domination of biomedical thinking, are said to lack impact or sustainability and to hinder systemic, intersectoral approaches.
- The balance between normative, global standard-setting activities and technical cooperation with countries is said to be wrong.
- Its priorities are constantly skewed by intense political pressure from member states.
- Its multiple and sometimes conflicting roles as advocate, technical adviser, monitor and evaluator limits its ability to discharge functions such as independent global reporting.
- It has not built effective partnerships with civil society.
- Its relations with other major international agencies, such as the Global Fund for AIDS, TB and Malaria, are dogged by turf wars.
- It is said to be compromising on values and moral principles by entering into public-private partnerships with business interests whose activities it should be condemning rather than courting.
- Its leadership is accused of being ineffective and is beset by rumours of corruption and nepotism.

- Its management is top-heavy, hierarchical, overpaid and centralized, ruling autocratically over an entrenched, bureaucratic subculture.
- Its staff are dominated by professionals from developed countries with insufficient experience of poor countries.

These criticisms and others appear in hundreds of books, articles and speeches and their range and scope is enormous. They may appear unbalanced simply because of the tendency to focus on bad news rather than good news. Some are diametrically opposed. Some reveal a tendency to use WHO as a scapegoat and a desire for quick-fix solutions. Strong critiques come from member states, often off the record, who then vote differently in WHO fora, act in ways that undermine or manipulate the organization, and fail to support the progressives within. The criticisms made by WHO staff and consultants are usually at least as tough as those of external academic observers, but also more rounded as their experience perhaps makes them more aware of the positives.

The problems laid at WHO's door are not just many, but are often way beyond its control. It is tempting to underestimate the complexity of the challenges, or to view the problem as the failures of an individual organization rather than a collective global one. Moreover, similar criticisms are being levelled at other international agencies in the prevailing mood of widespread discontent with the UN system and weak international governance (see the other chapters in part E). A recent survey commissioned by leading donor countries found the performance of WHO, UNICEF and the World Bank perceived to be broadly similar by its informants (Selbervik and Jerve 2003).

Finally, and perhaps crucially, the critiques are long on description and accusation, and short on practical solutions. There is little consensus about what needs to be done beyond indisputable statements about tackling poverty and inequality. The most powerful group of commentaries call for stronger global health governance. According to Buse and Walt (2002), globalization requires novel arrangements for health governance in which partners work together – international organizations; nation states; and global and local private, for-profit and civil society organizations. They ask how the present patchwork of alliances and partnerships in health can move towards a system of good global governance without losing their energy and creativity. Kickbusch (2004) says this means strengthening WHO and giving it a new and stronger mandate, including ensuring 'transparency and accountability in global health governance through a new kind of reporting system that is requested of all international health actors', even taking countries to an international court for crimes against humanity if they refuse to take action based on the best public health evidence and knowledge.



## 21 WHO – up in the clouds?

Reactions have been mixed to this idea of WHO as a ‘world policeman’ but director-general Lee at least agrees that ‘business as usual’ will not do. He promises a return to the aims and ethical commitments of Health for All – scale-up of health systems, guided by the principles and practice of primary health care, adapted to a rapidly changing health landscape and delivered through synergizing swift responses to health emergencies with long-term strengthening of health infrastructure. Asserting that a world torn by gross health inequalities is in serious trouble, he asks whether WHO and its partners are up to the challenge, and gives his answer: ‘We have to be’ (Lee 2003).

Yet can WHO make the enormous internal shifts in culture and practice and develop the leadership capacity essential at all levels to turn Dr Lee’s rhetoric into reality – to drive good global health governance, secure the necessary resources and deliver effective programmes? And can the other global health leaders sink their differences to support WHO and each other in a new spirit of co-operation and commitment? The prospects for WHO reform will now be considered with reference to its resources, internal environment and political context.

### **Inadequate resources**

Standing in the marble halls of WHO headquarters in Geneva, or seeing a WHO official check in to fly business class to a distant location, it is hard to imagine that the organization is in a long-running funding crisis. But

appearances can be deceptive. The global WHO biennial budget of US\$ 2,223 million for 2002 and 2003 was woefully inadequate for its purpose. It is a tiny fraction of the health spending of any high-income member state: equivalent, for example, to just over 0.5% of the approximate budget spent on England's national health service at the same time (Department of Health 2004).

WHO's core budget was US\$ 843 million for those two years. The ratio of core funds to extrabudgetary funds (voluntary donations from all sources) is therefore approximately 1 : 2.6. Each member state's contribution to the regular budget is determined by a complex formula that takes the size of its economy into account, so the percentage to be contributed (though it is not always paid) ranges from 0.001% to 25% of WHO's core funding (the latter from the US). Since the early 1980s WHO, along with other UN agencies, has had zero growth in its regular budget, whose value in real terms has diminished dramatically. Some countries fail to pay their dues on time, whether through indolence or policy. The US only pays 80% of its levy because of its dissatisfaction with WHO (and other UN agencies). The amounts are in any case modest. For example, the UK contributes only US\$ 22 million a year to the WHO regular budget (DFID 2002) – just 0.02% of England's national health service budget in 2004 – though it gives much more in extrabudgetary funds.

It is often mistakenly assumed that WHO is a donor agency. When hoping to start a new training programme for nurses, say, or an advocacy campaign on destigmatizing mental illness, people often say, 'Let's ask WHO for money.' In fact, in order to function, WHO itself has to take its begging bowl to countries, other agencies and charitable foundations and is increasingly turning to public-private partnerships (Buse and Walt 2002). The rich countries prefer to exert greater control over their money by giving WHO extrabudgetary funds earmarked for specific projects, rather than more core funding. Competition for such money is cut-throat and requires excellent internal coordination, as well as intensive input from professionals whose sole function is fundraising. Both are lacking in WHO so much time and effort is wasted. Programmes compete against each other for funds, internally and externally, while staff hired for their technical knowledge reluctantly find themselves fundraising. Thus the donors help to sustain an incentive system by which WHO must compete with itself, and with other organizations, for scarce funds, resulting in inefficiency and waste of human resources.

The most important negative consequence, however, is that health priorities are distorted and even neglected to conform with the desires of donors and the requirement to demonstrate quick results to them and their political paymasters. WHO has felt obliged to sideline the primary health care approach

in favour of so-called 'vertical' programmes that focus on controlling specific diseases to specific targets – 'a case of the tail wagging the dog so vigorously as to make it almost dysfunctional and disoriented' (Banerji 2004). This epidemic of donor-driven programmes is not cost-effective, not sustainable, and may damage health system infrastructures. WHO cannot fairly be blamed for it, since it is so often undermined by big global health initiatives, the focus of major donors on NGOs, and the policies of government donors and huge foundations like Gates; but it does stand accused of not fighting hard enough against the trend.

Other problems arise from the trend towards public-private partnerships: first, the way in which WHO's ability to safeguard the public interest is potentially compromised by greater interaction with the commercial sector. Programmes jointly funded and implemented by a consortium of public and private partners may, if care is not taken, inappropriately benefit the private partners rather than the target populations. Yet safeguards against conflicts of interest are underdeveloped in WHO. Second, there has been little consideration of whether it would be better to find alternatives to partnerships with business, given the fragmentation caused by adding further institutional partners to the international health aid mix (Richter 2004).

Most WHO programmes and departments have to spend their budget allocation on salaries and overheads rather than programme activities. This has far-reaching negative implications in the absence of adequate programme funding, or good coordination between or even within departments, or properly resourced central functions (for example, translation, interpretation and publishing). In one important and fairly typical HQ department, the biennial cost of employing over 30 staff runs into several millions of dollars while the regular programme budget is only US\$ 500,000, supplemented by very few extrabudgetary funds. Thus staff run essentially separate programmes that are barely funded from the regular budget, and in some cases barely funded at all.

All this has a strong impact on the organizational climate and staff development. While some motivated staff move elsewhere, many of those who remain for many years, often described as 'dead wood', have few other attractive options. Too many are stuck in a honey trap – they cannot afford to leave as similar employment back home may not pay so well, especially in developing countries. WHO staff members in professional grades in headquarters and regional offices have tax-free salaries, an excellent pension scheme and many other benefits, although they often also pay for two residences, one at home and one in their duty station, and other expenses such as school fees.

The hundreds of staff who work for long periods in WHO offices on a series of rolling short-term contracts are by contrast poorly paid and have few benefits. This saves the organization money and gives it greater power to hire and fire, but it damages the security and often productiveness of the individual worker, while undermining the effectiveness and sustainability of many programmes.

### **The internal environment: Jurassic Park or Changing History?**

New posters appeared all over WHO headquarters early in 2004 promoting its latest world health report (WHO 2004). No-one disagreed with its main message, a call for a comprehensive HIV/AIDS strategy, but its title caused tongues to wag furiously. *Changing History* was doubtless chosen to inspire WHO staff and partners to redouble their efforts in the battle against the pandemic. Many people, however, did not see it that way. It seemed to them just another example of the WHO leaders' delusions of grandeur: believing that WHO can change history when it cannot apparently even change itself.

This lack of capacity in management and leadership is just one of a formidable array of hindering forces that compound the funding problems described above. It receives special attention here for three main reasons. First, whatever changes occur in its external environment, WHO will not be able to improve without better leadership and management. Second, the policy analysts, academics and public health specialists who are the biggest group of published commentators on WHO pay it little attention beyond repeating the criticism. Third, reform from within is directly within WHO's grasp, unlike many of the other challenges it faces, and is therefore a good starting point.

In the interviews conducted for this chapter, a pattern of apathy, anger, cynicism and despair emerged. The positive talk mostly comes from the successful people at the top or from the idealistic newcomers, but not from the vast majority in the middle. People often like complaining about their bosses, but this is of a different order and the pervasively depressed but frantic mood inside WHO is a cause for huge concern. Neither is it new: the atmosphere changes so little over the years that when long-term WHO-watchers and workers return after an absence they feel they are in a time warp.

It is not only low morale that contributes to the time warp feeling. Most programmes continue to lack the human and financial resources needed to achieve their ambitious goals. Most staff still work extremely hard to achieve the impossible, though a few escape into endless, pointless duty travel or hide away in front of a computer producing the 10th or 20th draft of a paper that few will ever read, still less act on. People feel unsupported and unable

to speak openly, while bullying and sexual harassment are swept under the carpet. Despite the efforts of dedicated individual staff members, there are too few effective functioning mechanisms to give staff a collective voice or handle grievances well, let alone a robust, independent personnel department to lead much-needed improvements.

What happens to turn people motivated by altruism, full of ideas and expertise, and determined to make a difference, into tyrannical, cynical or fearful bureaucrats? The obvious answers are lack of leadership and poor management. Few staff have the necessary management skills when they start work in WHO, and little is done to develop them. Most senior WHO leaders are promoted from within, so they know their own system extremely well but may have had little exposure to different and better ways of doing things. Moreover, an overwhelming majority of the professional staff are doctors – an extraordinarily archaic feature given that teamwork, collaboration and intersectoral, interdisciplinary approaches are such frequent WHO buzzwords. Where are the nurses, social scientists, psychologists and action researchers? The doctors may have important medical knowledge but their training and professional socialization on the lone hero model rarely teaches them how to be effective managers or interdependent team members (Davies 1995).

The WHO regional offices have been scrutinized to a varying degree, depending on the openness of the regional directors. They tend to be elected on reform platforms, yet the politically charged environment, the corrosive effects of power and status, and their desire to ensure they are re-elected can gradually dampen their zeal. For example, in 1994 growing dissatisfaction with European regional director Dr Jo Eirik Asvall led to an unprecedented open letter from a significant number of programme managers, asking member states for active help with reform. Their pessimism contrasted with the upbeat earlier years under Asvall and his predecessor Dr Leo Kaprio (RD from 1967–1985), when Health for All guided and inspired the values, structure and programmes of the regional office.

The open letter changed little, and Asvall was re-elected in 1995. When he retired in 2000 hopes were high that his successor Dr Marc Danzon, who did not sign the letter but had seemed sympathetic to its messages, would provide a fresh approach. Yet his reaction to an external evaluation of WHO health care reform programmes in 2002 highlighted how such expectations had largely been dashed. Although pressure from member states ensured the report was presented to the next regional committee, there was no sense that it was ever taken seriously.

An internally commissioned programme review from the same period

found that the organizational culture of the European regional office was characterized by ‘scarcity affecting competition and creating a prevailing climate of insecurity and protectionism that stands as a fundamental barrier to integrated working’ (Panch 2002). It noted programme managers’ limited experience of multiagency working, and a pervasive lack of communication between programmes. The regional office was considered a peripheral presence in member states and its support of health systems development was described as incoherent, inward-looking, and reluctant to relinquish its historical ascendancy. Its lack of management capacity was also noted. All these shortcomings were reported by staff themselves and their sense of frustration was palpable.

These problems are not peculiar to the European regional office, which is considered by no means the worst performer of the six regional offices. The African regional office in particular has been strongly criticized in recent years (*The Lancet* 2004), along with most of the African country offices, including charges of inefficiency, nepotism and corruption.

### **The political context: power games**

*Member states* A third set of forces interacts with and compounds the funding and capacity problems described above: the attitude of member states. Their influence on the organization through the World Health Assembly, regional committees and collaborative country agreements, combined with their role in electing the DG and RDs, helps create an intensely political environment in which power games can easily supersede health goals.

In the race for top positions, both elected and appointed, support from the candidate’s own country may be decisive. Improper pressure may be exerted to ensure a particular appointment or secure votes from weaker countries. Getting your own national elected – regardless of suitability for the role – is the overriding concern in the crude arena of global politics. Thus the Japanese government manoeuvred strongly for the re-election of Dr Nakajima even though his first term showed no progress and support for him was waning. Furthermore, incumbent candidates are tempted into making pre-election promises to countries to attract their vote, promises that are not necessarily in line with agreed organizational priorities or health needs. These are familiar problems with electoral politics, and perhaps the surprise is that senior WHO staff are still regarded as technocrats first and politicians second, rather than the other way round.

Many member states, particularly developing countries, would like WHO to play a stronger stewardship role in bringing together and helping coordinate the role of international and bilateral agencies and international NGOs to de-



velop a unified, purposeful health strategy and activities to implement it. They see WHO as the natural international leader here, a trusted, independent and honest broker with strong humanitarian values that advocates adherence to key principles and international agreements.

Strengthening WHO's presence in countries technically, financially and politically could be a means of helping countries to develop a policy framework for better health that enables them to decide what donor assistance they want and to control it effectively. The senior WHO post in a country should be held by a highly qualified senior expert with director status, supported by an able team of national staff and rotated staff from elsewhere in WHO. A greater country focus, as promised by Dr Lee (and his predecessors, without very visible results), could counterbalance the centralized bureaucracy in HQ and regional offices – while recognizing that good intercountry work, including setting global and regional norms and standards, grows from and synergizes the bottom-up, intersectoral, collaborative approach to planning and implementation in countries.

The countries that are most in need of WHO support are usually, however, those with the least power and influence. The US and other OECD countries exert tight control over WHO, not least because of their control of funding. Recent public discussions have shown how the US in particular continually pressurizes WHO to steer clear of 'macroeconomics' and 'trade issues' that it says are outside its scope, and to avoid such terminology as 'the right to health'. The lack of consensus among member states about WHO's mandate naturally reflects the conflicts within the international order.

*Civil society* One way of circumventing inappropriate pressure from member states and other global institutions is to promote transparency and greater accountability to civil society. However, civil society's role in WHO is quite restricted. Around 200 civil society organizations are in 'formal' relations, meaning they can participate in WHO meetings, including those of the governing bodies (the Assembly and the executive board) where they have a right to make a statement – although not a vote. Another 500 organizations have no formal rights but 'informal' relationships with WHO, mostly through contacts made on work programmes. Both private for-profit and private nonprofit NGOs are included in the WHO definition of civil society, raising controversy about conflicts of interest and highlighting the need for policy-makers to distinguish between public-benefit and private-benefit organizations.

Perhaps mindful of her battles with member states during the row over the 2000 *World Health Report*, the higher profile of CSOs in securing access

### *Box E1.2 WHO and the People's Health Movement*

The idea of a People's Health Assembly emerged in the early 1990s when it was realized that WHO's World Health Assembly was unable to hear the people's voices. A new forum was required. The first People's Health Assembly in Bangladesh in 2000 attracted 1500 people – health professionals and activists from 75 countries. A common concern was the sidelining by governments and international agencies of the goals of Health for All. The dialogue led to a consensus People's Charter for Health, the manifesto of a nascent People's Health Movement, which is now a growing coalition of people's organizations, civil society organizations, NGOs, social activists, health professionals, academics and researchers. Its goal is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities.

The assembly agreed that the institutional mechanisms needed to implement comprehensive primary health care had been neglected. The dominant technical approach – medically driven, vertical and top-down – was reflected in the organizational structure of many ministries of health and of WHO itself. Since then, the links between the Movement and WHO have grown stronger, boosted by the interest of incoming director-general Dr Lee.

'Grassroots movements are enormously important, especially in the health field,' Dr Lee told PHM representatives at a meeting in 2003. 'These movements bring the views, feelings, and expressions of those who really know. It seems almost hypocritical for WHO people here in Geneva to be talking about poverty – here, as we pay \$2 for a cup of coffee, while millions struggle to survive and sustain their families on \$1 a day. For this very reason, we urgently need your input. We need to hear the voices of the communities you represent. It is vital for WHO to listen to you and your communities.'

Since 2000, PHM has called for a radical transformation of WHO so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests. It has made a wide-ranging series of recommendations to WHO, summarized in the Charter and available at <[www.phmovement.org](http://www.phmovement.org)>.

to medicines, and the mobilizing role of the first People's Health Assembly in 2000, Brundtland tried to raise the civil society profile, notably through the establishment of the Civil Society Initiative. These attempts have been hampered by member states and no new policy on the issue has been agreed, although meetings between Dr Lee and the People's Health Movement have been positive (Box E1.2). Greater openness to CSO involvement would bring many benefits, including closer scrutiny of policy and an institutionalized challenge to the ability of member states and corporate interests to bully WHO. It would also increase the political challenges of the environment in which WHO works, while CSOs would have to be accountable and differentiated on a public-interest basis.

*Relations with other international agencies* The diminished power of WHO in relation to the World Bank has been noted elsewhere in this report. The controversial nature of the Bank's policy advice to developing countries has barely been challenged in public by WHO, and for a period in the 1990s they often sang from the same hymn sheet. At other times WHO has been forced to take a weakened position: for example, its guide to the health implications of multilateral trade agreements was watered down under pressure from the World Trade Organization (Jawara and Kwa 2003). At country level WHO officials often find themselves in competition with the Bank: while the World Bank has a mandate that also includes influencing and interacting with the more powerful trade and financial ministries, WHO's mandate tends to be restricted to the health sector.

There have recently been signs of a change, with WHO making statements about restrictions on health spending imposed by the Bank and the International Monetary Fund. However, it is woefully lacking in social policy specialists, economists, and trade and intellectual property lawyers who could help create an alternative agenda. The headquarters department of health and development which should be responsible for these efforts has been reorganized twice in three years. Yet WHO's understanding of health and health systems must be rooted in a strong analytical framework in which social, economic, cultural and political determinants are taken into account. The present technomanagerial analysis, predominantly biomedical rather than social, is inadequate and leads to weak or skewed solutions.

### **Some ways forward**

Woefully inadequate resources, poor management and leadership practices, and the power games of international politics are just some of the forces

hindering sustainable change in WHO. The obstacles to change are powerful and in many ways are similar to the difficulties of achieving lasting change in the international order or in successfully reforming health care systems.

The revival of the Primary Health Care Approach (part B, chapter 1) is advocated by Dr Lee and supported by many internally. But an organization that does not listen to its own staff, punishes candour, rewards conformity and does not know how to co-operate with external partners is poorly placed to advocate those principles. An organization that does not practise what it preaches, and displays such a striking dissonance between its espoused values and its actual ways of working, lacks expertise as well as credibility and is in no shape to lead or support change internally or externally.

People who are not themselves empowered and constantly developing cannot empower or develop others. WHO cannot provide serious support to such initiatives as long as its own staff have so little understanding of change management and the ingredients of effective management practices and leadership. Ironically, these practices, drawn from researched experience and present in every successful change process, are embodied in the philosophy of Health for All.

Many organizations have successfully reinvented themselves and there is no reason why this cannot happen in WHO, but difficult choices will have to be made. WHO has neither the resources nor the authority to be all things to all people; its tendency to do too many things with too few resources is increasingly unsustainable. Member states must recognize this and work with WHO to develop a new and more focused action agenda based on its strengths and unique 'comparative advantage', with no exceptions made because of special pleading or donor demands. Some major roles for WHO that have been reiterated in the interviews and literature consulted in writing this chapter are noted in the recommendations as a starting point for discussion.

Dialogue with key actors can clarify and re-energize WHO's specific contribution to global health improvement and governance. Ways must be found to overcome the barriers of competitive rivalry that are destabilizing efforts to tackle the world's health problems. There is more than enough for everyone to do without wasting time and resources in turf wars. Links with civil society must be strengthened so that the top table round which the rich and powerful gather becomes an open, democratic, global decision-making forum where all can meet, speak their minds, listen and be heard. That will move us closer to WHO's noble objective, as set out in its constitution – 'the attainment by all peoples of the highest possible level of health'.

## Recommendations

*WHO's core purpose* Below are proposals for WHO's core roles derived from our literature review and interviews, which can be debated and fleshed out in the future:

- Acting as the world's health conscience, promoting a moral framework for health and development policy, and asserting the human right to health.
- Promoting the principles of the Alma Ata declaration on Health for All.
- Establishing, maintaining and monitoring global norms and standards on health and health care.
- Strengthening its role as an informed and trusted repository and disseminator of health information and experience.
- Conducting, commissioning and synthesizing health and health systems research, including research on the health impact of economic activities.
- Promoting and protecting the global commons, including the creation of transnational goods such as research and development capacity, and control of transnational externalities such as spread of pathogens.
- Providing a mechanism for coordinating transnational/cross-boundary threats to health.
- Strengthening WHO's presence in countries to play a stronger stewardship role in coordinating and bringing together international and bilateral agencies and international NGOs to develop a unified, purposeful multisectoral health strategy and activities to implement it.

### *Democratization/ governance*

- Take measures to position WHO as an organization of the people as well as of governments. This involves representation of broader groups of interests including civil society, and processes that ensure a wide range of voices is heard and heeded.
- Support and expand the Civil Society Initiative at WHO. Southern civil society organizations need support to have a more direct voice. Public-interest organizations must be differentiated from those representing commercial interests, including front organizations funded by transnational corporations.
- The politicized nature of the elections of the director-general and regional directors needs to be tempered. Possible solutions include a wider franchise, perhaps with an electoral college of international public health experts to complement the member states' votes, including representatives from civil society organizations. Candidates should be required to publish a manifesto and WHO should facilitate widespread debate about them, with

open selection criteria that reflect the roles' leadership and management requirements.

- There should be a strategic assessment of where WHO should be influential in the interests of health in relation to other multilateral bodies, and the existing liaison mechanisms between WHO and the international trade and financial institutions.

#### *Funding and programming*

- Donors should strive to increase their overall donations towards an agreed target.
- Donors should shift a proportion of their funding of extrabudgetary programmes into the regular budget. The aim should be a roughly equal apportioning of funding between the two arms of the budget, without any corresponding decline in the total budget.
- WHO should work on fewer priorities and ask donors to match their resources to them, to shift the balance between staff costs and activities and avoid 'project-chasing'; these priorities should be followed through in collaborative agreements with member states.
- Programmes (and the organization's structure) should be organized around the Primary Health Care Approach, resulting in the strengthening of systems-oriented units and divisions.
- Extrabudgetary donations should follow agreed overall priorities – donors should avoid tying them too tightly to specific programmes and outputs.
- Explicit resource allocation formulae should be developed to encourage better balances between core/extrabudgetary and staff/programme costs.
- The benefits, risks and costs of global public-private partnerships in health should be openly debated and compared to alternatives.
- WHO should develop strong safeguards against conflicts of interest in funding, priority-setting and partnerships.

*Leadership and management* Actions that WHO leaders can take to change the culture and improve their management and leadership:

- Revisit WHO's mission with all staff to renew their collective ownership and commitment: clarify priorities, agree comparative advantages, and from that develop a strategy, allocate funds and stick to it, including sufficient funding for core infrastructure functions.
- Recruit more diverse staff from different backgrounds and cultures, including more women, more people from the South, more people who are not

doctors, and more people with experience in a variety of settings in developing countries, intersectoral action and project management.

- Require proof of effective leadership and management experience as a criterion for staff recruitment, especially at senior levels.
- Make WHO a learning organization with a culture committed to continuous improvement, through giving all staff excellent continuing professional development opportunities; high-level management training for all senior staff; learning from good practice and sharing ideas, approaches and information; and regular, meaningful, non-blaming collective and individual performance review.
- Introduce regular rotation of staff to avoid stagnation and gain experience at global, regional and country levels.
- End casualization of the workforce, including reducing number of staff employed for long periods on a series of short-term contracts.
- Stop unstructured consultancies, internships and secondments that have little benefit for the individual, WHO or countries.
- Make better use of the expertise of senior WHO-friendly practitioners, academics, policy-makers and researchers, including short-term secondments.
- Review and streamline administrative processes and procedures.
- Strengthen the capacity and independence of WHO personnel departments, and introduce/enforce robust personnel policies with mechanisms for rapid response and staff support, and zero tolerance of corruption, nepotism and abuse of staff.
- Strengthen mechanisms to represent staff interests, including a staff association organized on trade union principles with collective bargaining powers and a properly resourced secretariat.

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- Information about WHO, many important documents, and links to its regional office websites and other health organizations are available at its global web site [www.who.int](http://www.who.int).