Whither the World Health Organization?

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ABSTRACT

- The outgoing Director-General of the World Health Organization, Gro Harlem Brundtland, has successfully returned health issues to the international arena.
- The new Director-General will have to cope with reduced control over funding, debate over WHO's mandate, and the relationships between WHO and other organisations.
- Despite the broad role described in WHO's constitution, many groups see WHO's mandate as narrowly directed at disease eradication.
- The method of choice for funding health programs has become public–private partnerships. These have the advantages of bringing private money, management expertise and research knowledge to bear on health problems, but rarely consider the health system as a whole, focusing instead on specific diseases. This has the potential to distort resource allocation and priorities.
- The international community needs to work to strengthen WHO and maintain its broad mandate to achieve the highest possible level of health for all people.

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THESE ARE WORRYING TIMES for the World Health Organization (WHO). The unexpected announcement in August this year by Gro Harlem Brundtland, WHO's Director-General, of her intention not to stand for re-election has resulted in considerable uncertainty within the organisation. It has also sparked intense lobbying for her position by, or on behalf of, nine aspirants. The Executive Board of WHO will make a recommendation on Brundtland's replacement in January 2003 for endorsement by the World Health Assembly in May 2003 (see Box 1).

During her four years in office, Brundtland successfully put the issue of health, especially health for the poor, back into the international arena. She focused the efforts of WHO into four areas — building health communities; combating communicable and non-communicable diseases; promoting more transparent, equitable and accountable health systems; and improving relationships of WHO with other organisations.[1]

Despite these achievements, the incoming Director-General will head a WHO weakened by two decades of zero growth in core budgets, diminished influence over the deployment of new sources of funding, and with ongoing challenges to its constitutional mandate. How he or she responds to the relationship of WHO with the private and non-government organisation sectors, and the promotion of the organisation's breadth of mandate, will determine his or her success. Some of the problems faced by the new Director-General can be addressed from within WHO; others reflect broader issues of globalisation and the role of organisations such as the World Trade Organization, the World Bank and the International Monetary Fund. There are different perceptions of what is the right path for WHO to take.

The WHO mandate

The past 50 years have witnessed significant improvement in life expectancy. In 1955, global average life expectancy at birth was just 48 years; in 1995, it was 65 years and it is estimated to increase to 73 years by 2025.[2] For these advances, WHO can claim success as a global participant in promoting better health.

However, these positive trends mask the inequalities between countries. More than 50 million people live in countries where life expectancy is less than 45 years. Indeed, 300 million live in 16 countries where life expectancies over the past 25 years have declined.[2] Many of these countries are in Africa, where the impact of HIV/AIDS has been most severe.

Since the HIV/AIDS epidemic began two decades ago, more than 60 million people have been infected with HIV, and up to 2001 an estimated three million had died.[3] Over the next 20 years, an estimated 68 million people will die prematurely as a result of AIDS in the 45 most affected countries. For example, in Botswana (which has the highest adult prevalence of HIV/AIDS in the world: 39%), life expectancy at birth has dropped below 40 years — a level not seen in that country since before 1950.[3]

Variations in health status are reflected in variations in economic status. The economic gap between the richest and the poorest nations widened between 1961 and 1997, from 12-fold to an astonishing 30-fold difference, and even more so between 1994 and 2000 as differences in life expectancy and infant mortality also further widened.[4] These problems can hardly be sheeted home to WHO; nevertheless, they create a climate in which the pursuit of its goals (Box 2) has been made harder.

Critics argue that WHO has been imbued by an ever-increasing focus on disease eradication to the detriment of health promotion, environmental health, standards setting and country capacity-building. This focus on individual diseases has promoted "vertical silos" in health program responses, and is antithetical to health system responses.

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1: Shortlist for the new Director-General of the World Health Organization

Dr Awa Marie Coll-Seck, Health Minister, Senegal
Sir Djamil Fareed, Health official, Mauritius
Dr Julio Frenk, Health Minister, Mexico
Dr Karam Karam, Tourism Minister (former Health Minister), Lebanon
Dr Jong Wook Lee, Director, STOP TB, WHO (South Korean national)
Dr Pasqual Manuel Mocumbi, Prime Minister, Mozambique
Dr Peter Piot, Executive Director, UNAIDS (Belgian national)
Dr Ismail Sallam, former Health Minister, Egypt
Dr Joseph Williams, former Prime Minister, Cook Islands

WHO budgeting has reflected this trend. The regular budget funding that WHO has received from countries has had zero real growth since the early 1980s. On the other hand, there has been an increase in extra-budgetary funds received from countries, other United Nations organisations, and private donors. These funds, which now make up 62% of WHO's total funding, tend to be earmarked for specific programs — usually disease-specific programs.

The large influx of philanthropic funding to groups outside WHO has also tended to be disease-specific. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), funded by the Bill and Melinda Gates Foundation, is one example. The Fund claims it will "address the three diseases in ways that will contribute to health systems",[6] but concern remains that "it has the potential to weaken fragile health systems, by diverting resources and staff from other activities".[7] The extent to which GFATM and other philanthropic foundations recognise that appropriate infrastructure, trained, motivated and suitably remunerated health personnel and adequate supplies of basic drugs are necessary prerequisites to fight diseases will be critical.

A recent report on WHO by the United Kingdom Department for International Development (DFID), which provides the third-largest extra-budgetary funding to WHO, also defines WHO's mandate narrowly.[8] The report repeatedly emphasises the need for WHO to focus on the achievement of the Millennium Development Goals: specific goals adopted by the General Assembly of the United Nations in September 2000 to address poverty and hunger, education, gender inequities, health and environmental sustainability. The health goals focus on HIV/AIDS, tuberculosis and malaria. Richard Horton, Editor of *The Lancet*, has argued that "DFID excludes discussion of maternal and child health, nutrition and food safety, non-communicable disease (mental health, violence, injuries, and the impact of tobacco), and many other important infections. Above all, while making much (rightly) of WHO's sometimes poor work within countries, DFID ignores the agency's global role in building health programmes and health systems, and in setting norms and standards".[9]

2: The goals of the World Health Organization

WHO's mission is broad and inclusive. The 1948 constitution of WHO describes the organisation's objective as the attainment by all people of the highest possible level of health.[5] Eradicating and controlling disease is its most visible and central role, but it also plays other important roles in:

- promoting maternal and child health, mental health and injury prevention;
- improving environmental health;
- creating information resources (eg, research, teaching and training);
- setting standards (eg, disease and death classifications, international conventions and regulations);
- country-level capacity-building (eg, promoting the development of sustainable, equitable, effective health services, technical assistance); and
- health advocacy and administration.

Public–private partnerships

In her first speech after her 1998 election, Dr Brundtland argued for "open and constructive relations with the private sector".[10] At that time, her speech caused some uneasiness both with major non-government organisations and within WHO.

Although partnerships between UN agencies and the private sector existed before her appointment, more recently public–private partnerships (PPPs) have become the method of choice to address a large component of international public health efforts. This has occasioned a reassessment of the strengths and limitations of public/governmental, private/commercial, and civil society institutions in grappling with world problems.[11] There is considerable debate between the proponents of such partnerships and opponents who worry deeply about the negative consequences.

These partnerships commonly involve at least one private for-profit organisation and one public organisation with shared objectives; the partners share the risks and benefits.[12] Major pharmaceutical companies such as Merck, Pfizer, Roche and Bristol Myers-Squibb are involved, as are many US private foundations — not a surprise, considering that the combined annual income of the world's three richest people (Bill Gates, Warren Buffet and Paul Allen) is greater than the combined GNP of the 43 poorest nations.[13]

Coupled with the growth of influence of these transnational companies has been the expectation that they demonstrate not just philanthropy, but good corporate citizenship and corporate responsibility. Kent Buse, of the Division of International Health, Department of Epidemiology and Public Health at Yale University of Medicine, and Gill Walt, of the Health Policy Unit, Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine, concluded that the growth in PPPs ". . . is in part due to the fact that the commercial sector has been increasingly challenged to show greater social responsibility, to invest in the well being of populations, to adhere to global labour and environmental standards, and to invest in research and development that benefits the poorest".[14]

Types and extent of PPPs

The website of the Geneva-based Initiative on Public–Private Partnerships for Health currently identifies 79 col-

Global Alliance for the Elimination of Lymphatic Filariasis[15]

The preliminary objective of the Alliance is to eliminate lymphatic filariasis by 2020. The strategy has two components: to stop the disease's transmission in all countries; and to alleviate and prevent the suffering of more than 20 million affected individuals. Additional aims of the Alliance are to support ongoing de-worming programs, provide an overall strengthening of the health services in endemic countries, enhance efficiency of drug distribution systems, and promote economic benefits to individuals and the community.

The efforts of GAELF have been aided, in part, by two major drug donations. In 1998, SmithKline Beecham, now GlaxoSmithKline, agreed to donate its drug albendazole free of charge until the disease is eliminated. This is likely to see 4–6 billion tablets donated over a 20-year period. Merck and Co has also pledged to expand its Mectizan Donation Program for Onchocerciasis in all areas of Africa where the two diseases coexist.

Major participants are WHO, the World Bank, UNICEF, GlaxoSmithKline, Merck and Co, Binax, and the Bill and Melinda Gates Foundation.

laborative partnerships.[15] The nature and purpose of these partnerships vary widely. Some have been created for product development (including vaccines), others for distribution of a subsidised product (such as drugs for HIV), others for health education purposes, others for product regulatory or quality improvements, and others more generally for health systems coordination.

Product development partnerships have included the Medicines for Malaria Venture, the International AIDS Vaccine Initiative, and the Global Alliance for TB Drug Development. For disease control, there are many examples of drug donation and distribution strategies, including those involving the delivery of albendazole, eflornithine, zithromax and leprosy multidrug therapy.[11]

More recent partnerships have recognised the need to strengthen health services and improve coordination between services. Examples here include the Gates Foundation/Merck Botswana Comprehensive HIV/AIDS Partnership, and the Bristol Myers-Squibb Secure the Future Initiative, developed to work with African governments and communities to bring local solutions to the HIV epidemic.

Benefits of PPPs

Proponents of PPPs argue that the collaboration between the public and private sectors enables the goals of both sectors to be achieved. For example, in addition to money, industry brings to many of the partnerships management expertise and extensive research knowledge, chemical discovery and development experience to facilitate drug development projects. The emergence of PPPs is a recognition that the health sector is so complex and large that partnership between UN agencies, governments and the private sector is the most appropriate way to respond. PPPs do not redirect monies from other health initiatives, as in most instances they mobilise new resources for health.[16] Furthermore, the response to health issues is often faster than with public (including WHO) or private sector approaches alone.[17]

Finally, PPPs provide a mechanism to address "disease transmission across national boundaries, and reduced capabilities of national governments to provide coordinated responses".[12]

Difficulties of PPPs

Only a small number of PPPs are health-system conscious, as, in the main, they focus on specific products or diseases. This alignment reinforces the current disease or specific-issue focus of WHO, to the detriment of macro-health policy issues and healthcare system responses.

PPPs have significantly increased the pool of money available for health. However, at what stage will the number of PPPs be enough? Will their proliferation distort resource allocation and priorities for healthcare, duplicating effort and weakening comprehensive approaches, including integrated primary healthcare?

Much of the criticism of PPPs centres on the pivotal roles of pharmaceutical companies. Although they are significant contributors to PPPs, there is considerable debate whether the objectives of such companies are sufficiently aligned with WHO. In general, pharmaceutical companies pay "less attention to poor populations than those that are rich, because of the need to provide a return to investors from the worldwide market."[11] Eighty per cent of the world pharmaceutical market is made up by the United States, Australasia, Europe and Japan[11] — it is thus understandable that the vast majority of pharmaceutical research is directed at diseases of people in developed countries. Spending on research and development (R&D) is skewed away from the developing world, with only 10% of the global pharmaceutical R&D expenditure going towards diseases that account for 90% of the world's disease burden.[18]

A further concern is that the shifting of the focus of technical groups outside WHO may result in global norms and standards more closely reflecting private interests and ". . . we may also witness a brain-drain from WHO to 'competing' partnership institutions, which could affect the organization's capacity and technical authority".[14] PPPs provide the private sector and scientists (predominantly European) with access to UN decision-making to the detriment of member countries, southern hemisphere scientists and the not-for-profit sector.[14]

Global Alliance for Vaccines and Immunization[15]

The Global Alliance for Vaccines and Immunization, established in 1999, is an alliance between the private and public sector and is committed to saving children's lives and improving people's health through the widespread use of vaccines. International organisations, governments, the vaccine industry, research institutions, and major philanthropists have formed a partnership to increase child immunisation levels around the world.

The four principal partners are WHO, UNICEF, the World Bank and the Bill and Melinda Gates Foundation. As of June 2002, the Vaccine Fund had committed $830 million over five years to 54 countries in immunisation program financing. Simultaneously, GAVI aims to stimulate the vaccine industry to develop and supply vaccines vital to low-income countries.

The history of WHO and the UN is of representative legitimacy, and the clear benefits of PPPs need to be constantly balanced against the inevitable diminution of established UN governance arrangements. For example, GFATM has been explicitly established outside the UN system. Yet, it is clear that in many, if not most, of the beneficiary countries GFATM will succeed only if the UN system, and WHO in particular, expends significant financial resources and provides staff in support of its country coordinating mechanisms.

The future

The role of countries' development aid agencies in strengthening the capacity of WHO is critical. The current Director-General has sponsored work to define more clearly the relationship between economic development and health development, in particular through establishing the Commission on Macroeconomics and Health. The Commission's report, issued in 2001, makes a strong case for health development as an essential and early element in comprehensive strategies designed to achieve economic uplift in the poorer five-sixths of the world's nations. The report was cognizant of the need for local political commitment and effective governance as a prerequisite for gains in health. The Commission estimated that expanding coverage for a small number of effective interventions targeted at conditions that contribute significantly to the burden of disease across the world would cost US$14 per person per year in low-income countries and US$22 per person in the least-developed countries.[4]

Expansion of access to these interventions, including treatment of tuberculosis, treatment and prevention of malaria and HIV, immunisation, and antenatal care, would contribute to "a decisive drop, a major reduction in avoidable deaths", and in turn have significant economic and development benefits for these countries. The Commission concluded that, while the lowest-income countries needed to increase local resources for these programs, there was a need for an increase in donor contributions from the wealthiest nations. The Commission estimated that additional investments in health by donor countries equating to one-tenth of one per cent of their national income would, by 2010, result in eight million lives saved per year, providing these monies were wisely spent. The report emphasises the importance of primary, close-to-client care as the essential health system requirement to achieve these targets.

The new Director-General of WHO thus faces massive political, financial and technical challenges, and these without considering the grim spectre of international biowarfare. Global health needs are substantial. The need for WHO to retain and implement its broad mandate is even more important to bring a better balance to the more disease-specific and vertically implemented mechanisms promoted by donors outside the UN system. Lessons from the indisputable successes of recent years need to be learned, sponsored and applied. Australia can play an important part in this enterprise.

International AIDS Vaccine Initiative[15]

International AIDS Vaccine Initiative (IAVI) is a not-for-profit scientific organisation established in 1996 to ensure the development of safe, effective and accessible HIV vaccines for use throughout the world. IAVI is a collaborating centre of UNAIDS, working with both public and private sector organisations to pursue its mission. IAVI's work focuses on four areas: creating global demand for AIDS vaccines through advocacy and education; accelerating scientific progress; encouraging industrial involvement in AIDS vaccine development; and assuring global access. IAVI funds and sponsors "fast-tracked" product development and clinical testing of promising AIDS vaccine candidates developed for the countries most affected by the disease.

IAVI's major supporters include the Bill and Melinda Gates Foundation; the Rockefeller, Sloan and Starr foundations; the World Bank; and the governments of Canada, Denmark, Ireland, the Netherlands, Norway, the United Kingdom, and the United States. IAVI has now secured commitments totalling US$230 million, more than 40% of its US$550 million target.

Competing interests

None identified.

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