

A new Director General for WHO—an opportunity for bold and inspirational leadership



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The sudden and sad death of Lee Jong-wook, the Director-General of WHO, has already prompted several articles in *The Lancet* about the organisation.¹⁻³ But further discussion is needed before the election of a new Director-General this November.

What challenges are faced by WHO and its new head, and how can individuals and institutions strengthen WHO's capacity to respond effectively to the world's health challenges? These are not idle questions, for all is not well at WHO. For millions of people, the prospect of a basic level of health security remains a distant hope. Furthermore, as the importance of global and supranational determinants of health increases, so does that of global public-health institutions.

In this article, the People's Health Movement, a worldwide network of individuals and civil society organisations committed to the vision and principles of the 1978 Alma Ata Declaration, identifies three sets of global health challenges and the kind of response it would like from WHO. We also discuss the constraints and barriers faced by WHO itself, and suggest actions that should be taken by WHO and its new Director-General, as well as by governments and civil society.

Key global health challenges

Poverty and the global political economy

Poverty remains the world's biggest health problem, underlying the HIV/AIDS crisis, the high mortality attributed to tuberculosis and malaria, and the 30 000 deaths of children every day from preventable and treatable causes. It also results in governments being unable to foster socioeconomic development and invest in effective health, welfare, and education systems.

Frequent references are made to the World Bank calculation that the number and proportion of people living on less than US\$1 per day has fallen since the late 1980s. However, less is said about this calculation's systematic underestimation of the extent of impoverishment.⁴ When a more appropriate \$2 per day income threshold is used, even by the World Bank's calculations the number of people living in poverty increased between 1981 and 2001 to about 2.7 billion people.⁵

This growth in poverty has been accompanied by a growth in wealth. While the number of people living in poverty in sub-Saharan Africa increased from 289 million to 514 million between 1981 and 2001, the world's gross domestic product (GDP) increased by US\$18 691 billion.⁶ 40% of the world's poorest people account for 5% of global income, while the richest 10%, mostly in high-income countries, account for 54%.⁷

Generation of wealth is supposed to lead to alleviation of poverty, but has disproportionately benefited a minority of the world's population while impoverishing others. According to the World Commission on the Social Dimensions of Globalisation, the governance of the global economy is "prejudicial to the interests of most developing countries, especially the poor within them".⁸ The deregulation of finance, the global property rights regime, and a winner-takes-all liberalisation of trade are aspects of a form of globalisation that traps many countries and households in poverty. Despite slow increases in development assistance and some debt cancellation, net flow of resources from poor to rich countries still work against global health challenges.⁹

Although some would argue that issues such as trade and global financial markets fall outside the remit of WHO, we believe that WHO should advocate changes to the macroeconomic and political determinants of ill health if we are to reduce child and maternal mortality, achieve universal access to antiretroviral treatment, and allow all countries to pay their health-care workforce an adequate living wage. Although interventions can be implemented by Ministries of Health to tackle the health-worker crisis, changes to macroeconomic policies will be needed in many countries to increase health-sector spending.

WHO could promote comprehensive assessments of global, regional, and bilateral trade agreements for effects on health and health systems, and develop a well-resourced unit to carry out such work. As it becomes evident that the growth-led concept of poverty eradication is untenable without an explicit redistribution strategy,⁶ WHO must demand further discussion about establishment of new, stable, and sustainable sources of global public financing for health—such as the airline levy introduced by France, which is estimated to be capable of raising about €200 million per year for health.¹⁰

Others have suggested that attention be focused on the development of an international system to reduce tax evasion, which results in an estimated US\$350 billion being lost from public accounts.¹¹

The launch of a Commission on the Social Determinants of Health in March, 2005, offers hope that WHO would become more active in assessing the health effects of the structures and rules of the global political economy. However, WHO's new Director-General must push the Commission to go beyond assessment and propose what WHO can do to engage with economic and social policy.

The new Director-General should also make human rights a pillar of WHO's work—for example, by giving visible and tangible support to the work of the UN's

Published Online

October 24, 2006

DOI:10.1016/S0140-

6736(06)69570-6

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Special Rapporteur on the Right to Health. However, WHO will need to elaborate its human rights principles to stress the transnational obligations and duties of rich countries' governments, international finance institutions, individuals, and private corporations towards citizens of developing countries, and emphasise the human rights transgressions that result from global rules and systems that cause or perpetuate poverty.

Development and rehabilitation of national health-care systems

The past few decades have seen many health-care systems become weak to the point of collapse, disintegrated, more inequitable, and increasingly commercialised.¹² Under Lee, WHO began to reassert its commitment to the principles of the Alma Ata Declaration. It now needs to commit to health-systems development policies that are consonant with the Declaration.

This aim should incorporate an evidence-based challenge to prevailing neoliberal reforms of the health sector, coupled with a coherent agenda to strengthen the capacity of Ministries of Health and public health-care systems. The former would require WHO to assist countries to introduce reforms aimed at integrating fragmented pools of public and private health-care finance, reversing commercialisation, and shaping the private sector to meet social health objectives. The latter would call for WHO to strengthen its own health-systems departments and develop the public management expertise needed to provide effective support to Ministries of Health.

Additionally, WHO must help to bring order to the chaotic proliferation of global health initiatives, many of which are characterised by selective vertical health programmes within countries. This problem has undermined not only WHO, but also Ministries of Health and coherent health-systems planning, by multiplying the number of donor-related conditionalities, increasing the transaction costs associated with having to liaise with several stakeholders, and accentuating the fragmentation of health-care systems.

Another practical step would be to resurrect the 2000 World Health Report initiative to measure and collate health-care system indicators country by country. Although the report had serious conceptual and methodological weaknesses, the underlying idea remains relevant and would enable better monitoring of progressive financing and equitable expenditure for health care, and ascertain whether governments are investing an adequate proportion of public revenue to health.

Protecting people from the hazard merchants

WHO's role in responding to severe acute respiratory syndrome, coordinating preparations for an avian flu epidemic, and establishing international health regulations to assist control of disease outbreaks demonstrates its importance as a global public-health agency. Its part in helping to formulate evidence-based guidelines and

standards on clinical and public-health practice are another valuable role. The new Director-General must continue to strengthen these core functions of WHO.

The challenge of protecting people from non-biological hazards, including commercial activity, should also be emphasised. The International Code of Marketing of Breastmilk Substitutes and the Framework Convention on Tobacco Control are examples of partly positive outcomes of struggles between public health and powerful corporate actors.¹³ The connections between commercially generated hazards, those who promote these hazards, and ill-health are both direct and indirect. For example, oil extraction can have direct negative effects on the health of surrounding communities as a result of environmental pollution, and is also a global industry that has undermined the science of climate change and retarded action to reduce carbon emissions, to the detriment of health. The automobile industry has successfully lobbied against sensible action to reduce the direct and indirect negative effects of current transport and travel patterns on health.

Pharmaceutical corporations are rarely referred to as hazard merchants. However, the Agreement on Trade-Related Aspects of Intellectual Property Rights, which was conceived and brokered largely by Big Pharma working through the official delegations of the USA, Japan, and European Union at the World Trade Organisation,¹⁴ has reduced affordability and availability of many medicines and entrenched an intellectual property regime that is inefficient at encouraging pharmaceutical research and development, un conducive to safe and ethical practice, and incapable of addressing the needs of poor patients.¹⁵ Regional and bilateral trade agreements are further expanding the cope for unsafe and unethical practice by reducing the capacity to regulate marketing and sale of medicines.¹⁶

Relations between governments, the corporate sector, and citizens have become increasingly unequal, accentuated by globalisation and the accompanying abridgement of national sovereignty and democratic accountability. The relative weakness of public-health institutions is illustrated by the 2004 Global Strategy on Diet, Physical Activity and Health, which was toned down because of opposition from the food and beverages industry (whose financial resources far exceed those of WHO and whose interests were strongly represented by US representatives at WHO).¹⁷ One of WHO's challenges will be to help correct the current imbalance between the liberal, pro-market economic dimension of globalisation with a public safety and social dimension.

Barriers to a more effective WHO

A key priority for WHO is an organisational development strategy for itself. Several challenges stand out. One is the need to strengthen WHO's regional and country offices, particularly in sub-Saharan Africa, a region that demands the best that WHO can offer.¹⁸ Under Lee, resources shifted from Geneva to the periphery,¹⁹ but some WHO

regional and country offices do not have the capacity to put increased resources to good use.

This problem is especially acute in poor countries and regions where actors from the UN, donors, non-governmental organisations, and the research community compete with each other for scarce resources and attention from the Ministry. Rather than providing a focus for improved coordination and integrated leadership, WHO offices in Africa can appear as small-time players in the field.

To rectify this problem, WHO needs to clarify the strategic functions and activities of its regional and country offices and then recruit (without eroding the skills base of local public and non-government organisations) and retain staff with the appropriate experience and competencies. It should initiate public discussions of its regional and country plans as a mechanism to strengthen public support and public monitoring of its performance.

The Lancet has commented that too many of WHO's programmes are inadequately appraised and allowed to perform suboptimally. However, WHO is not alone in this criticism. Many of its outputs and effects have been relatively cost-effective and impressive. However, *The Lancet* hits the nail on the head in calling for WHO "to act systematically as an accountability instrument for the work of other institutions" including the World Bank, the Global Fund to fight AIDS, TB and Malaria, and the US president's Emergency Plan for AIDS Relief.¹

Perhaps WHO can raise the bar for improving transparency and independent monitoring of key international agencies involved in promoting health by funding and encouraging academic and non-government organisations to act as critical friends, capable of simultaneously monitoring and supporting the performance of WHO in a transparent manner.

WHO should also address documented examples of weaknesses in internal management and administration, such as the absence of coordination between its different departments and programmes; overabundance of doctors relative to nurses, social scientists, economists, lawyers, and political scientists; tolerance of underperforming senior executives; arcane bureaucratic procedures; and poor personnel management practices that have demoralised staff.^{20,21}

An equally challenging set of barriers relate to WHO's operating environment. One such barrier is funding arrangements. WHO's core funding has remained static for many years and is currently inadequate, amounting to a tiny fraction of the health spending of high-income member states. Furthermore, more than two-thirds of WHO expenditure arises from conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries and other donors. This system makes it difficult for WHO to plan and fund a coherent programme of work, and forces departments and divisions to compete with each other (and other

organisations) and be susceptible to fragmented, donor-driven agendas.

As government contributions stagnate, WHO has been forced to rely on private sources of financing and public-private partnerships. This reliance has resulted in a subtle erosion of public accountability and public-health principles to accommodate the interests and orientation of new donors. For example, the development of new medical technologies has become overemphasised in comparison with strengthening the capacity to deliver existing technologies and the more integrated socio-developmental approach of the primary health-care philosophy.

Budgetary control is one mechanism by which some actors constrain the performance of WHO. But there is also direct political pressure on WHO. For example, some member country delegations have warned WHO to steer clear of macroeconomics and trade issues and avoid reference to terminology such as "the right to health". As a result, WHO has taken a weak position on important economic issues. Its guide to the health implications of multilateral trade agreements was watered down following pressure from some governments and the World Trade Organization.²² The USA forced WHO to sanction and recall an employee from Thailand for drawing attention to a negative aspect of the Free Trade Agreement between the USA and Thailand.³

Another barrier is the multitude of global health initiatives and agencies with funding and governance arrangements that contribute to a chaotic operating environment for WHO. The time has come for a significant rationalisation of the global health landscape. At least, developing country member states should lobby to capacitate WHO with the mandate and resources for a stewardship role in coordinating the work of official donor agencies and global health initiatives.

Finally, a comment on the current state of global governance and the UN in general is necessary. According to the World Commission on the Social Dimensions of Globalisation, there are "serious problems with the current structure and processes of global governance". The propensity of some nation states to flout international law and undermine the UN will make the task of the new Director-General harder. But it also makes the election of a new Director-General crucial because of the potential for WHO to act as a conduit towards a more effective and just system of global governance. The global health community, with its knowledge and understanding of the borderless nature of health threats, can play a vanguard part.

The right Director-General for the right manifesto

WHO already has a positive manifesto, embodied in its constitution and the Alma Ata Declaration—one that reflects fairness, global solidarity, effective health care for all, public accountability, and a strong sociodevelopmental orientation. In recent decades this manifesto has been subverted.

The aspiration of health for all has been replaced by a tacit acceptance of growing health inequalities and the timid aim to provide a minimum package for the poor. Strong global health leadership capable of acting as a health conscience for the world has been replaced by a fragmented landscape of selective global health initiatives designed to mitigate the underlying determinants of health rather than to challenge them. The social dimensions of health systems that stand out in the Alma Ata Declaration and District Health Systems model have weakened in the face of a narrow, neoliberal conceptualisation of cost-effectiveness and an uncritical faith in market-based incentives.

To adopt a bolder, broader, and more progressive public-health agenda, WHO will need charismatic, wise, and courageous leadership. The hundreds of millions of people with the least access to health care deserve a Director-General capable of providing decisive intellectual leadership and withstanding political pressure.

To encourage a more transparent and democratic process for the final selection of the Director-General, the People's Health Movement has asked all candidates to

respond to a set of questions (panel), the responses to which it will then publish. The Movement will also compile profiles to facilitate a more public examination of the strengths and weaknesses of each candidate.

However, the final selection will be the result of opaque power brokerage involving 34 members of the Executive Board. Behind closed doors, they will interview and then select from a shortlist. Structured criteria to assess the relative strengths and weaknesses of the candidates and how each individual scored will not be made public. This non-transparent process is unacceptable.

After the election, the People's Health Movement will lobby to reform this process for future Director-General appointments. Civil society organisations could take other action to make WHO an organisation of the people as well as of governments. They could develop a joint initiative to monitor discussions, debates, and decisions at WHO Executive Board meetings. A stronger civil society presence at the meetings, coupled with a facility to report on proceedings, would improve transparency and scrutiny of policy development, and would create a counterweight to the propensity of some member states and other actors to bully WHO. The civil society initiative established under Brundtland could be revived to allow a wider range of voices to be heard and heeded, particularly those of marginalised and poor communities.

Civil society could and should also prevail on governments and donors to improve the quantity and quality of funding to WHO. The formula for determining the level of contributions should be reviewed and a report card generated to rank countries according to amount of funding as well as the proportion of funding that is untied. Civil society should also demand that the amount, nature, and conditionalities of any private sources of financing be fully disclosed to the public.

The forthcoming election marks a crucial opportunity for WHO, and a critical juncture at which to examine global-health governance more broadly. We hope that the new Director-General will enable WHO to catalyse a radical and progressive public-health agenda fundamental to improving the health of the world's poor.

Conflict of interest statement

We declare that we have no conflict of interest. No external source of funding contributed to the writing of this article.

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Panel: Inquiries from the People's Health Movement to the candidates for the position of WHO's Director-General

- What will be your top priorities for WHO over the next 5 years?
- Will the development of a global strategy to strength primary health care be a priority for you? If so, what will you propose to strengthen comprehensive primary health care?
- Where do you stand on the need to repair the damage to public health-care systems caused by the inefficiencies and inequities brought about by the privatisation of such systems?
- There has been rapid proliferation of Global Health Initiatives and disease-specific initiatives. How will you seek supervision and control of this situation by WHO?
- How will you ensure that WHO plays a more assertive role in protecting public-health interests in the face of trade agreements (eg, the Agreement on Trade-Related Aspects of Intellectual Property Rights) that seem to be harmful?
- What steps would you take to ensure that WHO is able to resist pressures from corporate interests and their allies for WHO to adopt a weaker position on health promotion and protection?
- How will you counterbalance the disproportionate effect of the governments of rich countries, particularly the USA, on policy development in WHO?
- What action do you propose to increase the voice and influence of civil society groups in WHO?
- WHO has been criticised for many years for being dominated by doctors, and having a shortage of professionals from the social sciences, legal, economic, and non-medical disciplines. What is your view on this question, and what will you do to rectify the imbalance in disciplines and expertise within WHO?
- The phrase "Staff are our most important resource" is commonly stated by leaders when they take office. How will you maximise this most important resource in terms of WHO's work and in relation to staff representation in dealing with management?
- Many argue that there is a particular need to build the capacity of the WHO Regional Office in Africa? Do you agree and if so, how would you go about this?
- How will you support and promote the work of the Commission on the Social Determinants of Health from now until it reports in May, 2008, and then ensure that its recommendations are implemented?

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