Analysis and comment

International health

Open letter to the incoming director general of the World Health Organization: time to refocus

Ruth Levine

Ruth Levine argues that WHO needs to concentrate on confronting global health risks, improving the health of poor people, and marshalling technical expertise

As you take on what is arguably one of the most important leadership posts in the world, you have an opportunity for a moment of reflection: Is the World Health Organization, which was mandated at its founding in 1948 to be the “directing and coordinating authority on international health,” on the right track? The answer right now is a definitive “no.” Instead, it is on too many tracks simultaneously, suffering from years and perhaps decades of underfunded “mission creep.”

The central challenge of your new job—the task that will determine the success or failure of your tenure—is to refocus the organisation so it can identify cross country health priorities and provide credible technical expertise on public health problems and solutions that help national public health authorities to focus their resources effectively. To get there, you will have to institute recruitment, hiring, and firing policies based on merit (from the director general down); skillfully manage a transition to more adequate and secure funding for core activities; and foster a spirit of common purpose across the organisation.

You can see for yourself that WHO needs a major rethink. All around you narrowly focused yet intertwined global health initiatives have sprung up, and they aren’t going to disappear: the Global Fund to Fight AIDS, Tuberculosis and Malaria; UNAIDS; the Global Alliance for Vaccines and Immunization; public-private partnerships dedicated to everything from inventing a malaria vaccine to promoting hand washing; private foundations, most notably the super-sized Bill & Melinda Gates Foundation; and many more. The complexity and fragmentation of funds and functions is reproduced in a proliferation of public and private actors within each region and country.

From the outside, we have seen WHO struggle to keep up with the changes.¹ It has sought opportunities for funding and influence within new partnerships while fighting incursions into bureaucratically defined territory. For example, WHO hosts the embattled Roll Back Malaria secretariat but has recently established its own Global Malaria Programme, which seems to have little connection with Roll Back Malaria.²

Sorting out WHO’s future means facing up to three mutually reinforcing problems, all of which have been noticed in the past^{3–5}: the anaemic budget, the lack of clear priorities, and the tension between politics and science. To some extent, these problems reflect constraints inherent to many specialised United Nations agencies; you could blame it all on the WHO constitution and governing body. But just as healthy behaviour can often counteract genetic predisposition to disease, strong leadership can compensate in part for the institutional DNA.¹

What are the problems?

You are in charge of what is essentially a “soft money” institution. The agency’s core budget, now hovering around \$900m (£470m; €700m) a year, has been declining in real terms for almost a decade and, for

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WHO should focus on setting standards for reporting on health conditions, such as TB

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comparison, is less than the Gates foundation's annual expenditure on global health. Consequently, dependence on voluntary contributions by both public and private funders has grown. Extrabudgetary resources now total more than twice the regular budget. For some key programmes, donor support dwarfs core funds: WHO's tuberculosis programme—cited as a major institutional priority—receives only about a tenth of its funding from the regular budget; the rest is obtained by passing the hat. Perhaps even more alarmingly, and partly a consequence of WHO's soft money nature, many of the most technically able staff are hired on annual rolling contracts, limiting the security required for them to do their best work.

When budgets are funded through grants and trust funds, a form of entrepreneurship can result. And such has been the case at WHO, which eagerly seeks opportunities to attract potential donors. So you are at the helm of an organisation that interprets its mission to cover all facets of health, from opining about research and development for drugs to issuing reports about health financing to forecasting demand for malaria drugs, spearheading the scale-up of access to antiretroviral drugs, investigating the relation between poverty and illness, and inveighing against migration of health workers. Conceptually, a case could be made—and often is—that any limitation of scope would be artificial, given the acknowledged reality that health affects, and is affected by, just about everything. But no organisation can do everything, and institutional success is often found in the ability of a leader to politely say, “No thanks.” In the case of WHO, priority should go toward activities that are part of the global public goods agenda, including setting norms and building knowledge within public health, and away from operational tasks and advocacy for specific “cause of the day” diseases.

In the vicious cycle of institutional vulnerability, WHO's budget woes are also linked to the unfortunate reality that politics compromises its reputation as a source of technical information and evidence based advice. It cannot bring Taiwan into discussions about avian flu without asking China's permission. Discussions about intellectual property in the pharmaceutical industry and reproductive health are self censored because of concern about US reactions. The leadership selection itself has traditionally been subject to such extracurricular factors as a member state's ambitions to enter the UN Security Council or the ability of a country backing a candidate to dish out goodies to other voting members and strategically eliminate strong competitors from the shortlist.⁶ In sum, because maintaining WHO's budget requires pleasing constituencies, the agency's main product—impartial public health expertise—is undermined. In this, a strong leader can use diplomatic skills to make sure that the politics is kept at a safe distance from the technical work. If that fails, strategic “naming and shaming” can draw attention to the problem and transfer the pressure of politics back to those who would distort the facts or the process.

Where next?

Even if the problems are clear, the solutions require that you conduct further analysis and consultation—

and act with both integrity and courage. WHO's strength has to be found in actions on two key fronts. Firstly, WHO can focus attention on global public health priorities. These include setting and enforcing standards for reporting on health conditions in all countries and serving as the focal point for coordinating global preparedness and response to outbreaks of infectious disease.

Secondly, WHO should generate, mobilise, and communicate technical guidance to those who have the money and to governments and non-governmental organisations that operate programmes on the ground. WHO would provide a desperately needed and highly valued service by answering the question that so many others ask: “What should we do, and how should we do it?”

WHO does not have to have all the relevant technical expertise in-house or do the necessary research itself, but it needs to be the institutional venue through which the widely dispersed sources of knowledge about what works can come together. WHO can in the future, as it has sometimes in the past, foster international technical consensus about the nature and size of health problems; the relative effectiveness (and cost effectiveness) of both medical and non-medical interventions; and the practical, field tested strategies for health promotion and preventing and controlling disease. This consensus building, which is distinct from advocacy, has been shown to be a vital component for success of large scale programmes.⁷ It is a role that implies leadership and vision—to see not only the most high profile health concerns, like AIDS and avian flu, but to do more in-depth work on other problems that are creeping up on this ageing, smoking, overeating, and warming world.

Funding agencies such as the Global Fund and the World Bank, national governments, and private foundations need the products of this expertise to turn their money into health. Operational agencies such as ministries of health and Médecins Sans Frontières need it too, so they can focus their efforts using the best available evidence about how to change behaviour, control vectors, fortify foods, and undertake other actions that benefit the public's health.

Priorities for action

Success depends crucially on three institutional changes, which should be at the top of your priority list.

- Ensure that staff decisions are based on merit and that political and financial considerations do not threaten your best staff. Extend that principle to the selection of the director general, working with the governing body to make subsequent elections more transparent
- While committing to real and measurable institutional changes, demand an adequate core budget from member states and greatly reduce dependence on grants and trust funds. Ensure funding for priority functions is fully protected and avoid the temptation to take on non-priority work simply because funding can be found for it
- Work toward an alignment across the organisation, breaking up the current internal fiefdoms; dedicate staff, reporting to you, to ensuring institutional coherence. In particular, look for ways to bring regional

offices and headquarters closer together, so that all parts of the organisation share a core mission and communicate common information, with a particular focus on getting information from the field to Geneva. To get there, a re-read of the WHO constitution might be in order—there is room within it for regions to be more directly linked to the main part of WHO than they currently are.

Global health has never enjoyed a higher profile on the world stage, and WHO must figure out how to take the most constructive role possible, within the bounds of its institutional constraints. We need an international health agency that leads, focused on providing strong, uncompromised technical expertise to improve the health of poor people and fortify the international community's ability to confront global health risks. Good leadership, bolstered by support from the many outsiders who want WHO to succeed, can do just that.

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Health economics

Investment in health could be good for Europe's economies

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A sick population is an expensive population. But a new European report shows the benefits of improved public health are likely to extend beyond reduced healthcare costs

Five years ago, the Commission on Macroeconomics and Health concluded that ill health was contributing to the low level of economic growth in poor countries.¹ The landmark report showed that investment in some basic health interventions would lead to substantial economic growth.¹ However, the commission did not look at rich countries, where the situation is quite different. Production in poor countries—for example, from agriculture and mining—is much more obviously affected by physical wellbeing. In addition, the measures to improve health in poor countries, such as immunisation and access to essential drugs, are less complex than those needed to manage the large burden of non-communicable disease in rich countries. Understanding the role of health as a driver of economic growth in Europe is important, given the stated commitment of Europe's governments in March 2000 to make Europe the most competitive and dynamic knowledge driven economy by 2010.

In this article we summarise the findings of a study that we did for the European Commission examining the link between health and wealth in rich countries. The full report has been published elsewhere,² and a summary of the methods is available on bmj.com.

How might health affect the economy?

Healthier individuals might affect the economy in four ways:³

- They might be more productive at work and so earn higher incomes

- They may spend more time in the labour force, as less healthy people take sickness absence or retire early
- They may invest more in their own education, which will increase their productivity
- They may save more in expectation of a longer life—for example, for retirement—increasing the funds available for investment in the economy.

It is not straightforward to determine whether these mechanisms exist in practice or how important they might be. Most studies use household survey data, capturing individuals at one point in time, although an increasing number use cross sectional time series (panel data), which overcomes some of the difficulties with one-off data. In particular, it is important to take account of the possibility that how people report their health is influenced by their employment status, as there may be financial or other benefits associated with being more or less healthy than you actually are. Another problem is that the relation between measures such as employment or income and health can work in both ways and both measures can be influenced separately by other factors. However, several statistical methods can be used to overcome these problems. The evidence below uses these methods. We focus on productivity and time in the workforce as there is little evidence from rich countries to support the existence of the other two mechanisms.

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