about issues of responsibility, culpability, and restitution must typically be pragmatic.

Health professionals should beware of looking at responses to war through a Western medicotherapeutic prism. The question of how people recover from the catastrophe of war is profound, but the lesson of history is straightforward. "Recovery" is not a discrete process: it happens in people's lives rather than in their psychologies. It is practical and unspectacular, and it is grounded in the resumption of the ordinary rhythms of everyday life—the familial, sociocultural, religious, and economic activities that make the world intelligible.[17]

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WHO in 2002

Have the latest reforms reversed WHO's decline?

Gavin Yamey

In the mid-1990s the *BMJ* published a series on the World Health Organization by Fiona Godlee, an assistant editor at the journal. Godlee argued that WHO was in crisis—lacking effective leadership, direction, and priorities. Seven years later, has the organisation successfully reinvented itself?

This is the first of five articles

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In her book *Betrayal of Trust*, health writer Laurie Garrett described WHO's decade of decline: "The World Health Organization, once the conscience of global health, lost its way in the 1990s. Demoralized, rife with rumors of corruption, and lacking in leadership, WHO floundered."[1]

Fiona Godlee, in her series in the *BMJ* (box 1), came to a similar conclusion. She argued that Hiroshi Nakajima, then director general, had failed to communicate a coherent strategic direction for WHO. Its six regional offices were bureaucratic, rife with cronyism, and operating autonomously from headquarters and it had little impact at country level. Donors questioned WHO's effectiveness, seeing better "value for money" from channelling their funds into other agencies, especially the World Bank. Though WHO still carried out important work setting standards and giving technical support to countries, the bank took its place as the most influential global health agency. At the end of the series, Richard Smith wrote an editorial in which he challenged WHO to "change or die."[2]

Summary points

- In the 1990s WHO came under fire for poor leadership and lack of direction
- Gro Brundtland took office as director general in July 1998 and attempted sweeping reforms
- Brundtland prioritised WHO's activities and launched important global health campaigns
- She restored WHO'S credibility with donors and helped to place health on the international development agenda
- But her management changes have been unpopular, and critics argue that WHO is still too influenced by its donors
- Brundtland's reforms have not been felt where they matter most—at country level

A new leader

One woman was charged with saving the organisation. Gro Harlem Brundtland, a former prime minister of Norway, took office as director general on 21 July 1998 and promised radical reform for WHO. She restructured it, prioritised its activities, and launched new health campaigns. WHO made a comeback to the global political stage.

But in a few important ways, WHO is still struggling. Its new structure has created a different set of problems for the organisation. There are serious questions about whether Brundtland's reforms have

Box 1: Fiona Godlee's *BMJ* series on WHO

WHO in crisis. *BMJ* 1994;309:1424-8. (http://bmj.com/cgi/content/full/309/6966/1424)

WHO in retreat: is it losing its influence? *BMJ* 1994;309:1491-5. (http://bmj.com/cgi/content/full/309/6967/1491)

The regions—too much power, too little effect. *BMJ* 1994;309:1566-70. (http://bmj.com/cgi/content/full/309/6968/1566)

WHO at country level—a little impact, no strategy. *BMJ* 1994;309:1636-9. (http://bmj.com/cgi/content/full/309/6969/1636)

WHO fellowships—what do they achieve? *BMJ* 1995; 310:110-2. (http://bmj.com/cgi/content/full/310/6972/110/a)

WHO's special programmes: undermining from above. *BMJ* 1995;310:178-82. (http://bmj.com/cgi/content/full/310/6973/178/a)

WHO in Europe: does it have a role? *BMJ* 1995;310:389-93. (http://bmj.com/cgi/content/full/310/6976/389)

Interview with the director general. *BMJ* 1995;310:583-88. (http://bmj.com/cgi/content/full/310/6979/583)

been felt at country level. And in a surprise move, on 23 August this year Brundtland announced that she would not stand for a second term. A new director general takes office next July, leaving the future of Brundtland's reforms uncertain.

What impact have the reforms had on WHO's most important constituency—the poor? How has WHO engaged with other players in health? How is it responding to the multiplication of new global health initiatives? I will address these questions over the next few weeks, and begin here by discussing the reforms themselves.

Methods

I visited WHO's headquarters in Geneva, where I interviewed staff at many levels of the organisation, including Brundtland. I also interviewed WHO staff working in developing countries, former members of Brundtland's cabinet, three regional directors, health academics, and members of multinational and bilateral health agencies and non-governmental organisations. Finally, I read a wide selection of WHO documents, minutes of the meetings of WHO's executive board and the World Health Assembly, and journal articles and books dealing with WHO reform.

Mounting pressure for change

The five years before Brundtland came to power saw a growing international reform movement. This began from within WHO in 1993[3] and gained momentum with Godlee's *BMJ* series. Julio Frenk, Mexico's minister of health, a former executive director and a key architect of the Brundtland reforms, said that Godlee's series was "influential in shaping a debate about WHO, and internally it brought the critical situation to the fore. There was a realisation that WHO was at a crossroads."

Which direction should it take? Two government funded studies pointed the way.

A 1995 study provided evidence that WHO's donors were calling the shots (box 2).[4] The WHO has two funding sources. Its regular budget, frozen at about $800m (£517m; €817m) per two-year budget period, comes from dues paid by its member states. Its main funding source is from additional voluntary contributions (extrabudgetary funds) from a handful of donor countries, now worth $1.4bn per budget period. The study found that donors could influence how their donations were spent. The problem with this practice is that it can hinder WHO's ability to set its own long term priorities and budget for them accordingly.

A 1997 study examined the support that WHO was giving to countries to develop their health systems.[5] It found that some of the world's poorest countries received the least amount of support.

A series of gatherings of international health experts in 1996 and 1997 concluded that WHO's activities were uncoordinated, that its regional structure needed examining, and that the organisation was facing competition from other international health initiatives.[6] The meetings led to a declaration of issues that the next director general should address (box 3).[7]

Box 2: How donors can call the shots

WHO has two sources of funds. It receives "regular budget funds," which are the membership dues paid by its 192 member states. Since 1980 the regular budget has been frozen, limited by several member states defaulting on their contributions. It also receives "extrabudgetary funds," which are voluntary contributions from a handful of member states (called donor countries), other UN organisations, and private donors. These are largely used to fund disease-specific vertical programmes.

Funding from extrabudgetary funds first exceeded the regular budget in 1990-1, and today it makes up two thirds of WHO's total budget. Although extrabudgetary funds can benefit the health of low income countries, they come with strings attached—donors can influence WHO programmes "by deciding on the allocation, volume, designation, and specification of their extrabudgetary funds."[4]

Box 3: Key issues facing Brundtland at the start of her term[7]

- Defining WHO's essential functions
- Revising governance structures to give greater voice to new actors on the global stage
- Developing more effective mechanisms for responding to national requirements for capacity strengthening
- Creating effective arrangements for coordination between WHO and other agencies
- Enhancing the organisation's authority in scientific and technical matters
- Reassessing the relationships between WHO's headquarters, regional offices, and country offices
- Revising procedures for the allocation of resources to ensure that they give full weight to the needs of individual nations
- Ensuring that staff positions are created on the basis of need and filled on the basis of merit

Brundtland defines her agenda

How would Brundtland respond? Two months before taking office, she made her first speech to the World Health Assembly, the annual policy meeting of WHO member states.[8] She promised major organisational reform. She laid out four strategic directions for WHO: reducing the burden of disease, particularly in poor countries; reducing risks to health; creating sustainable health systems; and "developing an enabling policy and institutional environment in the health sector."[9]

The most important pledge she made—a pledge that some will judge her term by—was to create "one WHO." We must be able to say, she said, "WHO is one. Not two—meaning one financed by the regular budget and one financed by extrabudgetary funds. Not seven—meaning Geneva and the six regional offices."[8]

A hundred days of change

The first three months of Brundtland's leadership saw massive upheaval aimed at giving WHO a leaner structure. She reduced 50 programmes to 35 departments and grouped them into nine (now eight) clusters at headquarters (figure). The clusters were meant to reflect WHO's new strategic directions.

Gone were the assistant director general posts, widely held to be political appointments. Instead, an executive director was assigned to each cluster. This post was supposed to be held by a technical expert who controlled the cluster's budget. The idea was to create a more horizontal structure while bringing technical expertise towards WHO's centre.

Brundtland and her executive directors became a tight, government-style cabinet. Frenk believes that the cabinet "forces the executive directors to make collective decisions. Before these changes, WHO was a highly fragmented, feudal organisation." But one senior WHO insider said that there has been a gradual reversion to the old hierarchical system. There has also been a constant reshuffling of Brundtland's cabinet—only one original cabinet member remains. Brundtland argues that this was necessary to get the right mix of people, but many WHO staff say the changes created instability in the organisation.

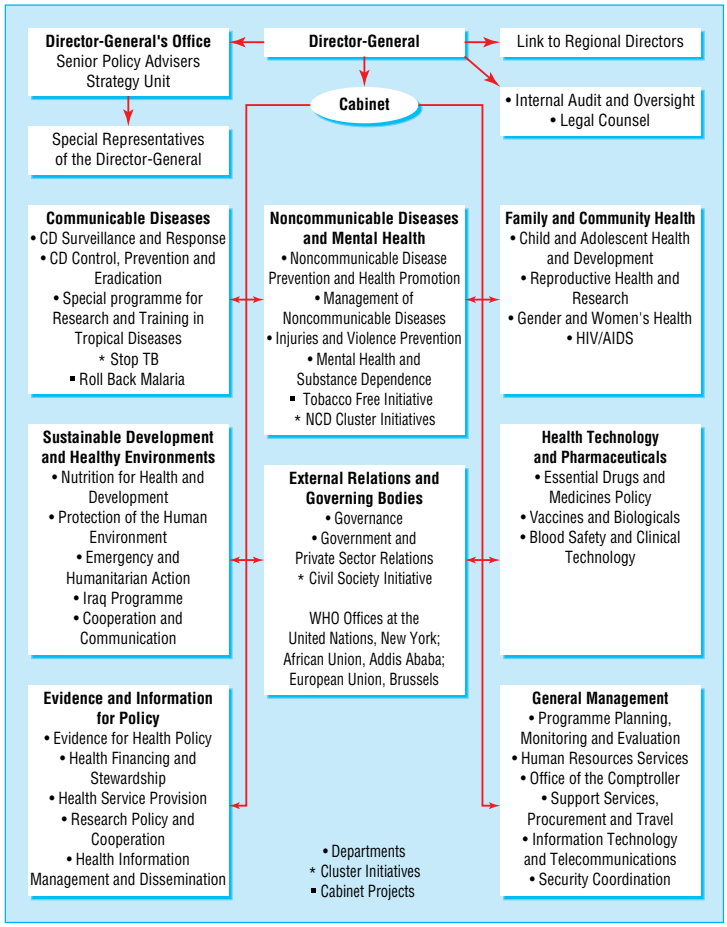
New partners, new campaigns

Brundtland galvanised important health campaigns with new partners from both the public and private sector.

In the months before taking office, she decided on two campaigns. The Tobacco Free Initiative, aimed at curbing the 4 million annual deaths from tobacco, led to two firsts for WHO. In October 2000, negotiations began towards WHO's first international treaty, the Framework Convention on Tobacco Control, set to be completed in May 2003.[10] Signatory states will be legally bound to implement measures for reducing tobacco consumption. In October 2000 WHO held its first public hearings, allowing civil society groups to give their input to the treaty.

The other campaign was Roll Back Malaria,[11] a public-private partnership that Brundtland called a "pathfinder project."[12] Malaria causes at least 3000 deaths a day, and the partnership aims to halve this rate by 2010.[11] Brundtland made no apologies for involving the private sector; she said it had "an important role to play, both in technology development and the provision of services."[8]

Partnerships have been a defining feature of Brundtland's term. But many of WHO's partners say that the organisation is finding it hard to give up its traditional driver's seat status. A recent external review of Roll Back Malaria found that WHO had a tendency to "go it alone" without adequate consultation with partners.[13]



WHO's cluster structure at headquarters. Source: WHO

A roadmap for WHO policy

"Brundtland," said Derek Yach, one of WHO's executive directors, is a "data oriented person." Over the course of her term, she emphasised the need for WHO to base its work on empirical evidence.

What is WHO?

WHO is an intergovernmental organisation with 192 member states, usually represented by their minister of health at WHO's decision making body, the World Health Assembly. This meets annually at WHO's headquarters in Geneva. The executive board, a group of 32 health experts elected for three year terms, advises the assembly.

WHO has six regional offices, shown on the map. It also has country offices, based within ministries of health, in selected member states.

The organisation's objective is "the attainment by all people of the highest possible level of health," where health is defined as complete physical, mental, and social wellbeing. WHO's strategy is to act through member states, advising their governments on technical matters and trying to influence health policy decisions. It also sets global standards for health promotion and disease control.

Box 4: Divided opinion on the DALY

The World Bank defines the DALY (disability adjusted life year) as "a unit used for measuring both the global burden of disease and the effectiveness of health interventions, as indicated by reductions in the disease burden. It is calculated as the present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year."[14]

One proponent of the DALY is Richard Feachem, executive director of the Global Fund for AIDS, TB, and Malaria. Feachem chaired the advisory committee for the *World Development Report 1993*. In 1999 he said that the report "broke new ground in presenting the global burden of disease analysis and inventing the metric of the DALY, which has now become widely adopted in discussions about health sector development. It broke new ground in taking forward the debate about cost effectiveness, as you're able to measure mortality outcomes and morbidity outcomes through the DALY."[15]

But critics questioned the methods and the ethical assumptions used in calculating the DALY, and they believed that DALYs were an inappropriate and unfair criterion for resource allocation. Sudhir Anand, professor of economics at the University of Oxford, and Kara Hanson of the London School of Hygiene and Tropical Medicine, argued that "the DALY information set consists only of age, sex, disability status, and time period, which does not allow individuals' socioeconomic circumstances to be taken into account. An equitable approach to resource allocation will use a criterion which attaches a greater weight to the illness of more disadvantaged people."[16]

As her roadmap for guiding WHO policy, she chose the World Bank's *World Development Report 1993*.[14] This measured the global burden of disease and the cost effectiveness of different health interventions using a new unit, the disability adjusted life year (DALY). The DALY was highly controversial (box 4).[15 16] The report argued that countries should prioritise cost effective interventions instead of broadly strengthening their health systems.

Brundtland brought many of the report's authors from Harvard to establish a new unit, Evidence and Information for Policy. The WHO, said one academic in global health, had become "a branch of Harvard and the World Bank."

The unit had a profound impact on Brundtland. She established priorities for the organisation (box 5) that are heavily influenced by the DALY.[17] She talked of a "new universalism" that sees cost effectiveness as a tool for choosing which health services governments should provide.[18] And it was this unit that produced the *World Health Report 2000*, released in June 2000, which measured the performance of countries' health systems and ranked them into a league table.[19]

Box 5: WHO's global priorities[16]

Malaria, tuberculosis and HIV/AIDS: major communicable diseases that pose a serious threat to health and economic development; all need new and affordable diagnostics, drugs, and vaccines

Cancer, cardiovascular disease, and diabetes: growing in importance in poor and transitional countries

Tobacco: a major killer in all societies and a rapidly growing problem in developing countries

Maternal health: the greatest difference in health outcomes between developed and developing countries shows up in maternal mortality data

Food safety: a growing public concern, with potentially serious economic consequences

Mental health: five of the 10 leading causes of disability are mental health problems

Safe blood: blood is a potential source of infection and a major component of treatment

Health systems: development of effective and sustainable health systems underpins all the other priorities

Investing in change in WHO: a prerequisite for WHO to become a more efficient and productive organisation

The report was explosive. Many countries objected to their ranking; the report's methods were savagely criticised and its relevance to developing countries was questioned.[20 21] At its meeting in January 2001, WHO's executive board, a group of 32 health experts that advises the World Health Assembly, requested that Brundtland commission an external review of the report's methods.[22] The future of the health systems ranking is now uncertain.

Was ranking a valuable exercise? It succeeded in igniting an important debate about what makes for a good health system and why various countries perform so differently. But Brundtland handled the release of the report poorly. There was too much secrecy around the process of data collection, and inadequate consultation with developing countries before its release. Many WHO staff I spoke to complained of an unhealthy atmosphere at headquarters in which internal dissent about the report was stifled.

Progress towards "one WHO"

What progress did Brundtland make towards streamlining activities at headquarters with those of the regions?

One stumbling block was the long-running autonomy of the regions. A 1946 report on an international meeting to elaborate WHO's constitution noted that the Pan-American Sanitary Bureau, which became WHO's regional office for the Americas, "desired to continue the Bureau as an automatous body."[23] The director general has little authority over the regional directors because she does not elect them—they are elected, like her, by WHO's member states, which puts them all on an equal footing. Reform of WHO's regional structure would have to address this structural problem.

My impression from interviewing WHO staff and health professionals outside the organisation is that the independent functioning of the regions is still getting in the way of WHO's effectiveness. The external review of Roll Back Malaria, for example, noted "an uneasy relationship between WHO headquarters and the regional offices," particularly with the African regional office.[13] Brundtland, say many WHO staff, managed to have closer working relationships with the regional directors but did nothing to challenge their long-held autonomy.

Too little, too late

Brundtland's senior staff say that her reform process has two phases. The first involved a shake up at headquarters. WHO is now entering the second phase—looking at the support it gives to countries.

At this year's World Health Assembly, in May 2002, Brundtland announced WHO's "country focus initiative," which is aimed at strengthening WHO's presence at country level.[24] But many WHO staff questioned why


WHO

Gro Brundtland restored WHO's credibility with donors

this initiative was so late in coming, and one asked whether it was just lip service. With a change of director general next year, phase two is surely now in jeopardy.

Gill Walt, professor of international health policy at the London School of Hygiene and Tropical Medicine, summed up the dilemma at the heart of the Brundtland term: "There's a huge gap between what's going on at the global level—such as new global partnerships—and what's happening at the country level, where they are struggling to deliver services and don't always know about these networked initiatives."

A changing landscape

Brundtland's term coincided with a surge of interest in international health. Rich governments started talking about global health at the G8 summit in 1997. The Gates Foundation put $2.8bn into global health initiatives that are largely outside of WHO's governance. The Global Fund is a new public-private health funding mechanism, with its own governing body, that committed up to $616m in April this year to the prevention and treatment of AIDS, tuberculosis, and malaria.

The landscape of global health is changing, fragmenting into a huge array of new initiatives and alliances. Where does this leave WHO? This is a question that the organisation is still grappling with. Peter Piot, executive director of the joint United Nations programme on HIV and AIDS, believes that in the new global set up "WHO still has to look for its place in the world."

Brundtland's legacy

Brundtland played a key role in restoring political interest in health. Her major contribution, said Piot, "will have been to put health on the international political agenda. That was her legacy."

One way in which she raised the profile of health was through the report of the Commission on Macroeconomics and Health.[25] Many of those I interviewed referred to this report as an outstanding piece of advocacy work, that made the compelling case that investing in health is vital for global economic development.

Brundtland stands down

One term is a brief period in the history of a huge UN bureaucracy, and so Brundtland's decision not to stand for a second term came as a shock. The reason she gave for not standing was that she would be 69 years old at the end of a second term.

I visited WHO's headquarters the week after her announcement. There was widespread speculation about whether there might have been other reasons for her departure, such as her increasing dislocation from her staff. There was a feeling that while she boosted staff morale when she took office, she squandered their initial enthusiasm by becoming increasingly isolated, uncommunicative, and hidden behind her cabinet. She also faced two huge pressures—mounting criticism of the *World Health Report 2000* and difficulty in making any real change to WHO's troubled regional structure.

Conclusion

Brundtland injected a strong sense of direction into an ailing bureaucracy by focusing its efforts on a few priorities. Through high profile global health campaigns and the Commission on Macroeconomics and Health, she put WHO back on the global map. Donor governments have a renewed confidence in WHO and have steadily increased their extrabudgetary donations.

But Brundtland's managerial changes have had a mixed reception from WHO staff, and she has failed to extend her reforms beyond headquarters. Her vision of "One WHO" has not yet been realised. There is still a dislocation between headquarters and the regions. The WHO continues to be funded by two distinct sources, and donors are still influencing how their donations are spent.

WHO

WHO's Tobacco Free Initiative aims to curb the 4 million annual deaths caused by tobacco

Brundtland recentralised WHO, concentrating its focus on Geneva. This tactic helped launch new alliances, such as Roll Back Malaria, but WHO is not comfortable in its partnership role and these alliances have not yet had a major impact on the world's poor.

Competing interests: The *BMJ* receives submissions and commissions papers from many WHO authors, but GY is not involved in decisions about publication of these. GY now works for BMJ Unified, a joint venture between the BMJ Publishing Group and United HealthCare Services Inc (www.besttreatments.org)

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Family history

A box on the cremation form requests a "description or occupation" of the deceased, an apparent anachronism in these days of DNA fingerprinting and mass unemployment.

In the first enthusiastic flushes of work, however, I tried to be meticulous about that box. If there was no occupational history in the patient's records, I would ask the nurses; sometimes they had listened to the patient's reminisces. Occasionally, when bereaved families seemed anxious to talk about their late relative, I could ask them directly. It rarely otherwise seemed appropriate, though, and consequently I often found myself writing "Retired" in the box.

Another month found me more pragmatic about the box: the quickest of glances through the notes became all that was necessary for the entry in the box to read "Retired." What harm could it do? The person was dead and would not be turned away from the crematorium on the grounds that he was specifically a retired milkman or had kept working part time in the Post Office. I saw no harm in it, in saving the precious time for my living patients and trying to ensure I would not be filling out any more cremation forms that week.

But then I encountered a document that changed everything: a genealogist's research into my maternal family history. The story of one's forebears makes for compelling reading, and the medic in me was intrigued by the antiquated diagnoses listed as cause of death—senile hypocarditis, phthisis pulmonalis.

The information obtainable was otherwise tantalisingly sparse. Only the occupation, recorded then on the death certificate, provided insight into our family history: rural poverty in 19th century Ireland giving way to Edinburgh trades by the end of the first world war, *Angela's Ashes* dragged out over half a dozen generations.

As doctors, we have a litany of roles to fulfil. Few of us probably consider ourselves historians, yet the testimony of long dead doctors is more or less all I now know of my ancestors who left Ireland to seek a better life. According to the records those doctors made, one great-great-great grandfather was a "hawker of old clothes," and another was a "scavenger." There were also numerous costermongers and chargirls, many of whom, unable to write, had to ink an X on their marriage certificates.

Would my relatives mind being recalled in this way? I am certain they would not. Family legend is of a proud people who would not have wished to hide behind the sheltering anonymity the word "retired" provides. A God-fearing bunch, their devotion to the religion they brought from Ireland was matched only by their belief in the value of hard work and education. That their children and grandchildren became electrical engineers and manufacturing chemists, as documented by our medical predecessors, serves as tribute to this.

Rarely now will I sign a form without having ascertained the deceased's occupation. At the crematorium no one seems to notice, but perhaps, a century from now, a great-great-great grandson will be grateful somebody took the time to find out.

Simon P Stephenson *on sabbatical, Glasgow*
(writesimon@hotmail.com)

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.