BRUNDTLAND'S WORLD HEALTH

A Test Case for United Nations Reform

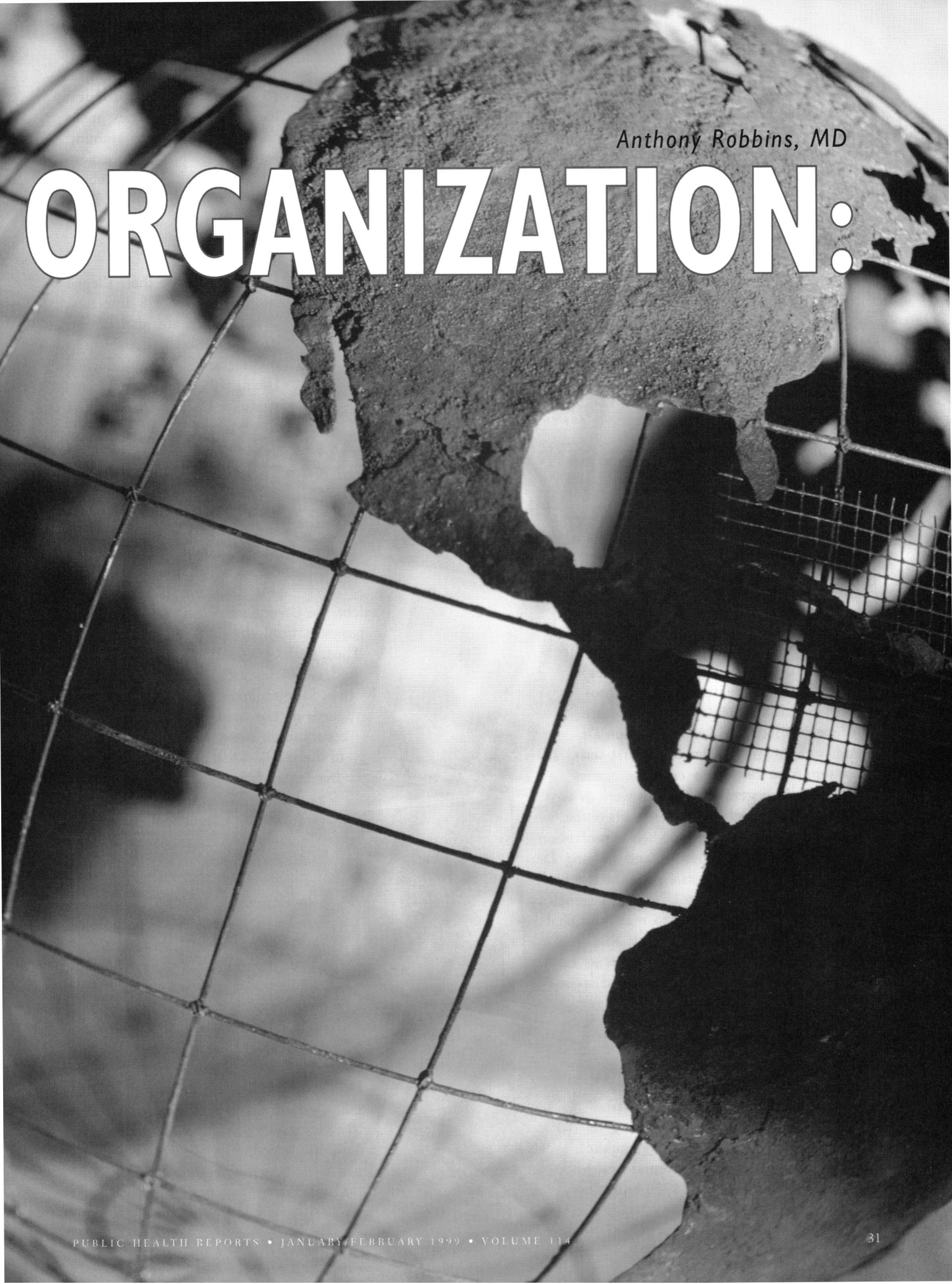
"GOOD RIDDANCE," editorialized the WASHINGTON POST on the announcement in 1997 of the departure of Hiroshi Nakajima from his post as Director General of the World Health Organization. "It is hard to think of any single person in the United Nations constellation who has done more harm to the effectiveness and reputation of the world organization."[1] Among the health professionals at WHO headquarters in Geneva, the rejoicing was cautiously more subdued, and has now been replaced by a sense of excitement and expectation about the new Director General, Gro Harlem Brundtland.

SYNOPSIS

Gro Harlem Brundtland, who became Director General of the World Health Organization in July 1998, has created a small revolution at the WHO headquarters in Geneva. She is in the process of changing how WHO works, how it interacts with other parts of the United Nations system, and how it enlists ministries, whole governments, universities, and other private organizations to improve health in the world. Here, the Editor describes the reorganization, the new people and resources, and prospects for setting a precedent in United Nations reform.

Dr. Brundtland, the former Prime Minister of Norway, is a physician with a master's degree in public health that she earned in the United States. Nominated in January 1998 by WHO's Executive Board, she was elected Director General by the World Health Assembly in May and assumed the post in July. I took the opportunity of a trip to Geneva in early September to get a glimpse of the Brundtland revolution and to find out where WHO is headed.

Aware of how little most of my US colleagues in public health are engaged with WHO and how much disdain is expressed in this country for UN bureaucracy, I began most of my conversations by asking how I should explain WHO to our readers and how to describe what Dr. Brundtland is doing. The replies were remarkably consistent, as if WHO had been struggling with ways to explain itself to people in the US and had settled on a particular approach. "Make the self-interest argument," they said. The United States, like other industrial countries, sees itself giving more to WHO than it receives back in benefit. The current conservative political climate has made our country even less willing than in the past to contribute to international organizations out of a sense of duty or global responsibility.



Anthony Robbins, MD

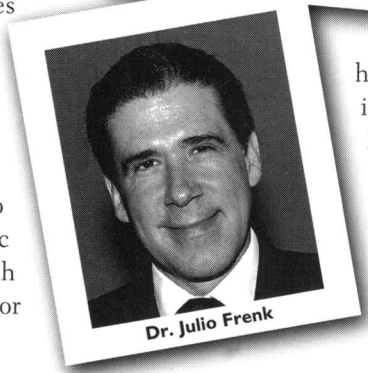
ORGANIZATION:

My WHO colleagues reassured me that we in the US are indeed reaping great benefit from our WHO contributions. Without WHO, the world would not have eradicated smallpox, a single achievement that saves us millions of dollars annually. Global surveillance and control of communicable diseases, quarterbacked by WHO, protect Americans at home and abroad. These activities make the world safer and more prosperous, and a thriving world economy has become essential to prosperity for us at home. In 1997, the Institute of Medicine (IOM) made the case eloquently for American investment in international health by marshalling the scientific evidence: the IOM concluded that we benefit because improved global health protects our people, enhances our economy, and advances our international interests.[2]

[Dr. Brundtland's] is the first serious attempt to rethink a complex agency within the UN system and make it work in a world vastly different from 1948, when the UN was founded.

Dr. Gro Harlem Brundtland

Dr. Jie Chen



Dr. Julio Frenk

It may take a while before the US heeds the IOM's advice and contributes generously to international health programs, including WHO, but there are other reasons for us to keep an eye on Dr. Brundtland's progress. Hers is the first serious attempt to rethink a complex agency within the UN system and make it work in a world vastly different from 1948, when the UN was founded. If US public health professionals are not engaged, watching and helping Dr. Brundtland's efforts, the lessons may be lost both for our country and for other UN system agencies that need similar revolutions to meet the challenges of the 21st century.

WHO and other UN system agencies have evolved far more slowly than the world around them. One of the most important changes is the relative importance of the world's health care sector. In contrast to the situation in 1948, spending on health today consumes a large fraction of the gross domestic product in every industrial country and this pattern is spreading to newly industrialized states. "In 1990 public and private expenditures on formal health services worldwide reached $1700 billion or 8% of total world product. Industrialized countries spent almost 90% of this amount, with average per capita expenditure on health care of about $1500. In contrast, developing countries spent the remaining 10% with per capita expenditure of only $41."[3]

In addition to their alleged failure to serve US interests, UN agencies are also viewed by most Americans as bloated and ineffective bureaucracies. Their existence raises a specter of world government and loss of sovereignty. Congressional skepticism or hostility has left the US heavily in arrears to the UN, threatening the world organization's effectiveness. The US owed WHO about $40 million at the start of the 1998-1999 budget biennium. Compounding the effect of this debt, the US regularly withholds our annual payment until the last calendar quarter. Thus, each October, WHO enters its final budget quarter without the US contribution, $108 million this year, equal to one-fourth of the total budget. Yet the US contribution is smaller than the budget of the smallest institute at the National Institutes of Health.

BRUNDTLAND'S REFORMS

American public health professionals can help assure that our investment at WHO is well spent and can play an important role in observing and supporting Dr. Brundtland's reforms. But to achieve this end we must understand what is happening at WHO.

Dr. Brundtland carefully planned her five-year term even before she was inaugurated, and then on her first day, July 21, 1998, gave her initial address to her colleagues in Geneva. With support from the Norwegian government, she had been able to assemble an independent group of experts from around the world in Oslo. She arrived in Geneva with her

MALARIA SITUATION

Shaded portions show areas of the world at moderate to high risk for malaria. WHO's Roll Back Malaria initiative urges governments of member states to exploit technical advances in malaria control to protect the two billion people at risk from the disease that kills 1.5 million to 2.7 million people a year.

SOURCE: WHO/CTD, 1997

leadership team selected and largely assembled. (See "The New Team," p. 34.) Many WHO staffers called my attention to the way she had introduced the changes she proposes: "Yes, there will be change. A change in focus. A change in the way we organize our work. A change in the way we do things. A change in the way we work as a team....[W]e must pull WHO together by focusing our efforts around our core businesses.... WHO is not and will not become a field agency. Our role is to give the best advice—support and develop the best policies—trigger and stimulate the best research."[4]

Dr. Brundtland seems, in large part, to be drawing from the work of others to understand WHO's "businesses." Dean Jamison, Julio Frenk (both part of her new team), and Felicia Knaul described in 1997 how WHO might distinguish between core and supportive functions.[5] "Core functions transcend the sovereignty of any one nation state, and include promotion of international public goods (e.g., research and development), and surveillance and control of international externalities (e.g., environmental risks and spread of pathogens)." In contrast, "supportive functions deal with problems that take place within individual countries, but which may justify collective action at [the] international level owing to shortcomings in national health systems—such as helping the dispossessed (e.g., victims of human rights violations) and technical cooperation and development financing." The core functions would be needed in all parts of the world—from the established market economies, to developing countries, to the least developed countries that these authors describe as "countries in crisis." The supportive functions would be most critical in the least developed countries and largely unneeded in the established market economies of the industrial world.

Jamison, Frenk, and Knaul emphasize the difference between core and supportive functions in their analysis. "The distinction between core and supportive functions has important implications. Core functions are an attempt to solve the global analog of 'market failures'—

i.e., situations in which cost and benefits of an action are not reaped exclusively by the individual agent, in this case, the nation state. Supportive functions, by contrast, are intended to compensate for 'government failures'—i.e., scenarios in which a government cannot fulfil its responsibilities independently. The ultimate goal of supportive functions is to help countries move from dependence to independence, whereas the goal of core functions is to help them move from independence to interdependence, which represents a higher level of international cooperation—and the only way to meet the challenges of the global era."[5]

The supportive functions, which help countries develop effective preventive and curative services within their borders, require the expertise of WHO's professionals, but they may also require resources well beyond WHO's means. And here is where Dr. Brundtland envisions intimate collaboration with the other UN agencies that specialize in development assistance, the World Bank, UNICEF, and the United Nations Development Programme, "uniting our forces for health, development, and poverty reduction."[4] Three other international agencies, the World Trade Organization, the World Intellectual Property Organization, and the United Nations Commission on Trade and Development can also be important players in the health sector, as their policies affect the availability and price of pharmaceuticals, vaccines, diagnostics, and devices.

As more nations become industrialized and establish market economies, Brundtland envisions WHO evolving. Often perceived as a development agency specializing in health, WHO would become a global health agency. The core functions will expand and the supportive functions will be shared with the true development agencies. Others have envisioned the stages as progress from an *interministerial* to an *intergovernmental*, to an *international*, to a *global* health organization.

THE NEW TEAM

Executive Directors:

- Jie Chen, Non-Communicable Diseases, from China, has the smallest budget but has perhaps the largest problems, including tobacco control.
- Julio Frenk, Evidence and Information for Policy, from Mexico is charged with creating a new program to guide both WHO's and countries' health policies.
- David Heymann, Communicable Diseases, from the United States, has spent most of his career working in developing countries.
- Ann Kern, General Management, from Australia, with a staff of 450, is responsible for budget and personnel.
- Souad Lyagoubi-Ouahchi, External Affairs and Governing Bodies, from Tunisia. She will manage external relations with all of WHO's potential partners.
- Michael Scholtz, Health Technology and Drugs, from Germany's private sector, is responsible for both advancing and helping regulate drugs and technology.
- Olive Shisana, Family and Health Services, from South Africa, directs 253 people. Her goal is to help countries improve health systems.
- Poonam Khetrapal Singh, Sustainable Development and Healthy Environments, from India, has responsibility for occupational and environmental health. She will be looking at how environmental and economic issue affect health.
- Yasuhiro Suzuki, Social Change and Mental Health, from Japan, has a budget of $21 million to work on mental health, substance abuse, violence, disability, rehabilitation, family structure, and aging.

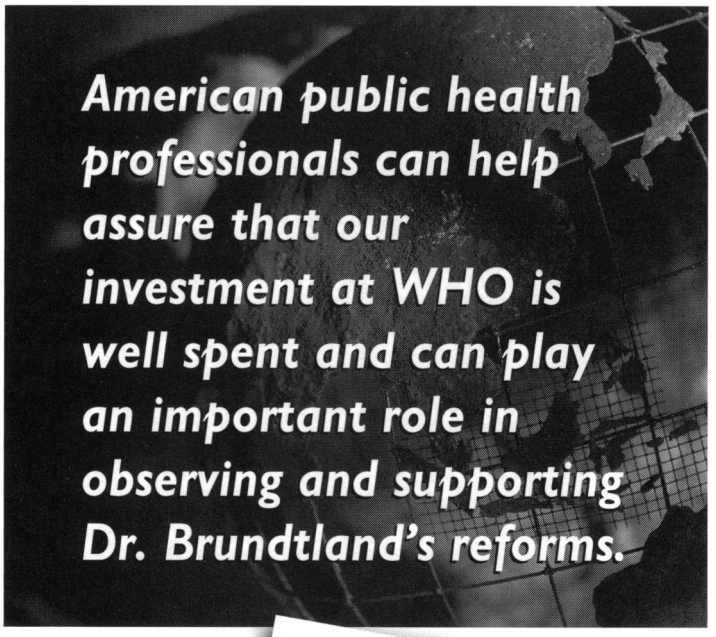
THE BRUNDTLAND STRATEGY

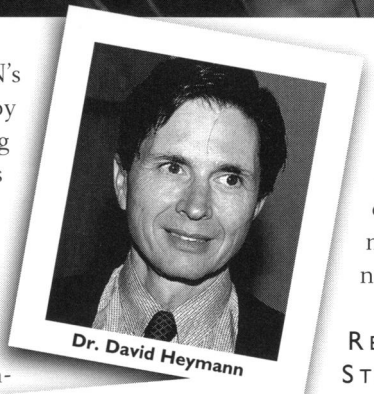
Today WHO is an *interministerial* organization, as each ministry of health is represented in the World Health Assembly, which governs WHO. Everyone in Geneva knows what this means, but the truth goes unspoken: WHO has gathered together 191 ministries, each of which is either the least powerful or nearly the least powerful in its government. It would be impossible to find a minister of health in the world who outranks the minister of defense or finance, and many are also outranked by ministers of transport, education, and communications. To make matters worse, these ministers of health come and go rapidly.

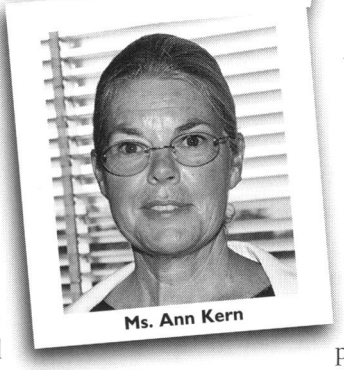
Can a new political approach to combating disease help make WHO programs intergovernmental, not simply interministerial? By bringing presidents, prime ministers, and ministers of finance and planning forward to discuss and then support efforts to control malaria, the Brundtland team is testing WHO's ability to engage whole governments of member states in a top priority—in this case the Roll Back Malaria initiative. Technical advances in malaria control might not seem to justify a new all-out assault on the disease that kills 1.5 million to 2.7 million people per year. WHO believes, however, that unless the countries at risk commit to using impregnated anti-mosquito bednets and vector control today, the problems of drug-resistant plasmodia will spread and intensify, making the world less able to employ new science and technology in the future. Today almost two billion people in Asia, Africa, and the Americas live in

zones of moderate or high risk.

Brundtland has entrusted the interim leadership of Roll Back Malaria to her countryman Tore Godal, who recently stepped down from his successful leadership of the Special Programme for Research and Training in Tropical Diseases, which prospered outside the regular WHO budget. Unlike in previous WHO campaigns, Brundtland seems wisely to have taken a chapter from the late James Grant of UNICEF (perhaps the UN's greatest success in mobilizing nations) by demanding that a country sign on, committing its will and resources before WHO experts are sent in.




Dr. David Heymann


Ms. Ann Kern

Dr. Brundtland would like to see WHO become an *intergovernmental* organization as a step toward becoming a truly international, and then a truly global one. If the malaria campaign is successful, efforts to control tobacco, eradicate polio, care for aging populations, and cope with the burden of mental illness may then adopt similar approaches that reach beyond the ministries of health, to whole governments.

As some of her key advisors explained to me, if WHO is to succeed with its mission of improving health, it will need to take the next step and become international, not just intergovernmental. WHO has created collaborating centers at universities and research institutions to capture their scientific expertise. Commercial firms with exceptional clout populate the health sectors of every industrial country and are beginning to take form in the newly industrialized nations that are in transition to market economies. WHO's Programme on Essential Drugs, for example, already engages consumer groups, manufacturers, and governments in its effort to assure that effective pharmaceutical products are widely available in the world. During the new Director General's first weeks, the Essential Drugs staff expressed a desire to draft a "consensus resolution" reflecting a compromise between the conflicting interests of governments, consumers, and the pharmaceutical industry. Despite her desire to engage all these parties, the Director General revealed her continuing attention to the science and substance in the organization's evolving process. Dr. Brundtland cautioned that WHO cannot measure success by consensus alone. Before proposing the basis for consensus, she wanted to be sure that "we know what we're talking about." That is, will the consensus serve the interests of health and will it work?

The final step, evolution from *international* to *global,* will come naturally as a strengthened WHO enlists all of the forces that can advance its efforts to improve health—governments plus industry, academia, and non-governmental organizations.

REORGANIZATION: THE STRUGGLE WITHIN

As anyone who has tried to manage a bureaucracy knows, the most difficult problems may reside within the organization. Dr. Brundtland wants to create an organization that can give the best advice, develop and support the best policies, and stimulate the best research. Although WHO will not be a field agency with large numbers of its personnel working in member countries, Brundtland recognizes that the ultimate test is how health programs function on the ground. And the six regional offices, including, for the Americas, the Pan American Health Organization (PAHO), are the elements of WHO closest to the field and farthest from Brundtland's control. The regional directors are not appointed by the Director General; rather they are elected by the ministers of health from the region. Thus each regional director has a constituency on whom he or she relies for the job.

The Director General has tried to include the regions in policy development, and each of her program clusters will have a contact person in each region, but

managerial changes may be more important. Brundtland has asked the regional directors to help her find vacant regional or country positions for some professionals currently in Geneva. This is the first time that headquarters has asked to be involved with regional personnel decisions. Is this a first step toward making WHO a more unified organization?

As Brundtland prepares for the big test of taking on the regional directors and making them part of her team, she has reorganized headquarters in Geneva in a most engaging way. The participation and democracy she brings to the organization is intrusive, in the best sense of the word—reaching far down into the ranks. Anxiety, however, is evident everywhere, provoked by a clear message that some programs will have to go. (See "WHO's Guidance in Identifying Activities to Be Phased Out," p. 37.)

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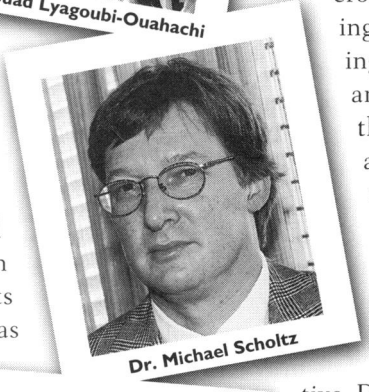
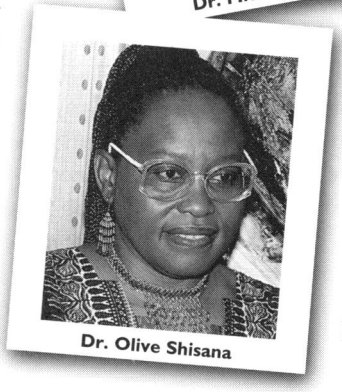
At the time of my visit, WHO was struggling at its top with principles, responsibilities, and crosscutting issues. At the base, deep in the ranks of the professional and support staff, the organization was struggling with uncertainty. I found that speculation and debate about internal changes dominated conversation around the offices and in the WHO staff cafeteria. The Geneva headquarters was drowning in the paper of reorganization, but only the broadest outlines had jelled by mid-September. Charts and matrices, some of which begged for third and fourth dimensions to incorporate all the concepts and interactions, had engaged participants in this sweeping reform, but in WHO's new spirit of openness, few of these concepts seemed destined to survive for long. Brundtland has stood by her promise that "no model is carved out in stone. We will learn as we go—being open to suggestions and ideas." Already, the catchiest title, "Cluster Head," had been replaced by "Executive Director" as the term "cluster" departed the formal WHO lexicon. While it lasted, cluster was an apt description of her drawing together groups of programs under one boss.

Dr. Souad Lyagoubi-Ouahachi



Dr. Michael Scholtz



Dr. Olive Shisana

Dr. Brundtland's cabinet of nine Executive Directors will make WHO policy with the help of six Cabinet Advisers. As one Executive Director said to me, "We will all own the policies that emerge from the cabinet. Thus we all expect there to be cooperation between programs." Each Executive Director has been charged with bringing forward a coherent plan and table of organization for the programs she (five are women) or he directs, and working with the other Executive Directors where collaboration is needed. While I was in Geneva, the Executive Director who leads the programs in Communicable Diseases, David Heymann, an American, convened all his program directors for a day-long retreat to hammer out responsibilities and clarify how they would handle crosscutting issues.

The Cabinet Advisers, including Jonas Store, Brundtland's Chief of Staff, will help Dr. Brundtland push the Cabinet's agenda, by shepherding crosscutting efforts and providing continuing oversight, keeping an eye on important goals and principles. For example, the Cabinet has handed one adviser, Dr. Daniel Tarantola, the responsibility for stimulating and coordinating blood safety activities, which will require participation from programs under at least three Executive Directors—Dr. Heymann, Dr. Olive Shisana for Family and Health Services, and Dr. Michael Sholtz for Technology and Drugs. Cabinet oversight, with the Advisers as watchdogs, will also assure that all WHO activities attend to the cabinet's overarching concerns, including gender, poverty, and human rights.

NEW PEOPLE AND RESOURCES

Is Brundtland likely to succeed in redirecting WHO? Many would judge such efforts by how much money becomes available for investment in new priorities and whether new people can be attracted to the endeavor. The money picture is not bright. In principle, up to 10% of WHO's budget can be reprogrammed in 1999, but every seasoned program director within WHO knew that a new Director General would search for unspent funds. Many program directors obligated their allotments early in the 1998-1999 biennium. Thus, virtually the whole biennial budget has been obligated, put beyond the reach of reprogramming, leaving only $9 million in a total two-year budget of $842 million to be reprogrammed by Brundtland. Any major shift in funding may have to await the start of the next biennium, January 2000.

In planning for the 2000-2001 biennium, the Director General's budget guidance called for freeing up approximately 5% of the budget through "efficiency savings" and another 10% by "sunsetting" unneeded programs. The money available to be reallocated for "sunrise activities," about $35 million, is more than most WHO staff had expected. As a seasoned bureaucrat I am tempted to ask whether the reallocated money will simply go to preserve activities, now renamed, from which the money was just taken?

So far, the single largest chunk of new money has gone to Executive Director Dr. Julio Frenk's new enterprise Evidence and Information for Policy. He will try to extend the kind of "value for money" analytic exercise that the World Bank undertook for its 1993 World Development Report and he then offered to the Secretary of Health in Mexico. Will this analytic exercise help bring new focus to WHO's programs—its "core businesses?"

The picture on the personnel side looks brighter because most of the professionals at WHO are hired on two-year contracts. If staff more appropriate to the tasks at hand can be found, almost half of WHO's professional cadre can be replaced within a year, and some will certainly go in the next few months. It is worth noting that US professionals are currently underrepresented in the WHO workforce, and more could be hired in the months ahead.

But not all of Brundtland's promises to move management out from a central core into the hands of her Executive Directors ring true. She said she would move hiring authority from a sluggish central bureaucracy to the Executive Directors, letting them move quickly on finding the people who will make or break their new undertakings. By September, only 19 of 450 central administrative people had been relocated to work directly for the programs, leaving skeptics wondering whether the WHO hiring process will really accelerate from its historically glacial pace.

WHO'S GUIDANCE IN IDENTIFYING ACTIVITIES TO BE PHASED OUT

DOES IT FIT WITH THE NEW WHO?
DOES IT MAKE A DIFFERENCE?

- Does it contribute to WHO's corporate goals (based on the Brundtland themes)?
- Does it have marginal or no impact on health and health sector development in countries?
- Are the primary beneficiaries the ones WHO is committed to reach?

IS ANYBODY GOING TO MISS IT?

- Would its absence in WHO's menu or response repertoire adversely affect cooperation with countries?
- Would its phasing out create major problems with any key stakeholders?

WHOSE JOB IS IT WITHIN THE ORGANIZATION?

- Is this an area of work which should be undertaken at only one level of the organization? If so, which?
- Could it be transferred to another level such as one or several regional Offices?
- If it is an "HQ only" activity, does it benefit regional and country levels?

HOW ABOUT A MERGER?

- Could it be merged with (subsumed into) another area of work/activity, within and/or between clusters?

CAN SOMEBODY ELSE DO IT BETTER?

- Could it be outsourced/contracted out to resource institutions and collaborating centers and what are the implications?
- Does it fit better with the mandate and comparative advantage of another UN/international organization?

LIFE CYCLE

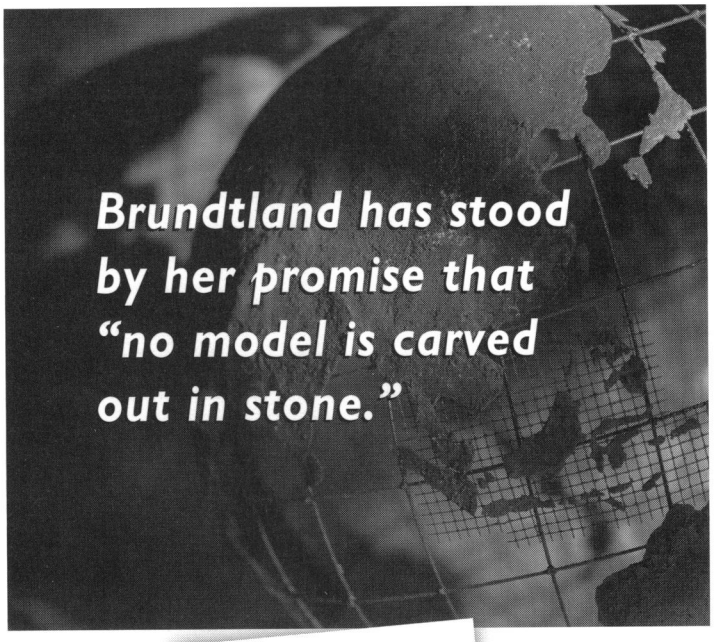
- Has it come to the end of its "natural" life? Is it a historical relic?

GLOBAL LEADERSHIP OFFICERS PROGRAMME

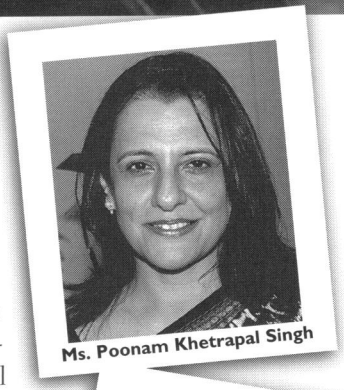
Change may have to come by bringing a new cadre in from the outside. To make this possible, the Rockefeller Foundation has provided the Director General with $2.5 million to bring new professionals into the organization. WHO has created the Global Programme on Evidence for Health Policy.

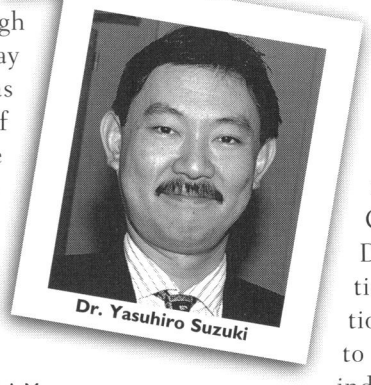
In addition, Rafe Henderson, formerly an Assistant

Director General, who will retire and return to Atlanta in March, is working on the new WHO Global Health Leadership Officers Programme, which already carries the acronym HLOP. The program will support professionals who are younger than 35 years of age during a two-year stint at WHO. They will have an opportunity to gain practical skills and knowledge for public health leadership—both formal training, including an introductory course in epidemiology, management, and communication, and supervised work at WHO.



In each of the next three years, WHO will select four "Health Leadership Officers (HLOs)" with advanced degrees in health-related fields and some work experience, preferably in developing countries. Women and candidates from developing countries will be especially encouraged to apply. Although Henderson hopes that the HLOs will stay and work for WHO, the organization has not committed to hiring them at the end of their two years. Dr. Henderson likened the HLOs to the Epidemic Intelligence Service officers at CDC. WHO has dreamed about such a program in the past, but under Brundtland it is coming to fruition.


Ms. Poonam Khetrapal Singh


Dr. Yasuhiro Suzuki

REINTEGRATING A SPECIAL PROGRAM

One further indication that Brundtland is serious about upgrading the professional cadre at WHO comes from a critical decision about the Special Programme in Research and Training in Tropical Diseases (TDR) which has received extrabudgetary funding and has stood outside of WHO's table of organization. In 1975, the World Bank, the United Nations Development Programme, and WHO chose to locate the program organizationally beyond the control of the WHO Director General and his regular WHO bureaucracy because the donors—the other UN agencies, the United States, the Nordic countries, and foundations—had grown wary of WHO—an interministerial organization that seemed to put politics ahead of science. In his address for the 75th anniversary at the Harvard School of Public Health, Barry Bloom, now Dean of that school, contrasted the scientifically sound support of research by TDR's leprosy program with WHO's incredible statement that for tuberculosis, research money "is wasted on projects that will be neither practical nor effective." TDR has assisted developing countries with highly targeted programs of research and training on tropical diseases and has established a fine scientific reputation under its directors, Adetokunbo O. Lucas and then Tore Godal.

At the risk of squelching this exemplary program, Brundtland's cabinet has decided to integrate it into Dr. Heymann's cluster of communicable disease programs. Brundtland succeeded in attracting a well-known researcher and administrator, Dr. Carlos Morel of Brazil, formerly the Director of the Oswaldo Cruz Foundation, to lead TDR. In its new organizational location, will Dr. Morel be able to protect TDR's tradition of scientific independence? Will success be infectious, spreading to the rest of WHO? Or will TDR's excellence slip beyond his control and into mediocrity? This is Dr. Morel's challenge.

The precedent of reintegrating TDR could be very important from a budgetary point of view. Extrabudgetary activities like TDR constitute more than 50% of WHO's spending, with country dues paying for less than half of WHO expenditures. If the donors and cosponsoring organizations find the new arrangement acceptable, the Director General may be able to increase the resources directly under her control.

CONCLUSION

I have risked presenting the details of reorganization—perhaps soporific for readers—to convey just how radical a change Brundtland brings to WHO. The scientific curiosity and intellectual rigor I found in the leadership will certainly enrich the organization. We in the US can learn from its endeavors. In the past, WHO experience enlightened many American public health leaders, including Bill Foege and D.A. Henderson. And occasionally Americans have had the temerity to seek direct help from WHO. A few years ago, the Kansas Health Department felt so strongly that it could learn from WHO that it invited Ciro de Quadros from PAHO to help it design statewide immunization days.

There is no question that as countries from the developing world enter the "epidemiologic transition"—to chronic diseases and the problems of aging in industrial societies—the experience of American public health professionals will be increasingly relevant. Talented Americans will be needed and sought out by WHO.

From 1948 to 1998, the nature of disease and the science of its prevention and treatment have changed radically. WHO is trying to catch up in a number of ways. Dr. Brundtland has called for focus from an organization with limited resources. At the same time, she has called for collaboration with others who can advance health. If she succeeds in leading governments, international organizations, consumers, and industry into organizing their actions and resources to advance health, we in the United States should pay attention. Perhaps we can achieve similar synergy at home. Not a bad idea, as our government fights the tobacco epidemic at home while continuing to support tobacco as a crop and the cigarette industry's efforts to market their addictive killers abroad.

Dr. Robbins is Editor of Public Health Reports.

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WHO

Dr. Gro Harlem Brundtland, center, with her new team of Executive Directors of the World Health Organization in Geneva. From left: Yasuhiro Suzuki, Japan; Jie Chen, China; Souad Lyagoubi-Ouahachi, Tunisia; David Heymann, United States; Dr. Brundtland, Norway; Julio Frenk, Mexico; Poonam Khetrapal Singh, India; Ann Kern, Australia; Michael Scholtz, Germany; and Olive Shisana, South Africa.