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WHO: Past, Present and Future

The World Health Organization and Global Health Governance: post-1990

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ABSTRACT

This article takes a historical perspective on the changing position of WHO in the global health architecture over the past two decades.

From the early 1990s a number of weaknesses within the structure and governance of the World Health Organization were becoming apparent, as a rapidly changing post Cold War world placed more complex demands on the international organizations generally, but significantly so in the field of global health.

Towards the end of that decade and during the first half of the next, WHO revitalized and played a crucial role in setting global health priorities. However, over the past decade, the organization has to some extent been bypassed for funding, and it lost some of its authority and its ability to set a global health agenda. The reasons for this decline are complex and multifaceted. Some of the main factors include WHO's inability to reform its core structure, the growing influence of non-governmental actors, a lack of coherence in the positions, priorities and funding decisions between the health ministries and the ministries overseeing development assistance in several donor member states, and the lack of strong leadership of the organization.

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Introduction

Since 1990, fundamental changes have been seen in both the wider political and economic context that influences health outcomes and in the shape of the global health architecture. To better understand these changes, this article attempts to draw up a brief chronology of the period.

There are several ways of indicating changing levels of activity in global health. For the purpose of this article the author have chosen to make use of three: The amount of Official Development Assistance (ODA) going to global health; the amount of innovation in terms of new initiatives/partnerships/institutions created to engender activity in global health; and global health outcomes.

It can be argued that these three indicators will emphasize the fight against infectious diseases and other poverty-related health problems at the expense of other vital functions of WHO, like non-communicable diseases, mental health, and global health policies, standards and regulations. However, as funding and health outcomes have become a central driver of global health priorities – and therefore also in shaping the views of WHO's successes and weaknesses – it is worth spending some time looking at the story these three indicators tell.

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Since 1990, these three indicators all show roughly similar trends. Together, they tell a story with three fairly distinct chapters: a period of relative stagnation or even deterioration in health outcomes, with stagnation in innovation and slow growth in funding from 1990 to 1997; a period of rapid expansion of funding, increasing complexity in health architecture and improving health outcomes from 1998 to 2009 and a period of uncertainty from 2010 onwards.

ODA and non-governmental funding for health increased by 49% from 1990 to 1997, from US$5.74 billion to US$8.54 billion. Most of this increase came in bilateral funding and in a significant increase in spending on health by the World Bank. This rate of growth pales in comparison with the funding during the following years. From 1998 to 2010, ODA and non-governmental funding for health grew 230%, to US$28.2 billion.[1]

Similarly, the period from 1990 to 1997 saw only a handful of new initiatives focused on global health. The period from 1998 to 2010, however, saw the birth of several dozen partnerships, initiatives, foundations and institutions dedicated to financing, coordinating or implementing global health programmes, or achieve global health goals.[2]

The 1990s was dominated by the rapid spread and acceleration of the HIV/AIDS pandemic from 8.9 million people living with HIV in 1990 to 23.1 million in 1997. AIDS deaths grew at a similarly rapid pace, from 380,000 in 1990 to 1.2 million seven years later.[3] TB incidence grew slightly globally, but an alarming growth in TB-HIV co-infection gave cause for concern and the rates of detection and completed treatment were worryingly low. Figures for malaria – although uncertain – indicated an increase in drug resistance, a growth in deaths and a breakdown of control-efforts in many countries.[4] Immunization rates of children stagnated at just over 70% coverage during these years[5] and efforts to introduce additional vaccines to the routine immunizations largely failed.[6] There was also substantial concern during this period about the reduction in research and development for new drugs and diagnostics for tropical diseases.[7]

These outcomes contrast with the positive results produced especially from 2004 onwards. Over the past ten years a reduction in new HIV infections and in AIDS mortality, a sharp decline in TB deaths, a significant reduction in malaria deaths, a steady increase in routine immunization coverage and the introduction of several additional vaccines as well as the arrival and widespread uptake of some important new drugs, vaccines and diagnostics for several diseases have been seen.

The evolution of the World Health Organization is closely tied to these trends and WHO has to a large extent been a driver of them. However, the author will argue that the organization has also been aversely affected by the rapidly changing landscape in global health, and that its influence and authority over time have diminished, partly as a result of its own actions, but mainly as a consequence of forces beyond its control.

The 1990s: a decade of backsliding in global health

In 1988, Dr Hiroshi Nakajima took over as Director General of the World Health Organization as Dr Halfdan Mahler stepped down after 15 years in office.

During Nakajima's first five-year term, the post World War II order, which for 40 years had provided stability and predictability in world affairs, unravelled. Some health consequences of the collapse of the Post War world order quickly became apparent. The most visible was the dramatic increase in tuberculosis in former Soviet states, as well as a deterioration of a wide range of health indicators in countries facing political and economic turbulence following the collapse of the Soviet Union.

WHO was largely unprepared for dealing with the health fallout of events that were rooted in larger political and economic developments, in particular since at the time it had a near exclusive interaction with nation states; states which governments during the 1990s were often in continual transition and severely weakened.

The rapid spread of the global HIV pandemic added to the pressures on WHO. Dr Jonathan Mann, who had built up the General Program on AIDS within WHO from a one-man operation when it started in 1986 to a $100 million program, resigned in 1990, citing 'major disagreements' with Nakajima.[8] The creation of a UNAIDS Secretariat independently of WHO in 1996 contributed to a sense that WHO was not equipped to lead the fight against such a 'modern' disease with its need for a complex, multifaceted response to issues like discrimination, judicial reform, behavioural change, and prevention strategies that challenged cultural and religious norms.[9]

Nakajima's focus was instead on using WHO for tasks that had brought successes for Mahler. He hoped that WHO could repeat the achievement from the smallpox eradication of the 1970s by creating a global campaign to eradicate polio. Alarmed by the steep rise in TB cases, WHO from 1995 onwards also promoted the adoption of the directly observed treatment short-course (DOTS), and in doing so, initiated a wide-ranging reform of most countries' TB treatment. While ultimately successful, these efforts only bore significant fruits in the following decade, giving Nakajima little credit during his time in office.

Much attention has been paid to the controversies around Nakajima's person and leadership – such as the conflict with Mann in 1990, a challenge to his re-election in 1992 and the following accusations of bribery, and a call for his resignation in 1995 following perceived racist remarks – but significant structural weaknesses within WHO were threatening the effectiveness of the institution independently of these scandals and they became increasingly apparent during the 1990s. Nakajima's main mistake may have been to fail to address these weaknesses head-on.[10,11]

In late 1994, a series of articles in the British Medical Journal,[12] listed the main weaknesses in WHO's existing structure and work, only putting into focus what had already been highlighted in several donor country and UN reports:[13]

1. WHO's country work was of greatly varying quality and impact, and saw little regional strategy and coordination;
2. its regional office structure fostered a lack of global coherence and coordination, added to bureaucracy, drove the politicization of health issues and promoted cronyism;
3. its extra-budgetary programmes were driven by donor priorities rather than reflecting global health priorities,

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