The World Health Organization and the World of Global Health

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Over the half century from 1948 to 1998, the World Health Organization (WHO) slipped from a commanding position as the unquestioned leader of international health to a much-diminished role in the crowded and contested world of global health. WHO began at a time of high idealism and heightened internationalist expectations, when visionary leaders saw the new organisation as the best hope for both health and peace in the post-war world (Fosdick 1944). That vision was glimpsed again at Alma-Ata in 1978, yet despite the dreams of many of its founders and early supporters, WHO was marked from its early days by political and diplomatic entanglements and budgetary constraints that, over five decades, compromised the organisation and restricted its operating capacity. Indeed, those entanglements and constraints eventually pushed WHO in the 1990s to try to reinvent itself as a coordinator of global health in a world with many new and powerful players.

The idea of a permanent, intergovernmental organisation for international health can be traced back to the creation in 1902 of the International Sanitary Office of the American Republics, which, some decades later, became the Pan American Health Organization (Cueto 2007a). Two European-based international health agencies also played critical historical roles. One was the Office Internationale d’Hygiène Publique (OIHP), which formally started functioning in Paris in 1907 and concentrated on the administration of negotiated international sanitary conventions and the exchange of information on reportable diseases (Abt 1933; Aykroyd 1968). The second agency, the League of Nations Health Organization (LNHO), began its work in 1920 (Balinska 1995; Dubin 1995). This organisation established its headquarters in Geneva, and over the course of the next decade and a half took on an increasingly ambitious range of activities (Borowy 2009; Weindling 2002). Although the LNHO was poorly budgeted by the League of Nations and faced opposition from some national health ministries and the OIHP, it received substantial support from the Rockefeller Foundation and was able to play an important and sometimes inspirational role in the inter-war period (Howard-Jones 1978; Weindling 1997). Both the OIHP and the LNHO survived through the Second World War, though barely, and were present at the critical post-war moment when the future of international health was defined (Borowy 2008).
WHO was planned and made operational by a series of international commissions which, working from 1946 to 1948 on a mandate voted in 1945 at the founding of the United Nations (UN), thrashed out a scope of work and basic administrative procedures (Goodman 1952). Country representatives were joined in this process by representatives of the Pan American Sanitary Bureau, OIHP, LNHO, and, until January 1947, of a well-funded and extremely powerful organisation new to the wartime and post-war 1940s, the UN Relief and Rehabilitation Administration (UNRRA), established in November 1943 (Sawyer 1947). For a brief few years, UNRRA played a crucial emergency role, working with a budget largely provided by the United States (US) and its the Second World War allies that far eclipsed the total resources of all other international health agencies. The first World Health Assembly convened in Geneva, Switzerland, in June 1948 and created the World Health Organization as a specialised agency of the UN, into which were formally merged the functions of OIHP, LNHO, and UNRRA. The Pan American Sanitary Bureau – then headed by former Rockefeller Foundation official Fred L. Soper – was allowed to retain semi-autonomous status as part of a regionalisation scheme, seen by many as forced upon WHO by the United States, that in the following years grew to a total of six WHO regional offices (in Africa, Europe, the Americas, south-east Asia, the eastern Mediterranean, and the western Pacific) (Howard-Jones 1981; Siddiqi 1995). The founding of WHO spanned post-war idealism and the hardening of the Cold War. Idealism was reflected in the preamble to its constitution (1948), in which health was defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ (WHO 2006: 1).

The first director-general of WHO, Canadian psychiatrist George Brock Chisholm, tried to maintain these broad global ideals. But he was frustrated at almost every turn by the intrusion of the national self-interest of WHO’s member countries, and especially by the rapidly intensifying politics of the Cold War (Farley 2008). The US played a contradictory role: on the one hand, it publicly supported the UN system and its broad worldwide goals and funded a significant portion of its budget, but on the other, it was insistent on its right to intervene unilaterally in the Americas and often elsewhere in the name of national security. As a main contributor to the WHO budget, the US threw around a lot of health policy weight.

As an intergovernmental agency, WHO was well-tuned to the larger political environment. The politics of the Cold War had an unmistakable impact on its policies and personnel. Thus, when the Soviet Union and other communist countries walked out of the UN system and, therefore, out of WHO in 1949, the US and its allies were easily able to exert a dominating influence. In 1953, Brock Chisholm, who had often testy relations with the US, completed his term as director-general and was replaced by the far more US-friendly Brazilian, Marcolino Candau. Candau had worked under Soper on malaria control in Brazil and was associated with the ‘vertical’ disease control programmes of the Rockefeller Foundation and their adoption by the Pan American Sanitary Bureau when Soper moved to that agency as director (Anonymous 1983). Candau would be director-general of WHO for over 20 years. During the period between 1949 and 1957 (when the Soviet Union returned to the UN and WHO), WHO was very closely allied with US interests.

In 1955, Candau was charged with overseeing WHO’s campaign of malaria eradication, approved that year by the World Health Assembly. The ambitious goal of malaria eradication had been conceived and promoted in the context of unexamined optimism about the ability of DDT indoor spraying to kill mosquitoes, and of new anti-malarial drugs to kill or neutralise the Plasmodium parasite. WHO’s malaria eradication programme was eagerly supported by another UN agency, UNICEF, and by the US State Department. The latter convinced the US Congress to fund the programme at a level of several million dollars (Cueto 2007b). Malaria eradication
advocates concentrated on the growing awareness of mosquito resistance to DDT, arguing that only a comprehensive and relatively quick campaign would eliminate malaria before it spread all over the world.

As Randall Packard has shown, the US and its allies also believed that global malaria eradication could not only be achieved, but would usher in economic growth and create expanded overseas markets for US technology and manufactured goods (Packard 1997, 1998). Eradication efforts would also help win ‘hearts and minds’ in the battle against communism. The campaign reproduced the development strategies of the time by importing technologies brought in from outside while making no attempt to enlist the participation of local populations in planning or implementation (Packard and Brown 1997). This model of development assistance fitted neatly into US Cold War efforts to promote ‘modernisation’ with limited social reform.

But when the Soviet Union and other communist countries returned to WHO in the late 1950s, they made their presence felt almost immediately. The Soviet representative to the 11th World Health Assembly (1958), Viktor Zhdanov, was the deputy minister of health of the USSR, who argued that it was now scientifically feasible and economically desirable to attempt to eradicate smallpox worldwide (Fenner et al. 1988). The USSR obviously wanted to challenge US influence and make its own mark on world health policy. In 1959, the Assembly committed WHO to a global smallpox eradication programme (SEP), for which the USSR promised to provide 25 million doses of freeze-dried vaccine. Recognising the shifting balance in the World Health Assembly, director-general Candau felt the need to accommodate to changing political realities by backing WHO’s smallpox eradication efforts. Yet for several years, WHO’s smallpox programme remained modest and minimal while the US-backed malaria eradication programme lumbered forward on a much larger scale (Fenner et al. 1988). During the 1960s, however, malaria eradication encountered major difficulties in the field that ultimately led to colossal and embarrassing failures. In 1969, the World Health Assembly declared that it was not feasible to eradicate malaria in many parts of the world and began a process of returning once again to a malaria control agenda, while the SEP went forward on an expanded scale.

As the latter programme grew, smallpox eradication gained considerable momentum from technical improvements – jet injectors and bifurcated needles – which made the process of vaccination cheaper, easier, and more effective. Even more importantly, the US’s interest in smallpox eradication sharply increased for foreign policy reasons (Manela 2010). The US did not want the USSR to gain unchallenged recognition for its global eradication efforts and thus felt the need to compete on the WHO stage. More positively, too, after a period of intensified tension in the early 1960s, both countries had begun to explore a more relaxed and collaborative détente phase of Cold War relations (Garthoff 1994). In 1965, the US pledged its support for a WHO-led programme to eradicate smallpox worldwide (Fenner et al. 1988). Candau was reluctant to commit WHO to a new US-endorsed global eradication campaign that might lead to another embarrassing failure, so insisted on US leadership to bear the blame if necessary (Henderson 1998a). At first disappointed that a Russian was not selected, the USSR agreed to the American choice of D. A. Henderson as head of the smallpox campaign, after deciding that he was both a good scientist and a person with whom they could work.

Thus began WHO’s stunningly successful intensified smallpox eradication campaign built on US-USSR collaboration and later celebrated as a major ‘cold war victory’. Henderson was an experienced and effective administrator who now proved himself also a masterful diplomat. He worked intimately and effectively with his Soviet counterparts to obtain the resources and personnel the programme needed, to smooth out problems when they inevitably occurred, and even to orchestrate diplomatic pressure to secure the cooperation of certain recalcitrant
countries (Henderson 1987, 1998). A good deal of his success depended on a de facto geopolitical understanding that the US would work primarily in Africa while the Soviet Union lent its major support to the Central Asian republics and the Indian subcontinent (Fenner et al. 1988). Even after Henderson left the programme and US–USSR tensions increased again in the late 1970s, WHO was able to bring the smallpox eradication programme to a successful conclusion (Fenner et al. 1988).

During the 1960s and 1970s, other major international events beyond US–USSR détente also influenced the course of WHO’s history. These included the emergence of decolonised African nations, the spread of nationalist and socialist movements, and the dissemination of new theories of development that emphasised long-term socio-economic growth rather than short-term technological intervention. Rallying in organisations such as the Non-Aligned Movement, developing countries argued vigorously for fairer terms of trade and the more generous financing of development (Bhagwati 1977; Rothstein 1979). This changing political environment was reflected in corresponding shifts within WHO. In the 1960s, WHO acknowledged that a strengthened health infrastructure was a prerequisite to the success of its eradication and control programmes, especially in Africa. In 1968, Candau called for a comprehensive and integrated approach to curative and preventive care services. Soviet representatives called for the study of organisational methods for promoting basic health services (Litsios 2002). In January 1971, the executive board agreed to undertake an internal study, and the results of this study were presented to the full executive board in 1973 (WHO 1972, 1973). WHO was beginning to move from an older model of health service to what would become the ‘primary health care’ approach (Litsios 2002, 2004). The new model drew upon the thinking and experiences of non-governmental organisations (NGOs) and medical missionaries working in Africa, Asia, and Latin America at the grass-roots level. It also gained saliency from China’s re-entry into the UN in 1973 and the widespread interest in Chinese ‘barefoot doctors’, who were reported to be transforming rural health conditions. These experiences underscored the urgency of a ‘primary health care’ perspective that included the training of community health workers, an emphasis on the creation of health outposts in underserved areas, and the tackling of basic economic and environmental problems (Bryant 1969; Newell 1975; Taylor 1976).

These new tendencies were embodied by Halfdan T. Mahler, a Dane, who served as WHO’s director-general from 1973 to 1988. In 1975, the World Health Assembly reinforced the trend, declaring the construction of national programmes in primary care an urgent matter. In the World Health Assembly the following year, Mahler proposed the goal of ‘Health for All by the Year 2000’. This slogan became an integral part of the primary health care movement. Mahler agreed to hold a major conference on the organisation of health services at Alma-Ata in the Soviet Union and to co-organise it with UNICEF. He was initially reluctant because he distrusted the Soviet Union’s highly centralised and medicalised approach to the provision of health services (Litsios 2002). And although the Soviet Union succeeded in having the conference on its territory, the results reflected Mahler’s views much more closely than it did those of the Soviets. The Alma-Ata Declaration of 1978 and the goal of ‘Health for All in the Year 2000’ advocated an inter-sectoral and multi-dimensional approach to health and socio-economic development, emphasised the use of ‘appropriate’ as opposed to excessive technology, and urged active community participation in health care and health education at every level (WHO 1978).

WHO now enjoyed considerable authority and esteem. Its smallpox eradication programme was in the final stages of successful completion, and Alma-Ata had added a sweeping vision and broad moral authority to WHO’s reputation. But this peak also marked the high point from which decline rapidly set in. Some tried to strategise for the next disease eradication campaign.
by naïvely imagining it as a simple vertical assault, despite Henderson's strenuous objections (Henderson 1998b). Even more disturbingly, a number of governments, agencies, and influential individuals saw WHO's view of primary health care as overly idealistic, unrealistic, and unattainable (Henderson 1980; Tejada de Rivero 2003). The process of reducing Alma-Ata’s idealism to a practical set of technical interventions that could be implemented more easily and assessed concretely began in 1979 at a small conference with a heavy US flavour held in Bellagio, Italy, and sponsored by the Rockefeller Foundation. Those in attendance included the president of the World Bank, the vice-president of the Ford Foundation, the administrator of USAID, and the new executive secretary of UNICEF (Black 1986, 1996). The Bellagio meeting focused on an alternative concept to that articulated at Alma-Ata – selective primary health care – which was built on the notion of pragmatic, low-cost interventions that were limited in scope and easy to monitor and evaluate. Pushed heavily by UNICEF, selective primary health care was soon operationalised under the acronym 'GOBI' (Growth monitoring to fight malnutrition in children, Oral rehydration techniques to defeat diarrhoeal diseases, Breastfeeding to protect children, and Immunisations) (Cueto 2004; UNICEF 1983).

In the 1980s, WHO also had to reckon with the rapidly growing influence of the World Bank. The Bank had initially been formed in 1946 to assist in the reconstruction of Europe and later expanded its mandate to provide loans, grants, and technical assistance to developing countries. At first, it funded large investments in physical capital and infrastructure, but then, in the 1970s, it began to invest in population control, health, and education, with the emphasis on population control (Ruger 2005). The World Bank approved its first loan for family planning in 1970. In 1979, the Bank created a population, health, and nutrition department and adopted a policy of funding both stand-alone health programmes and health components of other projects.

In its 1980 World Development Report, the Bank argued that both malnutrition and ill-health could be addressed by direct action with Bank assistance (World Bank 1980). It also suggested that improving health and nutrition could accelerate economic growth, thus providing a good argument for social sector spending. As the Bank began to make direct loans for health services, it called for the more ‘efficient’ use of available resources and discussed the roles of the private and public sectors in financing health care. Pushing a neo-liberal agenda that by the early 1980s the Bank and the International Monetary Fund had fully embraced, the Bank strongly promoted free markets and a diminished role for national governments (Harvey 2005; World Bank 1987). In the context of widespread developing-country indebtedness and increasingly scarce resources for health expenditures, the World Bank’s insistence on ‘structural adjustment’ measures to fulfil the terms of its loans at the very time that the HIV/AIDS epidemic erupted drew angry criticism but also underscored the Bank’s new influence.

In contrast to the World Bank’s increasing authority, in the 1980s the prestige of the WHO was beginning to diminish. One sign of trouble was the 1982 vote by the World Health Assembly to freeze WHO’s budget (Godlee 1994a). This was followed by the 1985 decision by the US to pay only 20 per cent of its assessed contribution to all UN agencies and to withhold its contribution to WHO’s regular budget, in part as a protest against WHO’s ‘essential drug program’, which was opposed by leading US-based pharmaceutical companies (Godlee 1994b). These events occurred amid growing tensions between WHO and UNICEF and other agencies, and the controversy over selective versus comprehensive primary health care. As part of a rancorous public debate conducted in the pages of Social Science & Medicine in 1988, Kenneth Newell, a highly placed WHO official and an architect of comprehensive primary health care, called selective primary health care a ‘threat … [that] can be thought of as a counter-revolution’ (Newell 1988: 906).
Another symptom of WHO’s problems in the late 1980s was the growth of extra-budgetary funding. As Gill Walt of the London School of Hygiene and Tropical Medicine noted, there was a crucial shift from predominant reliance on WHO’s ‘regular budget’ – drawn from member states’ contributions, based on population size and GNP – to greatly increased dependence on ‘extra-budgetary’ funding coming from donations by multilateral agencies or ‘donor’ nations (1993). By 1986–87, extra-budgetary funds of $437 million had almost caught up with the regular budget of $543 million. By the beginning of the 1990s, extra-budgetary funding had overtaken the regular budget by $21 million, thus contributing 54 per cent of WHO’s overall budget. Major problems for the organisation followed from this budgetary shift. Priorities and policies were still ostensibly set by the World Health Assembly, which was made up of all member nations, but this Assembly, now dominated numerically by poor and developing countries, had authority only over the regular budget, which had been frozen since the early 1980s. Wealthy donor nations and multilateral agencies like the World Bank could largely call the shots on the use of the extra-budgetary funds they contributed. They thus created, in effect, a series of ‘vertical’ programmes more or less independent of the rest of the WHO’s programmes and its decision-making structure. The dilemma for the organisation was that although the extra-budgetary funds added to the overall budget, ‘they increase difficulties of coordination and continuity, cause unpredictability in finance, and a great deal of dependence on the satisfaction of particular donors’ (Walt 1993: 129).

The growth of extra-budgetary funds and the embrace of selective primary health care resulted in some successful cases of disease control and new alliances between multinational agencies, NGOs, and the private sector. Two examples were the eradication of polio from the Americas and the control of onchocerciasis in Africa. In 1988, WHO and other multilateral agencies launched a campaign to eradicate polio by the year 2000, at a time when fewer than 50 per cent of the world’s children were receiving the recommended three doses of oral polio vaccine. An important private partner, Rotary International, raised funds, provided a network of volunteers, and ensured political support for the ‘Polio Plus’ initiative. Polio Plus was instrumental in setting guidelines and vaccination schedules, organising national vaccination days, and using modern refrigeration systems (the cold chain) to preserve the vaccine’s potency (Seytre and Shaffer 2005). Thanks to these activities, polio essentially disappeared from the Americas by 1991.

During the 1980s, onchocerciasis, a filarial disease causing wrinkling and depigmentation of the skin, eye lesions, and blindness, was brought under control thanks to WHO’s Onchocerciasis Control Programme (OCP) in West and Central Africa (WHO 1985a). When OCP began its work, about one million individuals were suffering from onchocerciasis, and at least 100,000 persons were blind. OCP concentrated its work in seven countries of the savannah zone, covering an area of 640,000 square kilometres, and established its headquarters in the Upper Volta (WHO 1976). Partners in OCP were bilateral agencies in several industrial countries, the UN Development Programme, the World Bank, the Food and Agriculture Organization, and the Special Programme for Research and Training in Tropical Diseases (TDR), hosted at WHO. TDR’s main goal was to identify new drugs for ‘neglected’ infectious diseases in poor nations (Morel 2000). Thanks to this broad partnership, the funding of OCP was significant.

Ebrahim M. Samba, a physician from Gambia, was appointed director of the OCP in 1980. In an unprecedented move, Samba travelled to the US and convinced Merck, Sharp & Dohme, which had developed and marketed ivermectin, an effective microfilaricide with few side effects, to provide the drug free of charge (Aziz et al. 1982). In addition, OCP used larvicides to destroy black fly vectors and produce a new biodegradable insecticide with no toxic effects for mammals and fish. By the late 1980s, it was estimated that 27,000 individuals were saved from
going blind and about 3 million children born within the OCP programme area since the start of operations were safe from onchocerciasis (WHO 1985b).

Despite these successes, from the late 1980s to the late 1990s, WHO struggled through the most difficult decade in its history. A decline in operating budget, competition with new organisations for the leadership of international health, and confrontation with the governments of industrialised countries critical of the UN eroded the agency’s former leadership position and created the perception that WHO was obsolete. This period coincided with Dr Hiroshi Nakajima’s two terms as director-general (1988–98). Nakajima’s critics blamed him for not doing enough to defend primary health care, for being incapable of adapting to new epidemiological and political realities, and for slowing the pace of institutional reform.

Particularly bitter criticism swirled around Nakajima because of his difficult relationship with Jonathan Mann, the controversial early leader in the fight against AIDS. Initially, WHO gave the disease low priority. Some changes occurred in 1985, when WHO co-sponsored the first international conference on AIDS in Atlanta, and in 1986 when the 39th World Health Assembly approved the creation of an AIDS programme within WHO. In February of the following year, the American physician Jonathan Mann became head of the Global Programme on AIDS (GPA) (Anonymous 1986). By the end of 1987, GPA was working with more than 90 countries, sending technical support missions to help design national AIDS programmes. In a 1987 briefing to the UN General Assembly, Mann sounded the alarm about the magnitude of the AIDS pandemic, and the danger of responses inspired by fear and discrimination. He argued that public health and human rights were fully compatible and that repressive policies endangered rather than protected public health (Altman 1987; Lewis 1987). Thus, in a short time, Mann was able to build GPA into the strongest and best-funded programme within WHO.

But Nakajima felt uncomfortable with the celebrity Mann enjoyed, the considerable independence with which he operated, and his expansive views on the importance of human rights for health. Nakajima also believed that the GPA had too much money and visibility and that attention needed to be paid to other diseases such as malaria and tuberculosis (Oestrich 2007). A study of all extra-budgetary funds for 1992 indicated that the GPA commanded over 25 per cent of these resources (Beigbeder 1998). Nakajima began to tighten control over Mann and restrict the operations of the GPA. In March 1990, after a series of angry exchanges in European newspapers, Mann resigned, citing his ‘major disagreements’ with the director-general. The US and many other industrial countries considered the event a major blow to the global campaign against AIDS and a black mark against Nakajima (Crosette 1997). The net result was that WHO lost its initial position in the world’s response to AIDS, and the agency that emerged as the new multilateral leader was the UN Programme on HIV/AIDS (UNAIDS), created in the mid-1990s and outside the control of WHO.

In the mid-1990s, Fiona Godlee published a series of articles vigorously critical of WHO and its current leadership (Godlee 1994a, 1994b, 1995), and concluded with this dire assessment going well beyond WHO’s bungled response to AIDS: ‘WHO is caught in a cycle of decline, with donors expressing their lack of faith in its central management by placing funds outside the management’s control. This has prevented WHO from [developing] … integrated responses to countries’ long-term needs’ (Godlee 1995: 182). As WHO lost credibility, the World Bank moved confidently into the vacuum. WHO officials were unable or unwilling to respond to the new international health economy structured around the Bank’s neo-liberal approaches (Brown 1993 1997; Zwi 2000). The Bank maintained that, not only in the case of AIDS but more generally, existing health systems were often wasteful, inefficient, and ineffective, and argued in favour of greater reliance on the private sector with the corresponding reduction of public involvement in the delivery of health services (World Bank 1987).
Controversies surrounded the Bank’s policies and practices, yet there was no doubt that it had become a dominant force in international health. The Bank’s greatest comparative advantage lay in its ability to mobilise large financial resources; by 1990, the Bank’s loans for health surpassed the total budget of WHO, and by the end of 1996, the Bank’s cumulative lending portfolio in health, nutrition, and population had reached $13.5 billion. Yet the Bank recognised that, whereas it had great economic strength and influence, WHO still had considerable technical expertise in matters of health. This was clearly reflected in the Bank’s widely influential 1993 World Development Report, ‘Investing in Health’, which gives credit to WHO, ‘a full partner with the World Bank at every stage in the preparation of the Report’ (World Bank 1993: iii–iv). Circumstances suggested that it was to the advantage of both parties for the Bank and WHO to work together.

This is the context in which WHO began to refashion itself as a coordinator, strategic planner, and leader of ‘global health’ initiatives. In January 1992, the 31-member executive board of the World Health Assembly decided to appoint a working group to recommend how WHO could be most effective in international health work in the light of the global change overtaking the world. The executive board may have been responding, in part, to the Children’s Vaccine Initiative, perceived within WHO as an attempted coup by UNICEF, the World Bank, the UN Development Programme (UNDP), the Rockefeller Foundation, and several other players, who were seeking to wrest control of vaccine development (Muraskin 1998). The working group’s final report of May 1993 recommended that WHO – if it were to maintain leadership of the health sector – must overhaul its fragmented management of global, regional, and country programmes, diminish competition between regular and extra-budgetary initiatives, and above all, increase the emphasis within WHO on global health issues and WHO’s coordinating role in that domain (Stenson and Sterky 1994).

In 1998, the World Health Assembly reached outside the ranks of WHO for a leader who could restore credibility to the organisation and provide it with a new vision – to Gro Harlem Brundtland, a former prime minister of Norway and a physician and public health professional who brought formidable expertise to the task. In the 1980s, she had been chair of the UN World Commission on Environment and Development and had produced the ‘Brundtland Report’, which led to the Earth Summit of 1992. She was familiar with the global thinking of the environmental movement and had a broad and clear understanding of the links between health, environment, and development (McMichael et al. 1996; McMichael and Haines 1997).

Brundtland was determined to position WHO as an important player on the global stage, to move beyond ministries of health and gain a seat at the table when decisions were being made (Kickbusch 2000). She wanted to refashion WHO as a ‘department of consequence’ able to monitor and influence other actors on the global scene (Kickbusch 2000: 985). Brundtland established a Commission on Macroeconomics and Health, chaired by the economist Jeffrey Sachs, then of Harvard University, and including former ministers of finance, and officers from the World Bank, the International Monetary Fund, the World Trade Organization and the UNDP, as well as public health leaders. The Commission issued a report in 2001, which was criticised by many for condemning the global status quo, but which won praise from some because it drew attention to the argument that improving health in developing countries was essential to their economic development (Commission on Macroeconomics and Health 2001; Mills et al. 2002; Waitzkin 2003).

Brundtland also began to strengthen the WHO’s financial position, largely by organising ‘global partnerships’ and ‘global funds’ to bring together ‘stakeholders’ – private donors, governments, and bilateral and multilateral agencies – to concentrate on specific targets (for
example, Roll Back Malaria in 1998, GAVI in 1999, and Stop TB in 2001). These were semi-autonomous programmes bringing in substantial outside funding, often in the form of public/private partnerships (Buse and Walt 2001; Reid and Pearce 2003; Widdus 2001). A very significant player in these ‘PPPs’ was the Bill & Melinda Gates Foundation, which committed more than $1.7 billion between 1998 and 2000 to an international programme to prevent or eliminate diseases in the world’s poorest nations, primarily through vaccines and immunisation programmes (McCarthy 2000). In 2002, the Gates Foundation donated $2.8 billion, $750 million of which went to GAVI (Maciocco 2008). But with the multiplication of PPPs came the multiplication of partners – Roll Back Malaria alone had more than 90 – which meant that leadership, management, and governance in global health had become extraordinarily complicated and confused (Yamey 2002c).

Brundtland’s tenure as director-general drew other criticisms, as well. Some looked with considerable scepticism at her worrisome bias towards the private sector and, particularly, the seeming favouritism of the pharmaceutical industry in the Commission on Macroeconomics and Health and the PPPs (Katz 2005; Motchane 2002; Richter 2004). Some have claimed that other urgent issues did not receive sufficient attention (health promotion, health and human rights, and social and economic restructuring to achieve health improvement) (Mittelmark 2001). Still others were frustrated by the director-general’s non-inclusive administrative style, the WHO’s poor staff morale, and the large gap between the rhetoric of transformation and the realities of institutional inertia (Yamey 2002a, 2002b). Nonetheless, few disputed the assertion that Brundtland succeeded in achieving her principal objective, which was to reposition WHO or, at least, begin to reposition it as a credible contributor to the rapidly changing field of global health (Aitken 2003; Horton 2002).

Yet rapid and dramatic changes over which Brundtland had little control continued during her term as director-general and in the years following. Perhaps most notable was the emergence of the G8 nations (France, the US, the UK, Germany, Italy, Japan, Canada, and the Russian Federation) as a major collective force in global health. Health first became an important agenda item for summit meetings under French and US leadership in the late 1990s, when the focus was primarily diseases that affected the member nations themselves (Kirtton et al. 2007). But when the Russian Federation became a full member, the G8 began to focus on HIV/AIDS. By 2000 the scope of health concern widened to include tuberculosis and malaria, and the G8 began to push for the creation of the ‘Global Fund to Fight AIDS, Tuberculosis and Malaria’, which was officially established in 2002 (The Global Fund to Fight AIDS, Tuberculosis and Malaria 2009; Labonte and Schrecker 2004). Since then the G8 has met regularly with African leaders, widened its agenda to include support for the health-related Millennium Development Goals, and broadened its approach still further to include health system strengthening (especially in developing nations) and maternal, newborn, and child health (Reich and Takemi 2009).

At recent G8 summits, increasing attention has been devoted to the reports and recommendations of a specially constituted G8 health experts group (G8 Health Experts Group 2008). But the G8 has also been listening to a group newly formed in July 2007 and calling itself the ‘H8’ (Health 8) – a self-appointed collaborative comprised of representatives from GAVI, the Global Fund, UNAIDS, the United Nations Population Fund (UNFPA), UNICEF, the World Bank, the Bill & Melinda Gates Foundation, and WHO (Reich and Takemi 2009; World Health Organization 2007). What is most notable about the H8 thus far is the World Bank’s acknowledgement that its financing is becoming a smaller proportion of global health funds overall and WHO’s new assertiveness in articulating a leadership role (Reich and Takemi 2009). WHO is only one of eight in the H8, but it is clearly jostling for recognition and authority as the global health leader with new energy and some success.
We thus return briefly to the issue with which this chapter began: what is WHO’s role in ‘global health’? The basic answer derives from the fact that WHO has had to work very hard to reinvent itself in order to maintain its authority in a new world that had initially bypassed it and declared it irrelevant. It had to find and keep a place on the rapidly evolving agenda it did not set and for which other, larger forces and stronger organisations were primarily responsible. But once in the mix, WHO contributed significantly to the dissemination of the new concepts and vocabulary of ‘global health’ and in that process gained recognition for what the organisation identified as a coordinating and leadership role (Yach and Bettcher 1998). Now many outside the organisation also promote this role for WHO, which suggests a brighter future on the basis of re-emerging legal, moral, and technical authority (Garrett 2007; Kickbusch 2000; Taylor 2002, 2004). Whether WHO’s organisational repositioning will succeed in re-establishing it as the acknowledged steward of the health of the world’s population remains an open question at this time.

References