WHO says competition is healthy - how civil society can change IGOs

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Veröffentlichungsversion / Published Version
Konferenzbeitrag / conference paper

Zur Verfügung gestellt in Kooperation mit / provided in cooperation with:

SSG Sozialwissenschaften, USB Köln

DISCUSSION PAPER

WZB

SP IV 2008-307

WHO Says Competition Is Healthy—How Civil Society Can Change IGOs[1]

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ZITIERWEISE ● CITATION

Abstract

In this paper I argue that the politicization of civil society can lead non-state actors to create new international institutions which compete with traditional intergovernmental organizations (IGOs) to provide global public goods; this competition over resources and authority, in turn, can put IGOs under pressure to undertake institutional change. I illustrate this argument by looking at the changing role of the World Health Organization in the field of global health. The case study shows how increased funding to support health initiatives in other UN agencies, the burgeoning of health NGOs, and the emergence of private foundations such as the Gates Foundation, put the WHO under pressure to change in order to avoid becoming irrelevant.

Zusammenfassung

Die WHO sagt: Wettbewerb ist gesund. Wie Zivilgesellschaft IGOs verändern kann.

Das Papier argumentiert, dass aufgrund der Legitimitätskrise intergouvernementaler Organisationen zivilgesellschaftliche Akteure selbst neue Institutionen gründen, um die anstehenden governance-Aufgaben anstelle der IGOs zu übernehmen. Diese neuen Institutionen können daher als Rivalen verstanden werden, die in Konkurrenz zu den traditionellen IGOs nach knappen Ressourcen wie Finanzen und Autorität streben. Diese Konkurrenz setzt IGOs zunehmend unter Druck, sich institutionell zu wandeln. Das vorliegende Papier illustriert dieses Argument anhand der Reform der Weltgesundheitsorganisation (WHO). Die Fallstudie zeigt, wie die zunehmende Bereitstellung von Mitteln für Gesundheitsinitiativen in anderen UN Organisationen, die steigende Zahl von Gesundheits-NGOs und die Entstehung von privaten Stiftungen wie der Gates Foundation, die WHO unter Druck setzte sich zu wandeln, um in diesem neuen Handlungsumfeld ein relevanter Akteur zu bleiben.

Contents

1. The Politicization Thesis and the Question of Institutional Change

International institutions are expanding their mandates to include more "behind the border issues" and this in turn means that societal actors, not just governments, are increasingly the target of international governance. According to a recent article entitled "The Unintended Formation of Political Order Beyond the Nation State," this increased interventionism has not gone unnoticed—or uncriticized—by civil society (see Zürn, Binder, Ecker-Ehrhardt, and Radtke 2007). On the one hand, the more prominent role of international institutions has led civil society actors to make increasing governance demands of them. On the other hand, as these increased demands are disappointed, they trigger political opposition based on the legitimacy deficit of such institutions. Thus politicization, according to Zürn et al. (2007), is the process of society's increased sensitization to questions of institutional power and legitimacy at the international level.

More specifically, Zürn et al. (2007) lays out a multi-step argument about the politicization of international governance. The first step in this process is the growing perception that international institutions are increasingly relevant to issues of global governance, which in turn changes expectations of societal actors. This leads more or less organized networks of social actors to make increasing demands on governance beyond the nation state. But as these increased expectations are inevitably disappointed, criticism of and opposition to decision-making procedures and policies increase. Disappointment is manifested as political opposition "whose outward forms can range from a lack of compliance and critical public focus to violent protests" (Zürn et al. 2007, 19). These disappointments reinforce normative demands for the democratic legitimation of these institutions. Demands are made for increased transparency, accountability, and representativity.

According to this argument, in the face of politicization, the "only option that may remain open is the path of renewed institutional adaptation" (Zürn et al. 2007, 19). One implication, then, of the politicization thesis is that it can lead to institutional change. This paper picks up on this insight and attempts to build on the politicization thesis by teasing out the mechanisms by which politicization can lead to institutional change. Thus the first step of this paper is to ask: By what mechanisms can this loss of

legitimacy and the consequent politicization of an international institution lead to institutional change?

Drawing on social closure theory, I identify two strategies of change that are already implied by the Zürn et al. thesis: conformity and protest. A conformist strategy is what we might call an "insider" strategy, by which civil society groups attempt to enter an intergovernmental organization (IGO) and change it from within. A protest strategy, in contrast, is an "outsider" strategy in that it is a rejection of the status quo and it attempts to change IGOs by bypassing them rather than reforming them. In addition to these two strategies, I argue that there is a third possibility which has received relatively less attention in this context: competition. My thesis is that introducing actors that compete with IGOs—either for authority or for resources—can create pressures that force an institution to undertake change. Although in reality these three strategies are not always neatly separable, and indeed they might sometimes work best in combination, it is worth teasing them apart analytically in order to better investigate how they operate. In this spirit, the next step of my analysis is to focus on competition as a mechanism of institutional change in the context of politicization.

I illustrate my argument through an analysis of the politicization of the World Health Organization (WHO). In its first several decades of existence, the WHO was the leading authority among just a few international health organizations. It lived in a sparsely populated institutional environment, was well-funded, and had a technical mandate that shielded it from political engagement and interventionist activities. But over the 1970s and 1980s, the area of global health changed from being an issue dominated by a technical, non-political discourse to an issue tightly connected in the public discourse to the political questions of development and human rights. In light of this change, the WHO came under increasing scrutiny and critique from national aid agencies, from health activists and NGOs, and in large part from the broader health epistemic community. By the end of the 1990s the WHO was suffering from a crisis of legitimacy as a result of almost ten years of not living up to the new expectation that it would be a leader on global health beyond its technical mandate. This crisis opened the door for competitors to flood the global health issue area, challenging the WHO's authority and funding base. Heightened competitive pressures forced the WHO to undertake institutional changes in order to recover its role as a leader on global health.

2. Mechanisms of Institutional Change

Research has thus far shown that there are a number of ways in which institutional change can occur. Institutional change can evolve gradually and organically over time (Thelen 2004; Hannan and Freeman 1989), it can occur from the top-down through rational design (Koremenos et al. 2001), or it can combine evolution and design (Viola and Snidal 2007). Institutional change can be driven by the goals of the principals, halted by entrenched bureaucratic cultures, or prompted by the need to find technical solutions to the political problems of coordination. But in the context of the politicization thesis, what is of interest to me here is to investigate a particular source of institutional change—change prompted by a politicized civil society. In my case, for example, I am interested in how the WHO changed as a reaction to politicization. I am not arguing that politicization *necessarily* leads to institutional change. And although it would be an interesting avenue of future research, I do not consider here the circumstances under which politicization is more or less likely to lead to change. Rather, I am interested in considering the mechanisms by which it *could* lead to institutional change.

International organizations are often set up to provide the international community with public goods. From this point of view, a legitimacy crisis can come from doing either too much (raising sovereignty concerns) or from doing too little (not delivering on the promised public goods).[1] In any case, opposition is likely to come from a sense of damage to the public good. But dissatisfaction with global governance is likely to arise not just when international institutions fall short of heightened expectations, but when these institutions remain closed to social actors. Indeed, the notion of social closure, I propose, can be fruitfully employed when investigating international institutions.

Thinking about International Organizations in Terms of Closure

Weber introduced the term "social closure" to refer to the process whereby one group of actors excludes others from participating in its privileges (Weber 1978, 43-46 and

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[1] While Zürn et al. (2007) focus on the former, the WHO case highlights the importance of the latter for politicization.

926-955; see also Parkin 1974; Collins 1979; Murphy 1988). In the case of international institutions, these privileges refer specifically to the powers of decision making, regulation, and resource distribution. Groups achieve closure by selectively excluding and including through specific conventions, rules, and practices. These can be what I would call allocative techniques which allow only select actors to participate in the group, or obfuscationist techniques which decrease the transparency of the group to outsiders.[2] Most international organizations are intergovernmental and use sovereignty as the key criterion of membership. Through this criterion, non-state actors are automatically excluded. Sometimes states are excluded too—as exemplified by the UN Security Council. The extent and nature of closure depends on the institutional rules that shape the body.

Closure has implications for distributive justice when those actors excluded from participating are nevertheless affected by the decisions made. Because of this, social closure theorists argue that closure has the potential to provoke a reaction on the part of excluded actors. Excluded actors may try to exercise power in an upward direction in order to open up the closed group (Murphy 1988, 10). In this light, politicization can be conceptualized as a struggle to gain access to a closed sphere, to recapture power over decisions and policies. This struggle for openness can manifest itself, as Zürn et al. (2007) argue, in a demand for transparency, accountability, and representativity. Closure theory articulates two basic strategies for opening up closed clubs: the conformist and the protest strategies. The *conformist strategy* is an insider strategy, while the protest strategy is an outsider strategy. The conformist strategy is to gain entry to a group and use that access to change it from within by becoming part of the policy process. The *protest strategy* is to exert pressure from the outside through mechanisms like shaming, boycotting, and public exposure of bad policies. In addition

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[2] Modern academic status offers examples of both. Belonging to academia is based on having certain credentials such as graduate school degrees, which represent an allocative technique. But group closure is also maintained through professional jargon, which represents an obfuscationist technique. These techniques need not imply a negative intentionality, but they nevertheless have distributional consequences vis-à-vis insiders and outsiders. See Collins (1979) for more on education as a form of social closure.

to these, I suggest that there is a third option—competition—missing from this traditional list.[3]

Conform

Conformist strategies, or what we might call "insider" strategies, involve making oneself appealing to the membership insiders.[4] Actors who use this strategy try to gain entrance by assimilating as closely as possible to the dominant political principles of the system. As the dominant attributes and norms change, then we should expect the conformist strategy to change accordingly. These actors seek equal opportunity with insiders, but they do not dispute the basic logic of the system. The idea is that by embracing the relevant institutions, change can be enacted from within. This strategy has a high potential for success since it offers access to the closed group's policy makers and the policy process. For this reason, Risse-Kappen says that "'clever' transnational actors adapt" to the existing structures to achieve their goals (1995, 26).

Many institutions now have formalized avenues for civil society participation. ECOSOC is the principal body responsible for channeling non-governmental organization (NGO) input into the UN and its subsidiary bodies. ECOSOC maintains a set of rules and criteria that govern the interaction between NGOs and IGOs. Through ECOSOC NGOs can gain consultative status at the UN, which allows them to attend meetings, make written and oral statements, and place items on the agenda at ECOSOC and other UN bodies. Civil society groups thus become "rationalized" in the sense that they get clear rules and they get assigned a formal status. These rules effectively turn international groups into interest groups that are allowed to lobby the organization in question. Although this strategy can be successful, actors who adopt the conformist strategy also run the risk of co-optation. This can in part explain why alternative strategies might be chosen.

Protest

The protest strategy, or what Murphy calls "revolutionary usurpation," is the direct attempt to change the structure of the group or society (Murphy 1988, 77). It is an

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[3] It would certainly be a promising avenue of research to think about when which strategy is pursued and which combinations might be most successful, but I do not do that in this paper.

[4] In Murphy's terminology this would be called "inclusionary usurpation" (1988, 77).

"outsider" strategy in that it implies a rejection of the status quo and a demand not just for different outcomes but for different standards of distributive justice. This strategy is revisionist. Although conformism may be more successful at gaining access, protest often arises out of the suspicion that conformist strategies lead to co-optation, thus the protest strategy often focuses on cracking open the closed group by undermining it. Usurpation constitutes a threat to the current stratification between insiders and outsiders which can range from the demand for alternative models of global governance or a complete overhaul of the dominant system. Consequently, usurpationists sometimes call for violence.

Protest, or usurpationist, strategies include those seen against the World Trade Organization (WTO) at Seattle in 1999 or against the G-8 Summits in Genoa in 2001 and Heiligendamm in 2007. NGOs such as ATTAC, dissent!, Greenpeace, Friends of the Earth, and People's Global Action against the World Trade Organization (PGA) use protest strategies to resist international organizations. Greenpeace, for example, has expressed less interest in reforming the WTO than in bypassing it altogether, as the title of a recent briefing paper asks "Is the WTO the only way?"[5] It sees the WTO as "fatally flawed" and as "moving the world in the wrong direction—away from peace, security and sustainability. By stalling on issues that are crucial to poorer countries, the WTO faces a crisis of legitimacy."[6] The PGA, to take another example, is based on direct action and civil disobedience and has recently decided to take the word "non-violent" out of its description. In its self-description the group claims "a confrontational attitude, since we do not think that lobbying can have a major impact in such biased and undemocratic organisations, in which transnational capital is the only real policy-maker."[7]

Competition

In addition to the conform and protest strategies, activists reacting to the low legitimacy of international institutions can also adopt the "do it yourself" strategy. Instead of working through an institution or protesting the use of that institution, actors can

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[5] <http://www.foeeurope.org/publications/2005/alternatives_wto.pdf> accessed 20 Nov. 2008.

[6] <http://www.greenpeace.org/international/campaigns/trade-and-the-environment>, accessed 20 Nov. 2008.

[7] <http://www.nadir.org/nadir/initiativ/agp/gender/desire/nutshell.htm>, accessed 20 Nov. 2008.

form institutions which aim to carry out the same functions as the IGO. These institutions may become rivals of an IGO to the extent that they successfully compete for resources. Specifically, for all types of international institutions the relevant resources are authority and funding. Competition over resources can, in turn, lead to pressures for adaptation. Competitive pressures are ultimately a function of the availability of resources in the environment. When resources are scarce, competitive pressures increase, and the pressure to adapt will be high. When resources are plentiful, then competition will be lower, and the pressure to adapt will also be lower. Competitiveness, or fitness, is a result of an institution's relationship to its resource environment. When exogenous changes occur in the environment, an institution can choose to do nothing and risk becoming irrelevant, or it can adapt by making internal changes.

There are good reasons to think that competitive pressures among international institutions are generally not high.[8] First, relative to the domestic environment, the international institutional environment is sparsely populated. The existence of many institutions would increase the relative scarcity of resources, making competition tougher and increasing the pressure to adapt. Second, many institutions do not compete over the same resources, further attenuating adaptive pressures. We would expect, then, that international institutions have relatively low pressures to adapt which, in turn, allows the persistence of institutions at low levels of efficiency or legitimacy. There are, however, some important exceptions. International trade institutions, for example, face a proliferation of regional arrangements which has arguably led to greater competition among institutions driven by "forum shopping" by states. More relevant to my discussion here is that some issue areas are also being flooded with civil society actors with important resources—whether these be financial or authority based—which can change the landscape in which IGOs operate. Competitive pressures can be increased intentionally in order to force change. But an unintentional increase in competitive pressures can also lead to change.

In the following section I use the case of the WHO to illustrate how politicization can lead to competition and how this, in turn, can lead to institutional change.

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[8] Realists however often claim that the international environment is highly competitive among states. But the low rate of state death calls this into question.

3. The WHO Says Competition Is Healthy

The WHO has undergone a change in the last twenty years that is illustrative of the politicization dynamic outlined earlier. In large part through the WHO's own activism, the perception of global health issues has shifted away from an insular technical issue to a multisectoral political issue. With this changed perception came an expanding mandate and rising expectations of what the WHO ought to achieve. But the organizational structure of the WHO was not equipped to successfully carry out these new demands. In the face of failures on the health front, various actors began to publicly criticize the management and vision of the WHO. The legitimacy of the WHO was called into question by national aid agencies, such as the Danish DANIDA, by health activists and NGOs, and in large part by the broader health epistemic community. Criticisms were levied against the leadership, organizational structure, and finances of the WHO. These critiques can be clearly seen in the journals that are the forum of the epistemic community. The WHO did not respond to these demands and the crisis escalated until the consensus in the public sphere was that the WHO had suffered a massive loss of confidence and legitimacy. WHO donors began diverting their investments elsewhere and health professionals began setting up alternative programs. As part of a general burgeoning of NGOs, new actors began to emerge as health-related authorities. In this environment resources became scarce and the WHO was forced to compete with other new actors for the limited financial resources available. If it wanted to recover its authority and funding, the WHO needed to change. These developments can be summarized as: (1) expanding mandate and rising expectations, (2) loss of legitimacy and politicization, and (3) competition and institutional change.

3.1 Expanding Mandate and Rising Expectations

Traditional Role of the WHO

The WHO Constitution, which entered into force in 1948, lays out a mandate that fulfills traditional institutional roles. The institution was charged primarily with facilitating government coordination, furnishing technical assistance, setting standards, and collecting and distributing information (WHO Constitution, Chapter II, Article 2). In its first decades, the WHO interpreted this mandate cautiously. Staffed almost

exclusively with (male) medical doctors, it offered technical advice; set normative standards on issues such as sanitation, food products, nomenclature, and teaching and training; and engaged in research and information gathering from its headquarters in Geneva. Through its focus on technocratic matters, the WHO avoided explicitly political questions. In 1952, for example, the WHO decided not to undertake a population program because of the religious and political implications it might have (Godlee 1994b). Meanwhile, in the same year John D. Rockefeller and a group of scientists agreed to form the Population Council, a non-governmental organization to guide governments on questions of demographic change because "the world was awakening to the rapid growth in population that was occurring around the globe."[9] While the WHO shied away, the Population Council (with the backing of a wealthy philanthropist) became an authority on population changes.

The WHO attempted to maintain its technocratic attitude even after the accession of a large number of newly decolonized states in the 1960s, but by the 1970s, in the face of faltering Third World programs and increasingly global and transnational problems, the WHO began to rethink its role. In particular, the WHO's malaria eradication program was failing and it realized that, in order to really combat malaria and other diseases in the Third World, it needed to address underlying problems of basic health infrastructure. These underlying problems, however, could no longer be defined as simply technical; they were problems with social, economic, and political ramifications. The shift away from a technological view of health to a broader focus on the socioeconomic causes of health problems began with WHO Director-General Dr. Halfdan Mahler who took office in 1973. Mahler argued that in order to address health, it is crucial to address other social issues such as working conditions, family life, community infrastructure, education, and agriculture. This new vision was based on the idea that the WHO should be an advocate of social justice between developing and developed worlds (Godlee 1994a; Cueto 2004). The World Health Assembly (WHA), for example, "endorsed expert reports on the dangers of nuclear weapons and the epidemiological effects of the Vietnam War" (Cortell and Peterson 2006, 266). It also took a stand on the Palestinian-Israeli conflict, arguing that the health of Pales-

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[9] <http://www.popcouncil.org/about/history.html>, accessed 20 Nov. 2008.

tinians was being compromised by Israeli policies. Mahler's approach was more interventionist and more political than the WHO had ever been.

New Role for the WHO

This new approach was expressed more systematically in 1977 when Mahler began an ambitious new initiative under the slogan "health for all by the year 2000." The idea was that all individuals in the world should have "a level of health that will permit them to lead a socially and economically productive life" (WHO, Declaration of Alma-Ata: V). In 1978 the WHO issued the Declaration of Alma-Ata which placed emphasis on the development of primary health care as a strategy for reaching the "health for all" goal. This declaration made explicit connections between health and social, economic, and political development. "Primary health care reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities" (*Op. cit.*: VII, 1). The declaration also expanded the potential role for the WHO by maintaining that health care "involves, in addition to the health sector, all related sectors and aspects of national and community develop-ment, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors" (*Op cit.*: VII, 4). The declaration defined primary health care broadly to include education, promotion of food supply and proper nutrition, safe water and sanitation, maternal and child health care including family planning, immu-nization, prevention and treatment of diseases, and provision of essential drugs (*Op. cit.*: VII, 3). The initiative also signaled a willingness to engage in a more interven-tionist role by "providing promotive, preventive, curative and rehabilitative services" (*Op. cit.*: VII, 2).

This new approach became most visible when in 1987 the WHO started the first global program on AIDS under the direction of Dr. Jonathan Mann. Over the course of the next few years this would grow to the biggest WHO program and one of the most important world-wide with a 100 million dollar a year budget. Mann began by bring-ing a group of researchers to Zaire to collect information about the disease and over the next few years established AIDS programs in over 100 countries. The AIDS program transformed the way the world discussed matters of health. Mann structured health as a human rights issue, not just a medical issue. He developed a four-step

multidisciplinary approach for evaluating the overlapping and interdependent aspects of health and human rights. Mann's approach to AIDS is "now considered axiomatic" (Leaning 1998, 754). At a time when the focus was on cleaning the blood supply, the WHO was arguing that prevention is essential and that the key to prevention is understanding the social and behavioral dynamics of transmission.

Mahler was described by the health community as a charismatic visionary who worked hard to bring a new perspective on health into the international consciousness. In doing so he clearly expanded the WHO's mission. This expansion was part of a realization occurring more broadly across international institutions that interdependence is increasing the transnational nature of problems. Nothing exemplified this trend better than the alarming spread of AIDS across the world. When he left office in 1988 the *New York Times* approvingly reported that "During Dr. Mahler's three five-year terms as Director General, the health organization oversaw the eradication of smallpox. It raised the rate of child inoculation from 5 percent of the world's children to 50 percent, and it recently began to coordinate global programs against acquired immune deficiency syndrome" (Lewis 1988). Nevertheless, this change of direction was at odds with the organizational structure and traditional mandate of the WHO.

3.2 Loss of Legitimacy and Politicization

As the WHO mandate was expanding, expectations—arguably unrealistic expectations—about what the WHO could achieve were also rising. The goal of "health for all by 2000" was illusory and even those who worked at the WHO at the time admit that it was unrealistic to think that such a vague and broad goal could be attained (Godlee 1994b). The prominence of the WHO had increased but the problems, like AIDS, became even more challenging. At the same time, the organizational capacity of the WHO went unchanged to meet these new challenges. The tension between the new vision and the old structure could only be successfully resolved by returning to the old mandate or by renewing the structure to reflect the new mission. Under Mahler's successor, Nakajima, the WHO would first try the former path. But a new health activism that developed in part out of Mahler's work made this path highly unpopular. The newly politicized issue of global health could not be erased from public awareness and simply returned to the technical backroom. The WHO was increasingly criticized

at the organizational, leadership, and financial level for not implementing a more activist agenda. As I discuss in section 3.3, the WHO was punished for its lack of activism until it was forced to "adapt or die."

Organizational Challenges

The WHO is comprised of four main bodies: the Director General's Office, the Executive Board, the World Health Assembly, and the Regional Offices. The World Health Assembly (WHA) is officially the decision making body of the WHO and is comprised of delegates from all the UN member states. It meets in Geneva once a year to determine policies, supervise and approve the program budgets, and to instruct the Executive Board about matters for further action. In practice, the WHO is run by the Executive Board which is currently composed of 34 members technically qualified in the field of health.[10] The Executive Board creates the agenda and resolutions to be considered by the Health Assembly. The Executive Board also nominates the Director-General. Although the Executive Board's nominee is subject to WHA approval, in practice the WHA always follows the recommendation of the Executive Board. In addition to headquarters in Geneva, there are six regional offices each run by a Regional Director. This structure, which combines a strong Director-General and Executive Board with a relatively weak assembly, might be appropriate for a low-profile technical agency, but became increasingly problematic when the WHO took on a more political role.

In general the WHO staff at all levels operates with little oversight from member states—an indication that at its creation the organization was not thought of as being a political actor. Although some decisions, such as amendments to the constitution, require a two-thirds majority vote by the WHA, most decisions require only a majority vote in the WHA (WHO Constitution 1948: Art. 60). For the most part, however, power is concentrated in the Executive Board (including the Director-General) whose members are voted on by the WHA. The Executive Board has no permanent members, every member has one equal vote, and there are usually not more than two developed states on the board at a time. This structure makes it difficult for powerful member

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[10] This number has changed over time and at the time of the WHO crisis in the 1990s there were 31 members of the Executive Board.

states to have a strong influence over the organization. But this is consistent with the intent of the institution; WHO leaders were thought of as being professionals and experts rather than representatives of political bodies. According to WHO doctrine, "members of the board serve as individuals, not as national representatives" (Cortell and Peterson 2006, 265).

In the running of the organization, the Director-General has wide discretionary power. The core work of the WHO, including reports that are drafted and research that is conducted, requires only the approval of the Director-General, not the WHA (Cortell and Peterson 2006, 265; Jacobson 1973). This, in combination with control over the budget, gives the Director-General power in setting the agenda for the organization. Moreover, the process of selecting the Director-General is non-transparent and largely left to the Executive Board. After Director-General Nakajima was successfully voted into office for a second term despite his widespread unpopularity among member states (especially powerful member states) and within the health community, the electoral process was heavily criticized. There had been no formal advertising of the post, no public debate, no open discussion of candidates' policy platforms. Jonathan Mann, speaking after he left the WHO remarked that "Thirty-one people have made what is probably the most important decision in global health with no public scrutiny" (Brown and Patel 1993). He, among other observers in the health community, argued that the system should be reformed to make it more open to public scrutiny (Peabody 1995). Of course, the idea of opening the election of the Director-General to public scrutiny and to having candidates formally propose their policy platforms reflects an understanding of the WHO as a politicized body. Under the technical understanding of the WHO, which dominated in 1948, such demands for public involvement were not taken into account.

Like the Director-General, the regional directors, too, are quite independent of the WHA. Regional directors are not directly answerable to the Director-General or to the WHA (Godlee 1994a) and they enjoy wide-ranging discretionary power over their own budgets, staff, and projects. The regional office for the Americas, for example, is almost completely autonomous. This regional office, also called the Pan American Health Organization, pre-dates the WHO as an organization by several decades. One could imagine that the decentralized regional structure might offer flexibility and the

ability to respond to the specific needs of individual countries, especially in the developing world. But although the regional offices in theory brought the organization closer to the field, in reality the officers were embedded in national health bureaucracies. Reflecting its original mandate to be a coordinating agency, the regional officers and country representatives were located in each country's ministry of health, where they could consult on national health policies and disperse information through government agencies. Regional officers also tended to be political appointees with career aspirations within the bureaucracy. In light of a technocratic, consultative mandate, this setup might make sense, but given the expanded and more interventionist course that Mahler set out, this structure was criticized as too tied to bureaucratic interests and too far from the lives being affected by health issues.

Decentralization appears to have led to the abuse of power in the 1990s. The UN Joint Inspection Unit, an internal body that examines the functioning of the UN agencies concluded that "the decentralized structure of the World Health Organization is currently handicapped by many problems" and is not functioning as effectively in the 1990s as in earlier decades (Godlee, 1994c). There were allegations that some regional directors were using their discretion over jobs and resources to influence their own personal career aims rather than to improve the performance of their substantive projects. According to critics in the health field, the WHO put "too much power and too little accountability in the hands of a few people" (Godlee 1994c). Calls for reform suggested devolving more control to the country level where officers were on the ground floor of project implementation (UN Joint Inspection Unit, report no. 2,1993). These critiques reflect a growing interest in transforming the WHO from a consultative body into an executing body.

The staffing of the organization also reflected its technical nature rather than the vision of health as a broader social, economic, and political issue. In the 1980s and 1990s, the WHO was mostly staffed by medical doctors rather than by economists or anthropologists or sociologists. Neither Mahler nor Nakajima gave the organization a truly multisectorial staff, although its goals were moving in this direction. Experts from other fields were not involved in WHO activities. Moreover, although the WHO had long worked with the broader epistemic community of health professionals, these civil society groups were used as technical experts. The WHO would hire, for

example, scientific groups to monitor and study specific health concerns (Jacobson 1973, 202). There was no real role for NGOs or civil society groups who were not directly medical professionals or scientists. The organization was also top heavy, with most of the fixed budget being spent on administrative costs rather than on country level projects. In sum, the WHO was narrowly focused on a small field of experts; it was not representative of the local communities that were suffering from health crises.

Leadership Crisis

The WHO's mission became increasingly political as a result of the activism of Director-General Mahler. Mahler was described by the health community as a charismatic visionary, and "almost like a priest" by Dr. Miroslaw Wysocki, head of health information at the WHO's South East Asia Regional Office (Godlee 1994b; Cueto 2004). He was hailed as a hero by health activists, some of whom looked to Mahler as an idol. One colleague said "Ever since I studied public health I have realized that Dr. Mahler must have taken an incredible risk in proposing WHO and UNICEF to break away from the classical medical paradigm somewhere in the 1970s."[11] There has been almost no revisionism of this view despite broad acknowledgement that Mahler, through his charisma, created a new set of demands which the WHO as an organization was ill-suited to meet. His idealism was not matched with the necessary practical tools. The same colleague who compared Mahler to a priest acknowledged that "health for all was an impossible concept" (Godlee 1994b). Mahler himself later said, "In Alma-Ata we came out with stars in our eyes."[12] Arguably, Mahler left the WHO just as the practical test of his vision was beginning.

After his departure in 1988,[13] Mahler was succeeded by Dr. Hiroshi Nakajima. As Director-General, Nakajima sought a return to the WHO's technical mandate and he began to scale back the expanded political role of the organization. Nakajima's style was more in keeping with the WHO Constitution, which states that the Director-General "shall be the chief technical and administrative officer of the Organization"

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[11] Evelyne de Leeuw (1995) in a speech delivered during the Andrija Stampar Medical Awards Ceremony.

[12] Online interview available from Lifeonline at <http://www.tve.org/lifeonline/index.cfm? aid= 1089>, accessed 23 Nov. 2008.

[13] According to the *New York Times*, everyone involved would have liked Mahler to stay but this did not happen as a result of "muddled" communication.

(Constitution, Ch. VII, Art. 31). But Mahler had raised the stakes, and the public discourse continued to argue that the WHO should be an active force for public good. Critics, mostly from the larger community of health experts and activists, measured the organization against its expanded mission and found it lacking. Under Nakajima the leadership, organization, and finances of the WHO came under increasing scrutiny and a public scandal began to unfold in which Nakajima—compared to the priest-like Mahler—became personally vilified.

Nakajima did not pursue the more controversial topics opened up during Mahler's tenure. Family planning was limited to a research program on contraception and infertility, tobacco control was not tackled, and he did not step up the drug programs, especially the AIDS drug program. When the WHA considered a resolution allowing the PLO to join the organization against the wishes of the US, Nakajima convinced them to back down. He began few new programs and did not develop the capacity of the organization to follow through on the old vision. He was committed to working through the existing government health ministries, which is how the WHO was structured to operate, and he did not pursue partnerships with NGOs or civil society outside of a technical nature. He returned, in essence, to a technical understanding of the WHO. Nakajima's refusal to expand the WHO into areas of political debate was, in fact, in keeping with the traditional mandate and role of the organization. Supporters of Nakajima criticized Mahler's vision for its "strong man style" that was too objective-driven, too outspoken, and too interventionist in the developing world (Godlee 1994a). But many in the medical community criticized Nakajima for lacking a coherent policy strategy and direction. As a report in the *British Medical Journal* saw it, his attempt to establish a new paradigm for health "floundered in a maze of incomprehension" (Godlee 1994a).

As Director-General, both Nakajima and Mahler had large amounts of discretionary power. While observers praised Mahler for using this autonomy to cast a new direction for the organization, they accused Nakajima of abusing his power. An exposé found that from 1988-1994 the number of highest paid employees at the WHO doubled and some were being paid beyond the top level salary recommended by the UN Secretary General (Godlee 1994a). Although investment in staff might be defensible under a technocratic mandate, the impression was that his personnel decisions were

driven by patronage and not by policy. Eventually the International Labor Organization (ILO) was called in to arbitrate a number of labor disputes and it issued damaging findings against the WHO (reported in *The Independent* May, 6 1995). This led to a demoralized atmosphere among employees, making recruitment difficult and leading to the loss of its best people.

The clash between the two visions struggling for dominance of the organization became most visible when Mann resigned his post as head of the AIDS program in 1990. Mann resigned in protest of the lack of response from the UN and the WHO on AIDS issues. In the words of one colleague, "when Dr. Mahler was replaced by Dr. Hiroshi Nakajima, he had to deal with people who did not share his sense of urgency about the AIDS epidemic. For two years he endured increasingly onerous bureaucratic obstacles until, in 1990, he resigned in protest and frustration" (Leaning 1998, 754). Nakajima "actually limited Jonathan's travel," according to Dr. Joseph McCormick a health leader who worked with Mann on the first AIDS research team in Zaire, "There were instances when he wouldn't let him go to a meeting, wouldn't sign off on travel. Whether Jonathan should have stayed and weathered the storm or whether he made the right move—I think that's an arguable point" (PBS interview). Mann's global program on AIDS accounted for almost a third of the WHO budget and he had raised that money mostly through his own fundraising efforts (Dr. Jim Yong Kim, PBS interview). Mann's resignation had a devastating impact on the AIDS program and the remaining WHO leadership did little to fill the gap. Dr. Jim Yong Kim of the WHO reports that "We have a chart that shows the number of employees in HIV/AIDS in WHO since 1986 or so, and it was as high as 250 during the height of Jonathan Mann's time here. Then it went down to four. And there was really very little activity going on here" (PBS interview). The loss was not just confined to the WHO; the larger AIDS research and activist community was also set back by the downsizing of the WHO's focus on AIDS. Oddly though, the blame for this loss was leveled squarely at Nakajima and not at Mann.

Western donors began to worry about the WHO's loss of influence under Nakajima's direction. In 1992 DANIDA, the Danish aid organization, was commissioned to investigate organizational weaknesses and to make recommendations. Members called for internal organizational changes, but Nakajima did not undertake major changes in

either of his two terms. In 1993, at the end of his first term, western donors took the unprecedented step of asking Japan to withdraw Nakajima's candidature for re-election. In January the *New Scientist* reported that the US and EC were against his nomination "because they believed Nakajima's management style was damaging the credibility of the WHO and the morale of its staff at a time when challenges such as tackling AIDS and malaria demand inspired leadership" (Brown and Patel, 1993). In April 1993 an editorial commentary in the *New Scientist* argued that Nakajima's leadership was harming the reputation of the WHO and its ability to carry out health work. It called for Nakajima to step down arguing that "The interests of the WHO would now best be served if the Japanese government persuaded Nakajima to with-draw his candidacy."

Despite a bitter public battle, Nakajima was re-elected which led to allegations of threats and bribery (similar accusations were levied when Nakajima won the original nomination in 1988). It was widely rumored that Japan threatened third world board members with the withdrawal of aid if they did not vote for him and were promised contracts if they did. An external auditor from Britain's National Audit Office was called on to investigate. The audit cleared Nakajima of corruption charges. It did, however, cite irregularities in the granting of contracts in the run up to the election. In the six months before the election, the contracts given out to members of the Execu-tive Board doubled in number and tripled in value compared to the year before (1991). Twenty-three of the 31 Executive Board members received contracts. The audit did criticize Nakajima's management style and made recommendations for reform (reported by Patel, 1993/Audit Report). The recommendations focused on a need to increase the organization's transparency and accountability.

The dominant narrative of the WHO crisis is one of failed leadership. Nakajima is largely blamed for having a bad personality, poor communication skills, and muddled vision. But this first-image analysis fails to take into account the growing demands on the WHO to become a political and not simply a technical organization. Nakajima's biggest problem was that he resisted Mahler's interventionist agenda, and this was unpopular given the new politics of health. Nakajima failed to realize that global health was already politicized and that a retreat to the technical mandate was no longer seen as legitimate. Neither Mahler nor Nakajima adapted the organization accordingly.

Financial Crisis

Since its beginning in 1948, the WHO has relied on a combination of a regular budget provided by the UN membership and Extrabudgetary Funds (EBFs) provided by various types of donors. Since 1982 the WHO has had a policy of zero growth of its regular budget, forcing it to rely increasingly on EBFs. In 1990-1991, the expenditure of EBFs exceeded the regular budget for the first time. Eighty percent of the EBFs are donated by member countries (almost all of which are donated by the US, Europe, and Japan), almost 15 percent are donated by over 700 different private actors—primarily foundations and NGOs—and the rest, about six percent, are donated by other UN agencies.

In 1994, Australia, Norway and the United Kingdom commissioned an international research consultancy team (Vaughan, Mogedal, Kruse, Lee, Walt, and Wilde) to assess the WHO expenditures. The report was commissioned because financial reporting was considered an important element in keeping the institution accountable. There were also rumors among health activists that the WHO was spending up to 75 percent of its budget on salaries and office supplies. The report did indeed find that from 1982-1993 an increasing proportion of funds was used on the global level as opposed to the country level, but not on the rumored scale (Vaughan et al. 1996, 233). In 1992-1993 about 39 percent of the regular budget went to support organizational expenses. Eighty percent of the EBFs went to disease prevention. A comparison from 1984-85 to 1992-93 shows "fairly consistent patterns for both funds with an increasing proportion of the regular budget being spent on organizational expenses (up 8% from 31% to 39%) and a decreasing amount for health and disease activities (down 6% from 35% to 29%)" (Vaughan et al. 1996, 240). The report concluded that in the years 1992-1993, "about US $50 million of regular budget funds were used to support the administration that might otherwise have been used directly for health related activities" (Vaughan et al. 1996, 240). Most of the WHO's budget goes to staff costs, followed by meetings and publications, which might be justified for a coordinating and information agency, but the report also found that spending on research was decreasing. "A disconcerting finding was the falling proportion of both the regular budget and EBFs being spent on supporting research activities. Regular budget funds for research have been dropping and are now less than 1% of the total, whereas about 20% of EBFs are still being

directed to research activities" (Vaughan et al. 1996, 233). If the goal is to eradicate health problems and to bring health to all, then these budget priorities seemed questionable.

The report largely confirmed the growing suspicion among donors and the epistemic community that the WHO was not making the best use of its resources to tackle growing challenges. The concern was that the WHO was becoming a bloated agency which, as a result of low accountability and transparency, could get away with low levels of efficiency and low value-for-money spending. Donors wanted more effective management and accountability, and they attempted to create this by specifying how their funds could be used. The biggest EBF is the Voluntary Fund for Health Promotion which contains twenty special accounts designated to special diseases or activities. Donors can contribute designated or undesignated funds, but by 1994 less than one percent were undesignated. Funds were designated to a high degree of specificity, as one manager explained, "Our AIDS money was to be allocated for HIV positive mothers in Lesotho" (quoted in Lerer and Matzopoulos 2001, 420-421). In response to this growing practice of earmarking, large programs that rely on EBFs have had to more clearly define their goals and create accountability and transparency mechanisms such as health indicators in their areas of work. "In this time of increased international competition for funds," according to the report, these programs "have had to be increasingly entrepreneurial and to find efficiency savings … They have done this partly to convince their sponsors and donors that they are in fact a good investment" (Vaughan et al. 1996, 242). This is one of the first ways in which competition was introduced to the WHO—internal competition. WHO programs had to compete with one anther to attract the earmarked funds of donors, and they did this by increasing their transparency, accountability, and output. Larger programs were more successful in creating accounting standards and clearly defined objectives, and as a result they also won more earmarked funds from donors than smaller programs did (Vaughan et al. 1996, 243).

In the face of low transparency and accountability, donors sought more leverage over the WHO. Many of the WHO's special programs receive at least half of their budget from EBFs (Vaughan et al. 1996, 238). But this in turn has its own problems, as donor countries begin to gain undue influence over the WHO's research and poli-

cies. "Some of these programmes are now heavily dependent on a small number of external donors, which calls into question their longer term independence, stability, and sustainability. There appears to be an urgent need for WHO to rethink its regular budget contributions to these programmes" (Vaughan et al. 1996, 243).

3.3 Competition and Institutional Change

As with any other international institution, the WHO possesses two crucial resources—its authority and its funding. For most of its existence, the WHO was the leading authority among just a very few global health organizations. Up until the 1980s, it received a regular budget and extrabudgetary funds which would increase annually. It lived in a sparsely populated institutional environment, was well-funded, and had a technical mandate that shielded it from political engagement and interventionist activities. But by the end of the 1990s the WHO was suffering a crisis of legitimacy as a result of almost ten years of not managing the new expectation that it would be a leader on issues of health beyond technical matters. This legitimacy crisis had a direct negative impact on both the WHO's authority and funding.

Critics of the WHO did not try to gain access to it, as the conformist strategy would suggest, in order to change it from within. Instead, civil society actors were staying away from the increasingly irrelevant WHO. They did not want to be associated with the de-legitimized organization. Critics also did not engage in a protest movement. Civil society was not fired up and angered by the activism of the WHO, rather they were demoralized and frustrated with its inactivity. Even within the WHO, morale was low. There was, in a sense, nothing to protest. But critics did do two things: (1) they began turning to other organizations or creating new organizations to fill the gap left by the WHO; and (2) donors—both government and nongovernment—began investing their funds elsewhere. The consequences of these moves included the loss of funding, the loss of expert personnel, and the growth of alternative venues for the pursuit of global health solutions. These consequences increased the competitive pressures on the WHO to the extent that institutional change was the only road to recovery. External pressures had the same effect on the organization writ large, as donor earmarking had within the organization on a smaller scale. If it wanted to continue to exist, the WHO needed to adapt; in particular, it needed to increase trans-

parency, accountability, and representativity in order to regain the authority and funding it had lost.

Competition from Other UN Agencies

As mentioned earlier, competitive pressures were first introduced when WHO donors began earmarking their funds in an effort to better account for their use. This practice created competition among the programs within the WHO because each wanted to be the recipient of the designated funds. Competitive pressures were intensified, however, when donors began supporting similar health programs sponsored by agencies other than the WHO. International funding was insufficient to maintain the increasing number of organizations operating in health-related fields, and even potential coopera-tion partners had to compete for resources. Each donor, having a budget for, say, childhood diseases, could decide whether to invest this budget in the WHO, the World Bank, UNICEF, or Save the Children. As the WHO suffered its crisis of legitimacy, it was handicapped in its ability to attract these funds. The WHO's role in all areas of health was in decline. For example, the area of food safety and world hunger was taken over by the WTO and the Food and Agriculture Organization of the UN (Lerer and Matzopoulos 2001, 432), children's health was mainly being addressed by UNICEF. But two events in particular capture the pressures on the WHO's authority and funding: the reinvention of the World Bank as a health agency and the creation of UNAIDS.

The World Bank had neither the expertise nor the mandate to handle health issues, but over the course of the 1970s and 1980s it realized that development and economic growth were closely linked to health issues, especially to population growth. The Bank created a program on Health Nutrition and Population, but health sector support remained only a minor part of the its lending up until 1987 (Wogart 2003). In that year the Bank issued a report called *Financing Health Services in Developing Countries—An Agenda for Reform* which stressed the need for targeted public health programs in developing countries. This report was followed in 1993 by another Bank report devoted to health, *Investing in Health*, whose goal was to set priorities for health spending and to sharpen the Bank's strategic direction on health. The report used new research techniques to estimate the global burden of disease and to examine the cost-effectiveness of health interventions. Among its recommendations was to "encourage

greater diversity and competition in the provision of health services by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by nongovernmental and other private organizations, and regulating insurance markets" (*Investing in Health* 1993).

The Bank's focus on efficiency and its commitment to investing in health as part of a broader neo-liberal agenda for the promotion of growth made it an attractive alternative to the floundering WHO. By 1990 the World Bank was the largest source of (multilateral) world health financing (Lerer and Matzopoulos 2001, 427). Through the 1993 *Investing in Health* report, the World Bank spearheaded "major directions for health policy at the global level and in Africa" (Walt 1998, 140). It was playing an increasing technical and financial role in the health sector, and it had effectively "wrested initiative from the WHO on health matters" (Godlee 1994b). While the Bank initiated its activity in the health field out of its own concerns with development and poverty, potential donors saw in the Bank a more effective, goal-oriented, and financially accountable instrument for addressing global health. Donors who were growing skeptical of the WHO's management of its health programs began redirecting their funds to the Bank. According to one analysis, "international funding was insufficient to maintain the increasing number of organizations operating in health-related fields, and cooperation soon turned to competition" (Lerer and Matzopoulos 2001, 427). While donors were getting impatient with the organizational structure and leadership of the WHO, health professionals in the epistemic community began worrying that the WHO was conceding its policy leadership to other agencies such as the World Bank (Walt 1998, 140).[14] These concerns increased pressure for the WHO to reform.

The second major blow to the authority of the WHO came on the issue of AIDS. Under the direction of Jonathan Mann, the WHO established one of the first global programs on AIDS in 1987. This program was widely recognized as a leader in researching AIDS and in championing prevention methods in the field. But after Mann left the WHO in 1990 as a result of a conflict of vision with Nakajima, the AIDS budget dropped off, the staff decreased radically, and the WHO leadership did little to build the program back up. Meanwhile, AIDS was growing dramatically in the number

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[14] It should also be noted that many, especially activists in the Third World, were concerned with the World Bank's approach to health. Although more efficient, the Bank's programs have also been heavily criticized.

of new infections, the number of deaths, and the number of countries affected. In 1994, after years of floundering,[15] members responded to the WHO's lack of leadership by closing down the Global Program on AIDS and in 1996 they removed the issue to a newly created agency, UNAIDS. UNAIDS was an innovative joint program that included a number of UN agencies, including the WHO. Although the WHO was still included, the move was widely seen as an expression of lack of confidence in the WHO. At one point the global program on AIDS within the WHO represented about a third of the WHO project budget. Now all funding and personnel resources were being managed by UNAIDS independently of the WHO. One UNAIDS program director at the time, Dr. Michael Merson, "acknowledged that many people in the United Nations felt that WHO's technical base was too narrowly medical for it to deal effectively with AIDS prevention and control" (Godlee 1994b). Dr. Peter Piot, who headed the new agency, commented that "I felt that the top priority was exactly to put AIDS on the political agenda" (PBS interview). By retreating into its technical mandate, the WHO undermined its authority in what would become one of the most significant health challenges of the century.

Competition from Civil Society Groups

For most of the WHO's existence, the number of health NGOs was low and constant. But if we take membership in ECOSOC as an indicator, the number of international health NGOs began to increase slowly in the late 1970s and then rapidly in the 1990s (figure 1). Certainly, this growth is a response to an increasing awareness of global health concerns and the growing discursive link being made between health, development, and human rights. All UN agencies were struggling in the 1990s to come to terms with the increased number of NGOs who were beginning to demand participatory rights. In 1990, for example, an NGO Working Group Position Paper urged the World Bank to be more supportive of equitable relationships with partners and more open decision-making. In 1991 the Bank began to review possibilities for civil society participation in policy processes. Similar NGO demands on the WHO are noticeably absent. A 1993 Harvard position paper on how civil society organizations can relate to

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[15] The total AIDS budget hardly changed in these six years according to the UNAIDS website. <http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/default.asp>, accessed 24 Nov. 2008.

aid agencies "in ways that promote both democracy and health," for example, failed to mention the WHO at all (Allison and Macinko 1993; Reich 1994). So while the number of health NGOs is increasing, in the 1990s they seem to have been working independently of the WHO. In any case, the growing number of civil society groups in the field of global health increased the number of potential authorities and increased the demand for limited resources from donors. As the WHO ignored calls to shift money and attention "to deal with concerns like resurgent tuberculosis, AIDS, maternal and child health, growing resistance to standard antibiotics and the final eradication of polio" (Crossette 1997), NGOs and private foundations were getting into action.
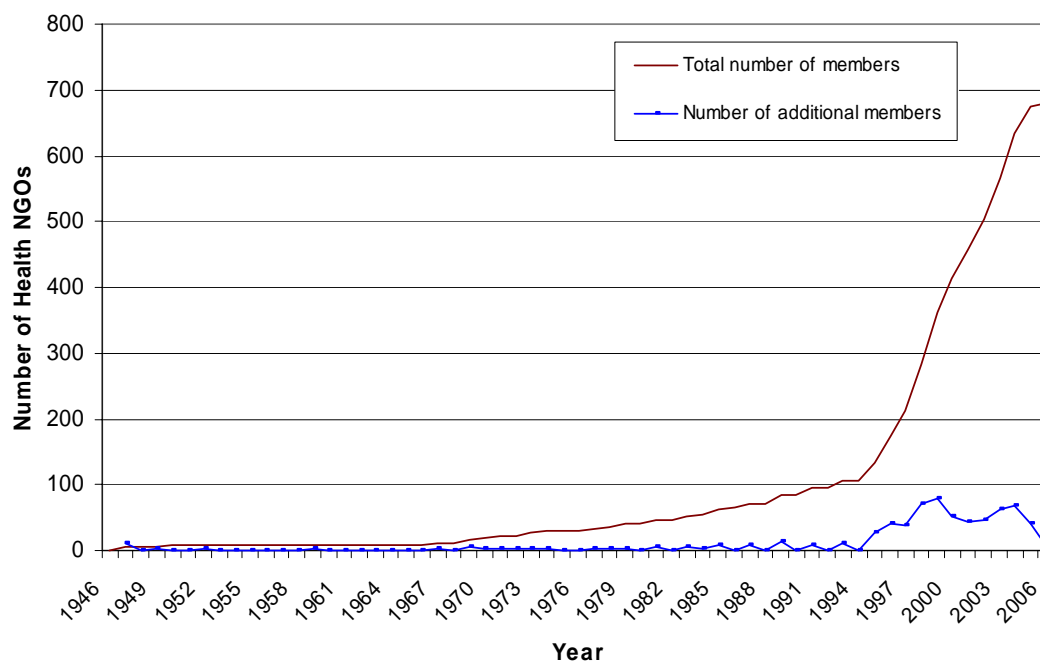
Figure 1: Health-Related NGO Membership in ECOSOC. *Source:* **ECOSOC.**

Some NGOs developed explicitly out of frustration with the WHO, thinking that they could do the same work better. A number of international health professionals, for example, created a movement for Essential National Health Research (ENHR). This movement grew out of frustration with the WHO and a belief that the organization could no longer help struggling developing countries meet their health goals. The movement believed that the only way to improve health in the developing world was

to gather better information on what the populations really needed. In 1990 the movement issued a report that surveyed health research worldwide, identified strengths and weaknesses, and proposed improvements. In 1993 the group established the Council on Health Research for Development (COHRED). The goal of the organization is to promote health research and to bring this research into the policy planning processes of developing countries, without the bureaucracy and non-transparency of the WHO. In 1993 *Science* began a report on COHRED like this: "For years, the World Health Organization (WHO) has had the field to itself as the premier international agency addressing the health concerns of developing nations. But now a potential rival has appeared" (Stone 1993). Interestingly, COHRED's emphasis on providing technical expertise overlapped greatly with the WHO's original mandate—even on this score the WHO's authority did not go unchallenged. And although COHRED's budget is much smaller than the WHO's, one of its primary aims has been to raise money from Western donors in order to channel those funds more directly to the Third World.[16]

Another development of the late 1990s was a role reversal for IGO interactions with civil society. Whereas partnerships usually meant that IGOs would cofinance NGO projects, with the advent of big private foundations, such as the Bill and Melinda Gates Foundation, UN agencies became beneficiaries of private foundations in a major new way.[17] By 2000 the Bill and Melinda Gates Foundation had become a leader in global health.[18] The Foundation gives out approximately 800 million dollars a year through its global health initiative, which is almost the size of the WHO's annual budget. In its first two years alone it spent more than twice the WHO's annual budget on global health (*Science* 2002). Similarly, in 2001 the Global Fund to Fight Aids, Tuberculosis, and Malaria was established out of dissatisfaction with the main UN health agencies' lack of progress in dealing with these diseases. These foundations put the WHO under pressure in two ways. First, donations that would normally go directly

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[16] Another similar example which I do not discuss here is the Global Forum on Health. The Global Forum on Health was founded in the same period directly as a result of a commission's finding that the WHO was not delivering the highest possible standards of health research. The WHO became a partner in the Global Forum, but the creation of a new organization to fulfill the mission of the WHO was another way of chipping away at the WHO's authority.

[17] Private foundations such as the Rockefeller Foundation and the Rotary International have long been involved in global health initiatives, but the activism and resources of the Gates Foundation have moved this interaction to a whole new level.

[18] Although the predecessor of this foundation was already making grants to the WHO in 1998.

to the WHO are often now diverted to one of these foundations first. Warren Buffet, for example, could in principle have donated money directly to the WHO, as Gates did before he created his foundation. When the WHO wants to receive money from the Gates Foundation or the Global Fund, it needs to apply. This means that the Gates Foundation and the Global Fund have a high degree of control over what projects the WHO pursues. Unlike its regular budget, which it can dispose of at its discretion, funds from foundations are usually awarded for specifically designated purposes. For example, the Gates Foundation awarded the WHO a grant over four years to "support an assessment of serological responses to vaccines in infants receiving Intermittent Preventive Treatment for Malaria." Both foundations have developed a reputation for having a transparent donation method which emphasizes accountability and goal-effectiveness. This means that the WHO is also under pressure to increase its transparency, accountability, and effectiveness if it wants to be eligible to compete for funds in the future.

Second, the WHO has to compete for these private funds with any number of other civil society groups because these foundations are also granting money to health related NGOs. In fact, these foundations have gone far in leveling the playing field between smaller NGOs and organizations such as the WHO. Through this funding NGOs are enabled to implement health research and programs that would otherwise be the domain of the WHO. This allows for new authorities to develop. In 2007, for example, the Gates Foundation announced the funding of a new health research center at the University of Washington in Seattle. The institute's purpose is to provide "high quality and timely information on health so that policy makers, researchers, donors, practitioners, local decision makers, and others can better allocate limited resources to achieve optimal results" (Moszynski 2007). The goal is to build a base of evidence so that health measures can be more closely guided by knowledge and data. The center's mandate is almost identical to the one driving the founding of the WHO. Seemingly unaware that this had been the WHO's mandate since 1948 the director, Dr. Christopher Murray, announced that "This was an idea whose time had come" (Moszynski 2007). The WHO Director-General responded wryly that "Strengthening global, regional, and country work on information and evidence is one of our priorities … I hope the newly announced institute will become an important partner in meeting these

goals." Meanwhile, Murray's focus is on the new institute: "We hope to set the gold standard for scientifically rigorous evaluation in health" (Moszynski 2007). Private foundations have put the WHO under competitive pressure by making it possible for new actors to enter the area of global health that it once dominated.

Institutional Change

By 1998, when Nakajima's second term was nearing an end, it was evident to member countries, staff, and observers in civil society that institutional change was needed. Evoking the survival of the fittest metaphor one health journal article was titled, "The WHO: Change or Die." With the title "Good Riddance" The *Washington Post* reported that Nakajima had finally agreed not to stand for re-election. He was replaced by Gro Harlem Brundtland who was chosen because she campaigned on the basis of promised reforms and as someone who had both the health background and the political back- ground to carry out change. Brundtland was trained as a medical doctor, but she was also an experienced politician having become Prime Minister of Norway in 1981. She brought the WHO back into relevance in part by putting it back into political debates over health. Speaking at the World Economic Forum in Davos in January 1999, just months after taking office, she stressed that the WHO can promote health by having a "firmer grasp of the political agenda" (quoted in Birmingham 1999).

According to a senior Brundtland adviser, "The challenge was to take WHO off the sidelines … It's a balancing act between high-profile projects—we need to get back into the mainstream but need to get the headquarters into shape first" (quoted in Lerer and Matzopoulos 2001, 421). The message of change was made visible when Brundtland and her new management team moved into a building outside of WHO headquarters in order to create a reform strategy. The team focused on different organizational problem areas and for each problem area internal interviews were done and a timetable for change was developed. Brundtland and her senior management team, known as the Cabinet, restructured the entire organization around nine substan- tive issues, or "clusters."[19] The many different large and small special programs were

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[19] The nine clusters, each headed by an executive director, are "social change and mental health," "family and health services," "sustainable development and healthy environments," "communicable diseases," "noncommunicable diseases," "evidence and information policy," "health technology and drugs," "general management," and "external affairs and governing bodies."

now reduced and organized thematically into the nine clusters. During the transition about 750 employees changed office (Lerer and Matzopoulos 2001, 427). Within the first six months, the Turner and Rockefeller Foundations established a Global Health Leadership Fellows Program as a sign of support for Brundtland and as reward for changes. The program allowed Brundtland to bring new people into the organization, especially highly regarded professors and researchers.

Brundtland worked especially hard to increase transparency and accountability. Resources were to be allocated on the basis of the new set of goals. There was also an explicit effort made to create implementation strategies and review mechanisms. Medium-term objectives were set for each cluster and leaders had to define measurable objectives. She also worked to reduce the WHO bureaucracy. Under Mahler and Nakajima the budgets were largely unspecified and there was no standardized reporting practice in place across the organization. Brundtland introduced the standard UN budget format and included a report on "deliverables" in order to enhance transparency and accountability. She also allocated regular budget funds away from Europe and to Africa, and she increased the proportion of funds going to the country level directly rather than the regional headquarters or Geneva (Lerer and Matzopoulos 2001, 416).

Brundtland also emphasized the need to work with partners in the UN and in civil society. In a speech at the opening of the WHA in 2000, her focus on "comparative advantage" indicates just how influenced she was by the competitive environment filled with new actors.

> What is our comparative advantage? Given our mandate and our human and financial resources, what are the functions that WHO is best placed to carry out more effectively than others? How can we shift the balance of our work to focus even more forcefully in areas where our comparative advantage really lies? And most importantly, how can we increase the impact of our contribution by engaging a variety of partners who can supplement and complement our contribution?

The WHO could no longer afford to remain isolated from the global health activist movements and in order to stay viable it needed to reach out into other sectors beyond the narrow group of health professionals that dominated its staff under Nakajima. Brundtland invited the economist Jeffery Sachs to come to the WHO to help them

think about the relationship between health and development. She increased partnerships with the private sector, including drug manufacturers. By the end of her first six months in office, she had announced a major new partnership with pharmaceutical companies who agreed to support the WHO's new Tobacco Free Initiative. The Framework Convention on Tobacco Control was also a venue for the visible inclusion of NGOs who directly took part in the Framework negotiations.

There was an explicit effort to clarify and articulate the WHO's vision and values, and to define mission goals for each cluster and region. The WHO once again became part of new health initiatives and began repairing its authority on global health. In molding a new vision for the WHO, Brundtland chose to focus on two flagship projects—Roll Back Malaria and the Tobacco Free Initiative—soon after taking office. The projects were expected to "raise the profile of the organization internationally and act as catalysts for institutional reform within the WHO" (Lerer and Matzopoulos 2001, 420). The idea was that these were projects where significant results could be achieved in a cost-effective way. In 2000 the WHO became a founding partner of GAVI, the Global Alliance for Vaccines and Immunization, along with the World Bank and the Gates Foundation. GAVI was heralded as a significant new approach to vaccinations and immunizations. According to one report, an important event that made this new step possible came when "the WHO appointed a dynamic new director, Gro Harlem Brundtland, who was determined to make a major mark and to revitalize the organization" (*Nature Immunology*). The WHO plays a key role in GAVI, chairing the Executive Board of the Alliance (along with UNICEF) and providing technical and substantive guidance. "The year 2000 was seen as a 'watershed year,' the first time that people within the organization would see satisfied stakeholders and the rewards of the organization's improved profile" (Lerer and Matzopoulos 2001, 422).

Brundtland's reforms certainly received their share of criticism and skepticism, with some claiming that she went too far and others not far enough (Brown 1999; Yamey 2002a; Yamey 2002b). The reality is that no amount of reform could transform the WHO once again into the sole leader on global health. Some developments, such as the increasing number of NGOs and the growing influence of private foundations, are bound to define the field of global health for decades to come. They are also likely to maintain the competitive pressure on organizations such as the WHO to stay trans-

parent and to implement accountability mechanisms. Nevertheless, it is clear that under Brundtland's leadership the WHO went through major changes that helped to bring it back into the global health issue area as a contending force. The WHO may be overshadowed by the Gates Foundation and Global Fund, but at least it can be seen as a reputable partner and investment rather than as an irrelevant bureaucracy.

Conclusion

The example of the WHO's trials and tribulations across the 1980s and 1990s illustrates the argument I developed at the beginning of this paper for how politicization, competition, and institutional change influence one another. I have attempted to show that competition can be the result of politicization and that competition, in turn, can result in institutional change. The increasing number of NGOs and private foundations acting as either advocates or executors of global public goods are putting UN institutions under pressure to increase their transparency, accountability, and representativity. This is because donors with limited resources have a wide choice of investments in almost every issue area. They will be more attracted to those programs that have well-defined goals, operate transparently, and can be held accountable for reaching their goals and for using their resources efficiently.

There is, however, more to discover about how this process works. Competition cannot be expected to result automatically from politicization. The nature of competitive pressures will likely vary with the nature of the organization and the number and capacities of real competitors in the environment. Not all civil society groups will have sufficient financial or authority resources to effectively challenge an IGO. Nor can we assume that competition is a necessary or sufficient condition for institutional change. IGOs have vested interests and sticky bureaucracies and regular budgets that come from UN member dues. These factors make change difficult and may allow even contested agencies to survive. Further study of politicization and institutional change will need to systematically address these factors.

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