Will a new leadership unleash new potentials for health?
Editorial
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In August 2002 Gro Harlen Bruntland, Director General (DG) of WHO, announced that she would not seek a second term as DG. This issue of the EQUINET newsletter compiles some of the debates and papers that have been presented around her record at WHO, the candidates for the new DG and the selection process itself. The political moment created by the election of a new DG stimulates debate about WHO's priorities and role in international and global health, as the leadership qualities sought in a new DG should reflect those roles.

Bruntland's achievements at WHO are notable. She raised the profile of health in the global agenda, including within economic and political forums and is reported to have restored WHO's credibility with donors. She launched a number of global health campaigns. During her period as DG, WHO has reasserted itself as an international standard setting body around areas such as tobacco control, pre-qualification for procurement of antiretrovirals, food safety standards, and essential drugs. Bruntland had some success at negotiating partnerships with foundations and the private sector.

Yet the debate on WHO priorities and the realities of health from the perspective of a southern African network indicate that there are many unresolved issues. Whatever the changes that were achieved at global level, they have not been felt at country level. Poverty and unavoidable and unfair inequalities in opportunities for and access to health are pronounced and persistent. Despite this WHO is not perceived to have been been a strong public advocate for health equity or for protecting public health in economic and trade policies. Neither is there a perception of the powerful advocacy of primary health care or of forms of health financing that enhance access to health care in poor communities, in women and other vulnerable groups. In contrast, in an environment of rapid and powerfully driven market reforms and privatization, there is some criticism of WHO unwillingness to confront commercial over patient interests in access to medicines under TRIPs, or protect national authority rights to regulate private health providers under the WTO GATS agreement.

Hence even while the Macroeconomic Commission on Health raised the profile of the US$27bn shortfall in global resources for health, and the Global Health Fund (GHF) created one vehicle for responding to this shortfall, the impact of these global shifts has been weak. Beyond the insufficient and poorly sustained funding of the GHF, WHO has not yet made clear or put its international policy weight behind the public policy measures needed nationally and globally to ensure that health services and systems spend more on those with greatest need. This has left a number of issues poorly addressed, such as for example

the attrition and loss in health personnel from public to private sectors and from low to high income countries; the collapse of primary care level services in some countries, the shift in the burden of caring for HIV/AIDS to poor households and inability to secure treatment access in many low income countries, or the still weak link between public health and the wider systems of rights and procedural justice needed to manage the contestation over scarce resources for health.

The nature of the issues to be addressed, and their significance in Africa make the policies of the next DG a matter of some concern for Africans. The public policy shortfalls identified above do not simply call for business as usual with a bit more focus on Africa. In the same way as poor people's health needs demand a wider review of public policy generally, so too does meeting the needs of health in Africa demand critical review of wider global, international and national health policies for where they generate vulnerability and impede public health authorities in Africa making coherent responses to ill health.

This editorial does not scrutinize the candidates – there are papers in the newsletter that provide this information. While effort has been made to make the process of selection of the DG more open to public debate through journal papers and email lists, in fact the process is still tightly controlled within the 32 health ministers in the Executive Board. It would however be important to make two comments. The first is to note the presence as a candidate of Pascal Mocumbi, a southern African who has championed health equity for many years, both working on ways of providing incentives for health equity and articulating equity oriented policies, including as at the 1997 Kasane meeting that launched EQUINET. The second is to note that while individual attributes, perspectives and experience are clearly important, the challenges to be addressed by the new DG call for wider alliances for health. Here perhaps WHO has untapped potential: A number of partnerships for service delivery have been built by WHO. Bruntland has mobilized resources and raised the political profile of health. The challenge for a new DG is to bring in new strategic alliances and constituencies that advance WHOs role as global advocate for public health and that bridge global opportunity with national practice. Beyond the technical and political support that has been raised, this implies tapping into the massive social support that exists for health rights and values.