Interview with the director general

Fiona Godlee

This is tk last article in a series examinrng the role of the World Health Organisation, its current problems, and its future prospects

Dr Hiroshi Nakajima was elected director general of WHO in 1988. Born in Japan, he trained as a psychiatrist before joining WHO in 1973. He was WHO's regional director for the Western Pacific from 1979 to 1988. His term of office has been marked by criticism of his management style and allegations of misuse of WHO's funds. I spoke to him at WHO's headquarters in Geneva in July. I have presented the interview in the form of questions and answers. It would be misleading, however, not to make clear that in doing so I have transcribed conversation which was at times extremely difficult to follow. I feel that it is important to emphasise this in the context of an interview with an international leader, one of whose primary tasks must be to communicate his views on health to people across the world, The interview gave me first hand experience of the difficulties in communication that staff, diplomats, and others, including Japanese leaders, have consistently commented on since Dr Nakajima took office.

UPPA

"Because of WHO 's decentralised structure we are very careful to be as transparent as possible. This means that sometimes WHO action is slow "

British Medical Journal, London WC1H 9JR
Fiona Godlee, assistant *editor*

Correspondence to:
Department of Ambulatory Care and Prevention, Harvard Medical School, 126 Brookline Avenue, Boston MA 02215 USA

FG: What do you see as the most important challenges for WHO over the next 10 years?

HN: We must first achieve our goal of Health for All by the year 2000.

FG: Do you think this is achievable?

HN: Disease-wise it is achievable. The problem is there are particular groups in particular countries whose health condition is deteriorating, and it is very difficult to provide them with access to health care. Even with a big effort, 40 to 60 countries, mainly in sub-Saharan Africa, may not achieve full health for all, which is why we are now looking at targets with special priorities for those countries. We cannot solve the problem with health action alone. We need economic development and assistance.

FG: There is much debate about whether WHO should carry on covering all aspects of health-the full menu approach--or whether, in view of financial constraints, it should concentrate on a few priority areas. What do you think?

HN: I think we should follow the first way. We are dealing in a very strange world. For example, the United States says oral health is a low priority. This year there was World Oral Health Day-it was not me, it was the member states who recommended this-and the Japanese dental association held a huge international congress of oral health. This is because in Japan the elderly population is rapidly increasing, and dental health is becoming a very serious problem despite the decline in dental caries. Why does the United States say oral health is not a priority for WHO? Maybe because if dental services are included in America's new health plan it is economically not feasible. That is my understanding. The same country says that cancer is not a priority for WHO, but for my country cancer is a priority.

FG: But shouldn't the money be going to the developing world?

HN: Priorities must change with the times. Diseases of affluence are no longer limited to the developed world. In developing countries heart disease and diabetes are now more common than in developed countries, so people in the developing world are facing a double burden, and they will benefit from WHO's work on lifestyle.

FG: Do you see any need for structural changes in WHO, such as moving disease programmes out of Geneva into endemic regions?

HN: Programmes dealing with locally endemic diseases, like dracunculiasis, onchocerciasis, and Chagas' disease, do not need to be based in **Geneva.** But many of WHO's priority programmes are on global diseases such as AIDS, malaria, cholera and the other **diarrhoeal** diseases and, most importantly, maternal and child health. These are **all global programmes and need to be based at the headquarters.** Two very high priorities are the **eradication of leprosy and the elimination of polio by the year 2000. This is 99% achievable, perhaps 95%, but to achieve it we need constantly to advocate involvement of more senior political people on a global level. This is best done from the centre.**

The regional structure: good and bad

FG: **What do you see as the main strengths of WHO?**

HN: **WHO's decenualised structure is the main strength-if it is well organised.**

FG: And if it is not?

H-N: Then we **may have difficulties. Sometimes today it does not work and we are criticised, but essentially the decentralised structure is a great strength.**

FG: And WHO's **main weakness?**

HN: **People say the bureaucracy.**

FG: Do you agree?

HN: The problem is that WHO is an intergovemmenta organisation. It is entirely different from Unicef. UNFPA [the United Nations Population Fund], and other organisations. We are working with government Also because of WHO's decentralised structure we art very careful to be as transparent as possible. This means that sometimes WHO action is slow. Maybe if I we acted directly from headquarters, operation would be quicker.

FG: So the regions slow things down?

HN: Sometimes. It's variable. It depends on the region.

FG: You yourself were a regional director in the Philippines, and like all regional directors you enjoyed a certain level of autonomy. Do you see this autonomy as a problem for WHO and would you like to see it controlled?

HN: You say that we enjoyed a level of autonomy. But in my time it was very well disciplined. There is a new trend that regional directors want more and more autonomy. Maybe it's because I was once a regional director, I was their colleague.

FG: And this presents big problems for WHO?

HN: Yes, but we are now working closely with regional directors. We are giving them more and more precise guidance. **Some** of them are not happy with this. But i we improve the transparency of regional operations the

majority of problems can **be solved. For example, we** have **a problem** when govemments change. **I have no** time to go and talk to the new people. This is what the regional director should be doing; this is precisely his job. During my time as regional director **I** visited almost all member states in the region and when the minister changed we would go to meet the new minister and talk.

FG: And does that not happen now?

HN: Sometimes no.

FG: Do you foresee changes in the way regional directors are elected?

HN: This is in the process of reform, how to select the regional director. There is a document coming up before the World Health Assembly recommending that regional directors should not be elected but appointed by the director general. Candidates from outside as well as inside the organisation would be put forward after wide ranging search and consultation with the regional committees and the executive board.

FG: Will the document be accepted?

HN: The executive board is seriously interested, but the regional committees may not accept it.

FG: Why not?

HN: **The** problem is that the participants on the regional committees are often at a higher level in their countries' hierarchies than the participants on the executive board. In the past the executive board members were very senior people and they stayed in office for long periods. Sir John Reid stayed on the executive board for almost 10 years. He was like a living dictionary and gave advice to the director general. Now members change more often and they are less senior (in political terms). But the regional committees are made up of country delegations and usually include at least the vice health minister. In the case of Africa most of the ministers of health attend.

FG: Do you think the regional committees are too powerful or the executive board too weak?

HN: Remember, executive board members serve in their personal capacity: regional committee delegates represent their governments. This difference is built into the constitution.

Influence and effectiveness

FG: Do you agree with people who say that WHO's influence is not as strong as it once was?

HN: I think if you go to developing countries WHO's influence is still very strong. **In recent years its** influence in developed countries may be declining for various reasons. Firstly, WHO's mission has become **not** only medical but economic, social, and political. **Secondly, perhaps as a result we** have lost contact with **the medical profession. People** look at WHO as the world medical association, but WHO's governing body **says** that **WHO's** mission is wider health and not only the absence of disease.

FG: So what are you doing to restore WHO's influence in the developed world?

HN: We are carrying out reforms in response to global change to ensure that our efforts benefit developed and developing countries alike. Many of the lessons learned and of the successes achieved in developing countries can be applied to the direct benefit of the developed world, such as the primary health care approach and cost containment.

> ***WHO's major mission, decided by its governing body, is to support countries. This is the spirit of technical cooperation.***

Dr Nakajima visited India in October 1994 [illegible] plague outbreak

POPPERFOTO

FG: What about WHO's effectiveness at country level? WHO is criticised for not having **a** coherent strategy and for failing to create an integrated primary health care network.

HN: In many countries we have been quite successful in developing a primary health care network, and those countries that arc successful have very striking reductions in, for example, maternal mortality.

FG: Which countries?

HN: **Mostly in Asia and Latin America. And** that's **the** problem: it's always the development process. For example, in Thailand 10 years ago we decided on two or three programmes to show the people how WHO and ministry of health programmes were effective. We selected water, malaria, and diarrhoea. In the first year we had some success with water sanitation and malaria spray, and the number of malaria cases dropped, so people liked it. The next year we introduced oral rehydration and family planning, which don't require medical facilities, and additional funds from the government did not even pass through the ministry of health. In 10 years all of our primary health care objectives had been achieved. This is a remarkable success.

FG: And where it's not working is because the other development issues aren't being addressed?

HN: It's one of the reasons. There are two schools **in economic development. One is, if you are a good boy I'll** give you money and if you achieve your target I'll give you more. So you reward success. But if you are a bad boy, if you don't achieve the target, I don't give you money. WHO is obliged to take care of those dropout countries, and that's one of our biggest problems.

FG: In what way is this a problem?

HN: A chain is only as strong as its weakest link. We cannot penalise the populations of countries whose governments appear **to some to be performing poorly. We have to strengthen their capacity to serve their people.**

Accountability

FG: Another criticism of WHO is that it is accountable to its member states but not to the people of the world.

HN: **WHO is an intergovernmental organisation and it should be accountable financially and technically to the member states. WHO's major mission, decided by its governing** body, is to support countries. This is the spirit of technical cooperation. We are working together with countries on strategy and on'prioritising programmes, and we train local people, but it is the countries' responsibility to **execute the health programme. They are accountable to their people.**

FG: Donors are increasingly giving money towards special programmes, like the global programme on AIDS and the programme for tropical diseases research, rather than putting money into WHO's central pot. Do you see any message for WHO in this trend?

HN: This is a serious problem, but not only for WHO, for the UN as a whole. If you talk with diplomats holding money, they say please present good programmes which will please our taxpayers, ones which the media can pick up-but these are not necessarily priority programmes for the developing countries. That's one of my dilemmas.

FG: What can you do to correct this imbalance?

HN: Our dialogue with governments helps them to define their priorities and strategies. We do our best to present this information to the donor community.

Staff discontent, lack of leadership

FG: You are no doubt aware of the discontent among staff in Geneva. What do you attribute this to?

HN: We have about 130 different nationalities. Some people have worked 30 years in WHO. In those days we didn't face such financial problems. Today either we must work harder or we must cut programmes. I think this is the major reason. Of course we have leadership problems.

FG: In what way?

HN: Some programme managers do not exercise sufficient leadership.

FG: But isn't it your job to do something about that?

HN: Today we cannot change programme managers so easily. We have industrial tribunals, which usually favour the staff. We also have the staff association, and we have the member states.

FG: People say that meritocracy is not strong in WHO, that people are appointed or promoted not because they are the best but because it is their country's turn or because of the director general's personal loyalties.

HN: We try to avoid this. For me a person's productivity is the first thing, the working performance. Maybe this is a Japanese weakness. Maybe I ask people too much. But today with our financial situation, if we follow the regular working hours that's no good.

MOYSE/WHO

Dr Hiroshi Nakajima has been director general of WHO since 1988

Politics of re-election

FG: When you were re-elected last year it was alleged that WHO's funds had been misused for political ends, and you received a lot of criticism for the way you were managing WHO, mainly from Western donors. What is your explanation for all of this?

HK: Everybody interprets events in different ways, but this is the first time that developing and developed countries have been divided very clearly. I understand the problem for donor countries. I come from a country that is a major donor. But like the UN, WHO works on one country one vote. no matter how much money a country donates, not like the World Bank or the International Monetary Fund. which have weighted voting systems. It was a very strange election **because Western donors supported a candidate [Dr Abdelmoumene] from a developing country [Algeria] which is not at all successful with its health service, while** I come from a developed country and **was** supported by developing countries.

FG: And by Japan.

HN: Yes.

FG: Why do you think that people thought there **was vote** rigging?

HN: I think it was political.

FG: Do you think there are fundamental cultural differences in the way Europeans and Japanese deal in politics?

HN: Maybe some countries thought there were too **man):** Japanese in humanitarian affairs so they must eliminate one or two. And I am the only Japanese UN agency head who was elected, not selected by the UN secretary general, so obviously I am the most targeted person. But I have my policies and my priorities, which may not find favour with some people.

It is *always the question, should political reform precede economic reform or should we leave political reform and work on the economics.*

The director general's role

FG: What do you think is the most important part of your job?

HN: To be an advocate, but not only to ministers of health. Today ministers of health alone cannot achieve health goals, so I am obliged to use any opportunity to talk to higher and higher levels of people to obtain the result. And I not only promise things, I watch what countries do. WHO is now preparing the annual report on world health status. For example, Brazil is a very rich country. But Brazil has not even started leprosy elimination. All other surrounding countries started two or three years ago. Mexico says it will eliminate leprosy in 1995. I can go to countries and say you are not doing well.

FG: What do you think is your most important contribution to world health?

HS: That many developing countries have started to organise primary health care and Health for All activities. I have also selected some priority programmes which have worked well, such as polio and leprosy. Multi-drug therapy, which is the key to leprosy elimination, started when I was regional director in Manila. Even the mosquito net impregnated with pesticide, which is now all over Africa, we started in Manila. But the biggest thing that I am personally very proud of is that I was the first person who started rehabilitating the Vietnamese health service and the Laotian health service after the liberation of Saigon. And WHO was the first UN organisation to establish a programme in China in 1978.

FG: What would you like to be remembered for?

HN: For my work in the essential drugs programtne. This is one of the most difficult and successful programtnes at the country level, but it has had a lot of conflict among the staff and the member states and the drug industry. It was designed for developing countries. Now the problem is that the rich member states are starting to use it and are using generic drugs. Rut the raw materials are usually not patented, so they

"Our basic strategy to achieve Health for All is to identify what is needed in response to global change, and then to encourage governments and other partners to do what is required"

are less profitable and the developed countries are not producing them They buy them from China, Brazil, India, pulling in materials originally destined for developing countries, so we have a shortage of drugs and now fake drugs. The problem for developing countries is that quality control systems are poor.

FG: Do you enjoy your work?

HN: Yes, and still at my age I am working quite hard.

FG: What are your remaining ambitions?

HN: There are several targets I must finish: leprosy and polio, and the target of reducing child deaths by 3 million a year by the year 2000. So these are at least modest ambitions. Maybe an AIDS vaccine. But I must also find time to get all researchers to work together. There are so many prima donnas and they go this way and that way and the media is behind each prima donna so it is uncontrollable.

FG: What about personal ambitions?

HN: Maybe 3 book after retirement. I was originally a psychiatrist. Maybe I will write on diplomatic psychiatry, or political psychiatry. We are living in very challenging times. This world is unpredictable and irrational. The global community has forgotten the 40 African countries, so I must do everything I can for those. Dealing with 40 African countries is hard work because of the politics. It is always the question, should political reform precede economic reform or should we leave political reform and work on the economics? Africa and Asia are entirely different situations. So this is really a very interesting challenge.

Vital signs of WHO

FG: I have a list from an American business school of 15 vital signs of organisational health. Could you give me a quick response to each with respect to WHO? Firstly, does WHO have strong values and beliefs?

HN: We have strong values and beliefs. But the value issue is very difficult. We are a global organisation so ideally we must have universal values, hut today we must accept so called relative value, and this is represented in our regional structure.

FG Common purpose?

HN The common purpose is very well spelt out in Health for All. But common purpose needs common vision. WHO must have a common vision with member states, nd so member states must also have a common vision, nd this vision must be revised from time to time.

G: Commitment, conviction, confidence, and pride?

IN: We are very proud. We are one of the four largest UN organisations. We have a very strong professional pride, at least I do.

FG: Exceptional people?

IN: Yes, but the problem is that we are limited by the UN salary and we are getting fewer and fewer exceptional people.

FG: You don't think the salaries are high enough?

HN: No, we cannot pay enough.

FG: Superior services?

HN: Our service is directed through the government so ometimes the visibility is not high. But this is WHO's constitution, that we should cooperate with the governments.

FG: So you depend on them to provide the service.

HN: Yes, I must support and strengthen them.

FG: Customer driven?

HN: Customer power is very strong, but I can't satisfy all my customers.

FG: Most people believe WHO is donor driven?

HN: But donor driven by money or by vote? WHO is, like the UN, based on one country one vote or one voice. I know that some countries, particularly the Nordic countries, want to have weighted direction based on financial contributions.

FG: You don't approve?

HN: I cannot approve 100%. We should keep our democracy.

FG: Good economics and solid financial condition?

HS: We have a relatively good financial condition. The whole UN is suffenng from delayed payment from major contributors, particularly the former USSR. We are not like some other organisations. We never borrow money from the bank to pay salaries and we never delay paying salaries to staff.

FG: Clear and well executed strategy?

HN: Our basic strategy to achieve Health for All is to identify what is needed in response to global change, and then to encourage governments and other partners to do what is required. This is our role as the directing and coordinating authority on international health work.

FG: Attention to business fundamentals-performance evaluation, effective management control, budgeting, cash flow, etc?

HN: We are trying to improve this, but the bottleneck is that we have not got a strong management information system. We have a very good budget and financial system, but this does not correspond with programme implementqation and information. We are a professional organisation so cash flow evaluation does not mean effectiveness.

FG: Creativity and innovation; positive attitude to change; people not afraid to make mistakes?

HN: I am not afraid to make mistakes.

FG: What about your staff?

HN: If a mistake is intentional they may be afraid. But unintentional mistakes I must accept.

FG: And what of the changes within the organisation since last year, in response to the executive board's report on the global response to change?

HN: Yes, very few organisations in the system are changing as much as WHO. Maybe it is too fast. Too fast means conflict among the staff.

FG: Non-bureaucratic, lean, and decisive?

HN: That's a difficult one. We are an intergovernmental organisation and we have a regional structure, not decisions from the centre. All of this means some bureaucracy.

FG: Mutual trust, good communication, and team work?

HN: This is what I am promoting, but in an international organisation it is very difficult. We have different civilisations, cultures, individual backgrounds, but so far we have no Nordic mafia, no American mafia, no Japanese mafia, no European mafia. We are quite homogeneous. But still 70-80% of our headquarters staff come from Europe and North America.

FG: Willingness to see reality and act on it?

HN: Ah, this is my speciality. Working with reality and pragmatism. The real situation.

FG: Long term orientation?

HN: We have long term orientation. All our programmes and targets go through beyond the year 2000.

FG: And finally. strong and effective leadership?

HS: Maybe I am not a strong leader. Effective but not strong.

FG: Do you think strong leadership is a good thing?

HN: The European way of strong leadership may not be applicable in international organisations. I have talked often with Boutros-Ghali (secretary general of the United Nations). He is not a very strong leader. He believes more in consensus. Not like the approach of Jii Grant (head of Unicef), which is very strong. But each person has their own style.