To preserve WHO’s core functions cannot wait for organisational reform

While WHO undergoes a wide-ranging reform sparked by a US$300 million budget shortfall, the agency is facing an exodus of qualified staff that is affecting its ability to work. The Executive Board is due to meet on Jan 16 to agree long-term principles and priorities for the organisation; it must ensure, in particular, that core functions are accorded the priority they merit. Oxfam is especially concerned that inadequate funding will severely diminish the WHO Essential Medicines Department, which for more than three decades has had an indispensable role in enabling developing countries to access affordable medicines.

A key cause of WHO’s financial predicament is its declining budget, exacerbated by the adverse exchange rate of the Swiss franc against the US dollar. Money to pay for salaries and management, as well as for its vitally important core functions, has diminished while voluntary funding for projects has increased. Thus the basic costs are squeezed while specific, often vertical, activities that might be limited to a number of countries only are supported.

The planned reforms will take time—2015 is the estimated endpoint for achieving financial stability. In the interim, continued staff losses will put at risk essential WHO functions that support public health, such as the global norms, guidelines, and standards produced through the expert committees and similar bodies. The Medicines Department, although not the only unit under threat, is a sobering illustration of the consequences of failing to protect core functions of the organisation.

Between 2000 and 2010, income for core medicines functions dropped sharply. Experienced and specialised staff in key posts lost through mandatory redundancies and voluntary losses cannot be replaced in the current uncertain climate. Crucial work is running late, or is made possible only through cross-subsidisation taken from project work.

Today only 10% of the Expert Committee on Specifications for Pharmaceutical Preparations, which underpins all quality assurance guidance for the development, production, quality control, regulation, inspection, and distribution of medicines, is paid from the regular budget. Updating the Essential Medicines List, which is the key to rational management of pharmaceutical systems, and the new Essential Medicines List for Children, are paid for by the Bill and Melinda Gates Foundation (personal communication). Pain guidelines have been put on hold. Work to monitor drug safety (pharmacovigilance) and use, antibiotic resistance, guidelines for medicines pricing and availability, and WHO support to the Vienna-based International Narcotics Control Board is faltering or in danger of being discontinued (personal communication).

WHO has been the global leader on medicines since 1978. Since then it has provided credible and evidence-based guidelines for member states, non-governmental organisations, industry, and agencies such as the Global Fund, UNITAID, and public-private partnerships. Yet this core work, which informs all of public health involving medicines, is now challenged by funding shortfalls and survives through support from voluntary contributions, with the risk of donors dictating the agenda. Allowing continuing erosion and outsourcing of its component parts would risk irreparable loss.

To restore them to optimal efficiency and reverse the brain drain, WHO’s core functions must be adequately and securely funded once more from the regular budget—a move that the Executive Board should advance this month. A rescue package will not wait until 2015.

I declare that I have no conflicts of interest.

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Screening for congenital heart disease with newborn pulse oximetry

Andrew Ewer and colleagues (Aug 27, p 785) claim that their testing protocol has superior sensitivity to that advocated by de-Wahl Granelli and colleagues. This claim is incorrect for several reasons.

First, Ewer and colleagues’ sensitivity figure includes patients known to have critical congenital heart disease by fetal ultrasound scanning. For infants screened blind, as ours were, the sensitivity of Ewer and colleagues’ protocol was 58%; our protocol had a sensitivity of 62%. Second, Ewer and colleagues claim that our protocol would have missed one of their critical cases (prenatally diagnosed hypoplastic left heart syndrome). Our protocol would class the first reading of 92%/97% as abnormal, but the second reading of 100%/97% is impossible in a patient with aortic atresia who is breathing air; presumably he or she was by then receiving prostaglandin infusion and probably oxygen.

Ewer and colleagues’ protocol results in a significantly lower positive predictive value (9·2%) than does ours (20·7%, 95% CI 12·8–30·7), and