WHO's African regional office must evolve or die

A resounding silence surrounds an event to take place at the end of this month that, in theory at least, has great significance for the health of the people of Africa. Dr Ebrahim Samba is to step down after serving his maximum two terms of office as Director of WHO's Africa Region (WHO/AFRO). A new leader for WHO's governing body in the African region must therefore be nominated when the Regional Committee meets in Brazzaville, Republic of Congo, between Aug 31 and Sept 3.

Such disinterest in a new UN health leader in the continent with the world's most pressing disease burden seems at first glance astonishing. However, a little familiarity with WHO and its African Office makes the lack of debate more understandable. Although five candidates have been put forward for the post, none has mounted a public election campaign and their names do not even merit mention on WHO's website. In addition, the political negotiations key to the nomination are taking place behind closed doors and committee members will vote for their favoured candidate by secret ballot. The five candidates are Dr Déogratias Barakamfitiye (Burundi), Dr Phetsile Kholekile Dlamini (Swaziland), Dr Evaristo Njelesani (Zambia), Dr Francis Gervase Omaswa (Uganda), and Dr Luís Gomes Sambo (Angola).

Few would envy the job that the new WHO/AFRO Director must take on. This region has by far the highest disease burden coupled with the lowest level of economic development in the world, and is besieged by corruption, poor governance, political instability, and civil strife. Despite these constraints, it is clear that the regional office could do better. Indeed many commentators are privately and scathingly critical of its composition and working practices.

WHO/AFRO's weaknesses are typical of a large organisation: ineffective and self-serving central management and demoralised and unsupported rank-and-file staff. At the heart of the regional office's ineffectiveness is its acting as a political rather than a technical agency. Recruitment of senior staff is rarely based on competence or qualification. In particular, appointments of country representatives, who should coordinate WHO efforts in their countries, are often paybacks for political or other favours. The regional office thus has strong, some might say incestuous, relations with African governments at the ministry level, to the extent that senior health ministry officials see WHO/AFRO as their future retirement home. As a result, the culture of leadership within the regional organisation tends to be autocratic, excessively bureaucratic, and highly centralised—a culture that dismally fails to motivate staff at the country level.

There is much that WHO can do at the Geneva headquarters, at regional, and at country level to improve this failing situation. First and foremost, the damagingly close political ties between WHO/AFRO and the member-state governments must be loosened and the agency must reorient its core function towards technical health expertise. Accordingly, transparent, binding procedures must be put in place to ensure that country representatives are appointed on the basis of competence and qualification. There are strong arguments for decentralisation of WHO/AFRO to at least four or five subregions. Such action could allow better assessment of the array of health problems within the 46 countries that make up the African region and more tailored support to struggling country offices.

The overall Director of the region should be selected on the basis of management expertise and a proven record of leadership in a large organisation. Moreover, the Director should ensure that funds from WHO headquarters and donors are channelled effectively to where they are needed on the basis of evidence rather than ideology or political expedience. One African doctor emphasised to *The Lancet* that the regional office needs to adopt a more analytic and targeted approach to its work rather than saying, "We are dying, please help us".

The fault, of course, does not rest with WHO/AFRO staff alone, many of whom make valiant efforts in difficult circumstances. WHO's regionalised structure, where real, albeit limited, authority is vested in the regions, is clearly preferable to the more centralised organisation of other UN agencies, such as the Food and Agriculture Organization where the regional offices have no independent authority. Nevertheless, WHO's structure can lead to relations between Geneva and the regions ranging from strained to indifferent, with the regions allowed to operate as little fiefdoms presided over by an omnipotent director. WHO's Geneva headquarters must take a

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good part of the blame for this poor oversight. WHO/AFRO, because of its close ties with ministries of health, provides an excellent potential entry point for the roll-out of initiatives from WHO headquarters. But as one commentator put it: "People at headquarters often seem to forget that the Regions exist, while Regions can be irritated by headquarters acting as if it presumed to know what goes on at regional level better than [regional office] staff."

Moreover, WHO/AFRO has a very limited core budget and focuses on vertical donor-driven initiatives, almost certainly because this strategy is seen as the best way to ensure the agency survives. This approach is completely at odds with the current trend for the major funders, the development banks and bilateral donors, to adopt sector-wide approaches and budget support to health sectors. The regional office therefore needs solid long-term support from WHO headquarters to allow WHO/AFRO to evolve into an expert technical agency to assist these large sector-wide programmes—which is surely a much healthier survival strategy.

The legal documentation on the procedure for the nomination indicates that WHO/AFRO expects a new Director of exceptional calibre: "The candidate must be visionary, dynamic and results-oriented. It is very important that the candidate possess the ability to communicate both orally and in writing, in a clear, effective and inspiring way to varying target groups, including the mass media, political leaders, other leaders in the public health field, health personnel, a wide range of academic and professional groups within and outside the health sector as well as WHO staff. He or she should have personal integrity and a great capacity to withstand pressures from both official and private sources on issues that could jeopardize the Organization's interests."

Will WHO/AFRO nominate such a person? Given the lack of transparency and public debate surrounding the vote, it is impossible to tell. However, a new nominee gives opportunity for a joint re-examination of relations between Geneva and Brazzaville to ensure that WHO/AFRO can exploit the rich resources of Geneva while accepting its oversight and support. Unless WHO's African office is transformed from a political club to an effective health agency, its right to existence is questionable. ■ *The Lancet*

How not to grade hospital safety

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The number of jumbo jets crashing a day is not a common statistic in mortality measurement, and seems designed to catch attention. But such a denominator features highly in *Patient safety in American hospitals*, a recent report by HealthGrades, a US company that rates health care. According to their press release: "The equivalent of 390 jumbo jets full of people are dying each year due to likely preventable, in-hospital medical errors." HealthGrades studied 37 million hospital admissions by Medicare patients in 2000–02, and found 1·14 million patient-safety incidents. Nearly 324 000 patients who had such an incident died, and HealthGrades says that nearly 264 000 (81%) of these deaths were potentially attributable to the incident. Not only that, says the report, but the safety events cost hospitals an extra US$2·85 billion a year.

If a fifth of this excess attributable mortality could be prevented in four key areas, the HealthGrades' report continues, 18 000 Medicare patients a year could avoid dying due to a hospital error. The key areas are failure to rescue (ie, to diagnose or treat in time), decubitus ulcer, postoperative sepsis, and postoperative pulmonary embolism or deep-vein thrombosis.

HealthGrades used a set of safety indicators developed by the federal Agency for Healthcare Research and Quality that were not designed to model excess mortality or costs. HealthGrades bravely extrapolated attributable mortality and costs from a 2003 paper in *JAMA*, which studied all payers at all ages and excluded failure to rescue, into the Medicare elderly population. But Medicare patients are obviously sicker, more likely to have concurrent diseases, and their adverse-event rates will be higher. Finally, HealthGrades should not have assumed that deaths after failure to rescue are necessarily preventable.

Overall, the HealthGrades' data are probably an overestimate. On the same day, HealthGrades used the same criteria to list the top 7·5% of hospitals with the best safety record—probably not the way to choose one's place of treatment. ■ *The Lancet*

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