

## The WHO Director-General election finale

Margaret Chan's election as the Director-General of WHO (Nov 18, p1743)<sup>1</sup> raises the question of whether she can deliver in this role. In the *Lancet* debate between candidates<sup>2</sup> she came through as someone cautious, yet keen to use the potential of corporate skills and the power of communication. However, it is her pledge to champion the Bangkok Charter for Health Promotion that pitches her against a broad range of objectives; achieving these will necessitate ensuring the success of WHO's ongoing global programmes with time-bound targets, such as polio eradication, as well as its County Cooperation Strategy benchmarks. Given that these hinge on complex interdependencies, a few issues need closer attention.

First, the question of prioritising the sensibilities of the government over the wellbeing of people is crucial. Extrapolated to the constitutional context "the organization shall not seek or receive instructions from any government or from any authority external to the organization", this will entail going beyond involving international civil society and calls for redefinition of the intergovernmental agency prerogatives in view of the understanding that these can affect WHO's role as a custodian of health.

Second, the role played by governments in health is changing as the environment gets dominated by market dynamics with liberalisation of services traditionally in the public domain. WHO will have to broaden its focus outside the traditional sphere of influence to considerations around Member States' roles in the regulation and financing of care provision, rather than in the direct provision of care, and open avenues for engagement in broader regulatory considerations with new stakeholders, including the private

sector and those in the intersectoral domain.

Third, as the lead health agency in the UN family with the legitimacy and mandate, WHO should exercise its interorganisational might to improve cooperation in areas such as joint donor assistance, the multilateral sector-wise approach, drawing together disease-specific initiatives in WHO and other partner organisations, the United Nations Disaster Assistance Fund, health-security-related issues, outbreak situations, and disasters. Recent examples of disasters, including the 2005 earthquake in Pakistan and the post-conflict situations in Iraq and Afghanistan, emphasise the value that WHO can bring to such arrangements and the acceptability it has in that role.

Finally, WHO should create the right intraorganisational synergies to garner the support of countries that wish to engage in the normative and standard-setting terms and assist others that need to be supported technically, thus creating options for country engagement.

A radical reform to address these issues seems daunting in view of the vulnerabilities that resource constraints bring in their wake. Ultimately, it might also be a question of prioritising long-term strategic choices over short-term gains. The key to the former is overcoming inherent weaknesses in WHO's structure; this will necessitate drawing more than just the fine line between being political, which WHO needs to be, and being politicised, which WHO cannot afford to become.

I declare that I have no conflict of interest.

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- 1 The *Lancet*. WHO 2007–12: the era of Margaret Chan. *Lancet* 2006; **368**: 1743.
- 2 Brown H. WHO's Director-General candidates respond. *Lancet* 2006; **368**: 1225–28.

## Prevention of cardiovascular disease with a polypill

Thomas Gaziano and colleagues (Aug 19, p 679)<sup>1</sup> report on the usefulness of a multidrug regimen for prevention of cardiovascular disease in the developing world. However, we disagree with the drugs chosen to treat hypertension and to the overall prevention strategy.

Gaziano and colleagues justify the use of a calcium-channel blocker in treating hypertension by referring to the ASCOT-BPLA trial<sup>2</sup> which showed that an amlodipine-based regimen (amlodipine plus perindopril) was more effective than an atenolol-based one (atenolol plus bendroflumethiazide). This study has already been criticised for the drugs chosen for treatment comparison.<sup>3</sup> As an additional criticism, even though a possible beneficial effect of the calcium-channel blocker regimen might be assumed, it would be marginal, because the estimated number of patients needed to treat per year to prevent one event (NNT) is about 1000. We wonder why, in a cost-controlling health policy, a thiazide diuretic was not included. Since there is no evidence to support a greater efficacy of calcium-channel blockers over thiazides, use of a diuretic instead of a calcium-channel blocker would cost 10–20 times less.<sup>4</sup>

Moreover, we wonder why a strategy to reduce cardiovascular mortality centred on a multidrug regimen and not on a smoking cessation campaign. The importance of smoking in determining the cardiovascular risk profile in lower social classes has been underlined by Jha and colleagues.<sup>5</sup> Prescribing a single pill, without lifestyle changes, to prevent cardiovascular diseases is perverse. Indeed, it could lead to excessive medicalisation, masking the major causes of cardiovascular mortality such as those related to lifestyle or socioeconomic status.

We declare that we have no conflict of interest.



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