U. N. Studies

The World Health Organization

Resisting Third World Ideological Pressures

by
John M. Starrels

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Introduction

> Much discussion of policy is not in terms of process characteristics but of noble goals—'social justice,' 'decent housing,' 'freedom from hunger,' etc. The desirability of these goals is not at issue. Their emotional and political appeal makes it all the more necessary to remember that human beings can only create processes, not direct results. The nature of these processes must therefore be scrutinized to see whether they in fact take us closer to, or further away from, humanitarian goals.
>
> –Thomas Sowell[1]

Since the end of World War II, the United States has led the multilateral global effort to create a healthier world. U.S. membership in and strong support of the World Health Organization (WHO) are pivotal in that endeavor. Even now, despite budgetary stringency at home and a significant increase in the Organization's membership (it currently numbers 161), the United States remains by far its most generous contributor.[2]

Over the past few years, however, WHO's activities and purposes have been scrutinized anxiously in the United States. It is feared that the World Health Organization, like many United Nations agencies, is about to embark on a political campaign that diverges seriously from the purpose for which the Organization was founded. A number of member governments appear intent on regulating private enterprise—especially, though not exclusively, pharmaceutical companies. In May 1981, the World Health Assembly, WHO's governing parliament, voted to recommend an international code regulating the promotion and use of infant formula and other nutrients for small children.[3] Wrote Kenneth L. Adelman, at the time deputy representative of the U.S. to the United Nations:

> Thus, it appears that the infant formula drive was just the opening skirmish in a much larger campaign. The stunning defeat it dealt to Western interests, health groups, and corporate enterprises opposing international regulation

[1] *The Economics and Politics of Race* (New York: William Morrow & Co., 1983), p. 253.
[2] Aside from its voluntary contributions (which account for 20 to 25 percent of all voluntary contributions), the United States currently pays in 25 percent of WHO's assessed budget. The Organization is funded over a two-year cycle: for the 1984-1985 period, the U.S. will be assessed approximately $122 million, out of a total figure of $475 million. Information obtained from *Thirty-Sixth World Health Assembly: Resolutions and Decisions, Annexes* (Geneva: May 2-16, 1983), p. 44. This excludes a separate U.S. assessment that is paid into the Pan-American Health Organization.
[3] See Carol Adelman, "The Case Against the Case Against Infant Formula," *Policy Review*, Winter 1983, pp. 107-126.

should have stirred them to muster their forces for the campaign yet ahead. And this larger campaign could reach beyond regulation of pharmaceuticals to encompass United Nations codes on hazardous chemicals, trans-border data flow, and an array of so-called consumer protection activities. Victory in one realm raises expectations for victory in another.[4]

Adelman was hardly alone. The Reagan Administration expressed its concerns in various ways. In May 1982, then Secretary of Health and Human Services Richard Schweiker addressed a meeting of the World Health Assembly in Geneva, making it clear that the Administration opposed such interventions. At about the same time, the Washington, D.C.-based Pharmaceutical Manufacturers Association voiced its growing alarm. "Industry's relations with WHO remain practical and effective," a PMA memo stated then:

However, since the mid-seventies, WHO has expanded its scope beyond health-related technical and medical matters concerning pharmaceuticals to include consideration of such economic and commercial factors as industrial property rights, the source of raw materials, international prices, and government procurement and/or control of national drug supplies.[5]

How substantive are these concerns? Certainly there are grounds for some U.S. anxiety. The May 1981 vote on infant formula, for instance, signalled a major break in the World Health Organization's nonpolitical tradition. But it is not just WHO's support for a dubious code that bothers American observers. They now wonder whether the World Health Assembly's adoption of the infant formula code will constitute a step toward more restrictive codes regulating the activities of multinational enterprises. Certain consumerist groups advocate such a step.

Beyond U.S. concerns about marketing codes is the relationship between WHO and the U.N.'s grandiose call for a New International Economic Order (NIEO). Specifically, it must be asked if the World Health Organization's widely heralded "Health For All by the Year 2000" strategy is only an adjunct of the NIEO idea.

The findings here, in large measure derived from an investigative trip by this writer to the WHO Geneva headquarters in the Fall of 1983, however, are generally reassuring to supporters of the World Health Organization.[6] WHO's technical personnel have clearly learned the hard lesson of the infant formula episode, and have gone on record in support of policies and

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[4] Kenneth L. Adelman, "Biting the Hand That Cures Them," *Regulation*, July-August 1982, p. 16.

[5] "The World Health Organization and the Pharmaceutical Industry," background brief, June 1982.

[6] In preparation for this study, the author conducted interviews with WHO policymakers at its Geneva, Switzerland headquarters in September 1983.

procedures that reaffirm the Organization's original mandate—to encourage the development of health care methods and policies that improve global health standards. Recourse to ideological campaigns now is seen by almost all WHO personnel as a dangerous, counterproductive undertaking. Working together with private sector groups, and buttressed by the Reagan Administration's strong support for a WHO that pursues its original mandate, the Organization's professional staff is convinced that it must adhere to the principles upon which it was founded.[7]

To ensure that this in fact comes to pass, the United States must take a new hard look at the World Health Organization, in light of the following crucial questions:

- What is WHO's health mandate?
- How is it fulfilled?
- What financial, bureaucratic, and political resources are available to the Organization in pursuit of its mandate?
- Are there resources that have yet to be tapped?
- What role—if any—does WHO play in the U.N.'s call for a New International Economic Order? How does this affect WHO's pursuit of its technical goals?
- Cutting through all of these questions is the role of the private medical, particularly the pharmaceutical, sector and its increasing importance to the World Health Organization.

[7] The author has discussed these matters with industry sources, including representatives of the U.S.-based Pharmaceutical Manufacturers Association and the International Pharmaceutical Manufacturers Association (IFPMA).

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The WHO in Perspective

Global health has been a major concern of the international community since the turn of the 20th Century. Before World War II, three organizations defined the global health agenda: the Office of International Public Hygiene (OIPH); the Pan-American Sanitary Organization (PASO); and the Health Organization of the League of Nations (HO). The HO's exemplary effort to facilitate cooperation between governmental and private medical institutions was an especially significant influence on its direct successor, WHO.

After 1945, the United Nations Conference on International Organization unanimously approved a proposal for an international conference to establish a single global health organization. In July 1946, that conference (comprising representatives of 61 nations) convened in New York and adopted the Constitution of the World Health Organization. WHO's Constitution (consisting of 82 articles) entered into force on April 7, 1948, when it had been ratified by 26 U.N. member states.

Organization

Now, as then, the Organization consists of three organs: the Executive Board, the World Health Assembly, and the Secretariat. The Board is composed of up to thirty persons technically qualified in the field of health, appointed by as many member states elected by the Assembly. The Board acts as the executive organ of the Assembly and is responsible for preparing the agenda for each Assembly session. The World Health Assembly's major function is to set policy and adopt the annual program and budget.

WHO's functional responsibilities are carried out by six regional organizations, each of which consists of a regional committee and regional office. A regional director heads these six offices now located in Alexandria (Eastern Mediterranean Region), Brazzaville (African Region), Copenhagen (European Region), Manila (Western Pacific Region), New Delhi (South-East Asia Region), and Washington (Region of the Americas). This decentralized structure sets WHO aside from most other U.N. bodies, and the regional headquarters ensure better than usual communications and followup with projects in the field.

The Secretariat is the real seat of power, however, responsible for articulating WHO's major policy goals, and WHO's most important official therefore is its Director General. Appointed by the World Health Assembly on the nomination of the Executive Board, the Director General serves a five-year term. The incumbent is Dr. Halfdan Mahler, who was reelected to the office at the Thirty-Sixth World Health Assembly meeting at WHO Geneva headquarters in May 1983. Mahler is from Denmark and is a specialist in tuberculosis. Prior to becoming Director General, he devoted himself to improving health conditions in developing countries, particularly India where he worked for a number of years.

Since its establishment nearly four decades ago, WHO has functioned as an integral part of the United Nations system. As a "specialized agency" provided for in the U.N. Charter, it works closely with its parent organization through a formal agreement, which provides, *inter alia*, for reciprocity between the two in adoption of common administrative practices and the exchange of information. Specifically, Article 57 of the U.N. Charter and Article 69 of the WHO Constitution call for a close relationship between the two in connection with: personnel arrangements (for example, the interchange of personnel); statistical cooperation, to avoid duplication; budgetary and financial arrangements (notably, WHO "agrees to transmit its proposed budget to the United Nations annually. . . " according to Article XV(b) of the Agreement between the United Nations and WHO).

WHO also is involved with the United Nations through a network of agreements calling for cooperation with other U.N. agencies, including the International Labor Organization (ILO), the Food and Agriculture Organization (FAO), and the U.N. Educational, Scientific, and Cultural Organization (UNESCO). Overlapping policy interests result in an especially close partnership between WHO and the United Nations Children's Fund (UNICEF).

WHO's international health program is funded on a two-year basis. Income is derived from: (1) the *regular* budget, generated by contributions assessed according to a national formula approved by the World Health Assembly; (2) *extrabudgetary* resources, which consist of voluntary contributions and participation by other governmental and nongovernmental (including individual) sources. Assessments range from 0.01 percent to the U.S. portion, which amounts to 25 percent of the WHO's regular budget. The next largest contribution is 12.01 percent from the Soviet Union (including Mongolia, Byelorussia, and the Ukraine), followed by Japan at 10.14 percent, and the Federal Republic of Germany at 8.39 percent, for the current 1984-1985 budgetary cycle. U.S. outlays to the WHO in 1983 were $60 million, and this year are expected to be $62.5 million.

The regular budget is supplemented through a number of extrabudgetary sources. U.N. agencies, such as the United Nations Children's Fund, regularly contribute funds to WHO in order to carry out joint programs. Another source of extrabudgetary income derives from the WHO Voluntary

Fund for Health Promotion. Established in 1955, the VFHP consists of a number of special accounts that WHO uses to carry out target programs in specialized areas, such as the control of blindness, diarrheal disease, and the expanded program on immunization. These extrabudgetary sources average $140 million per year and, like the regular budget, are targeted to support programs over a two-year period. They actually have become a source of "expected" revenue and are regularly included in WHO's proposed program budget. Aside from funds generated through other U.N. agencies, extrabudgetary resources come from individual countries. In 1981, for instance, there were sixteen main donors, headed by Sweden, the United States, and Denmark, who contributed $110, $80, and $42 million respectively for the budgetary period of 1980-1981.

WHO's regular budget is developed from a zero base and within a real increase ceiling established in advance by the World Health Assembly. Also considered in this calculation are estimated inflationary costs and allowance for the impact of currency fluctuations on the value of assessed contributions paid in U.S. dollars. Over the past decade, the World Health Organization has managed on the smallest percentage growth rate in its regular budget of all comparable organizations in the United Nations family.

The budgetary performance of WHO generally receives good-to-high marks, though there is waste. Observers have dubbed the Organization's Secretariat a "movable feast," as a number of its members owe their well-paying comfortable jobs to good political connections rather than to their professional qualifications. There have been reports, moreover, that some of WHO's regional offices are inefficiently run. Indeed, on one recent occasion, the Region of the Americas Washington, D.C., office is reported to have discovered that it was sitting on $10 million that it had "failed" to spend and was looking around for ways to spend it before the end of the funding year. But U.S. officials closely involved with WHO claim nonetheless that WHO has undertaken a conscientious effort to trim excessive costs.[8] In any event, the 1984-1985 budget calls for close to zero budgetary growth, after controlling for inflation, with regular assessments for the two-year period projected to be only $475,800,000. At least on paper, one important indicator of WHO's budgetary seriousness is number of staff, which from October 1980 to October 1982 remained virtually static: 1,425 in 1980 and 1,423 two years later.

The Policy Mandate

The World Health Organization derives its mandate from three sources: the United Nations, a number of its specialized agencies, and, most relevantly, itself.

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[8] Conversation, October 27, 1983.

The United Nations has been involved with health issues since its inception in 1945. Article 25 of the U.N. Universal Declaration of Human Rights provides an overview of the scope of those interests. It states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of livelihood in circumstances behind his control."[9]

Other pertinent articles from the Declaration are Article 22, which affirms that "everyone, as a member of society has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality." And Article 29 states that "everyone has duties to the community in which alone the free and full development of his personality is possible."[10]

In addition to WHO, several specialized U.N. agencies are involved with health matters:

U.N. Center for Transnational Corporations—The Center has become one of the U.N.'s most politicized bodies. It gathers information on corporate operations, especially in the Third World, and provides advice to member governments. One major focus—a controversial one—is the Center's study of pharmaceutical company activities in developing areas. To date it has published two reports, both of which have been criticized by private sector groups.

U.N. Industrial Development Organization—UNIDO advocates revisions of trademark and patent laws, which could have a major impact on marketing prospects for pharmaceutical companies.[11] Though developments have yet to reach this stage, pharmaceutical companies worry that UNIDO could make it easier for governments to abrogate the patent rights of private firms operating in their countries.

UNIDO also proposes exclusive public sector production of bulk materials that are held to be essential ingredients in drug manufacturing and establishment of price schemes that, in effect, index bulk drug prices to raw materials costs.

U.N. Development Program—At the initiation of WHO, the UNDP and the World Bank are engaged in a Special Programme for Research and Training in Tropical Diseases. The Programme's objectives are to develop better tools for control of tropical diseases and to train health personnel in developing countries to combat various tropical diseases.

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[9] *Everyone's United Nations* (New York: United Nations, December 1979), p. 415.
[10] *Ibid.*, pp. 414 and 415, respectively.
[11] See, for example, Barry McTaggart, "Stealing from the Mind," *The New York Times*, July 9, 1982.

U.N. Conference on Trade and Development—UNCTAD was founded in 1964 and has emerged as the main U.N. agency dealing with Third World economic demands. It gives the U.N. some advice on how developing countries can establish national drug procurement entities to enable them to pool purchases and market information. These activities grew out of UNCTAD's determination to become the leading U.N. advocate of the New International Economic Order. UNCTAD also commissions occasional papers on pharmaceutical company activities in Third World areas.

U.N. Children's Fund—UNICEF advocates bulk purchasing schemes for essential drugs to combat major diseases affecting children's health—diarrheal infection, tetanus, and whooping cough. UNICEF also has sponsored studies to determine the health impact of infant formula on newborn infants.

Primary responsibility for improving international health in the U.N. system is exercised by the World Health Organization. It is an ambitious mandate. In the words of a U.N. document:

> The objective of WHO is the attainment by all peoples of the highest possible level of health. It provides worldwide services to promote health, cooperates with member countries in their health efforts, and coordinates biomedical research. Its services . . . include a day-to-day information service on the occurrence of internationally important diseases, injury and death, disseminating information on the effect on human health of environmental pollutants and laying global standards for antibiotics, vaccines, etc. Assistance rendered to individual countries at their request includes support for national programmes to fight diseases, training health workers and strengthening health services.[12]

Article 2 of the WHO Constitution lists twenty-two major functions, which—taken together—constitute the range of the Organization's short- and long-term activities. The most important of those functions, most experts agree, is WHO's attempt to direct and coordinate the health policies of its individual members. "The critical question," explains a WHO document," is whether WHO is truly effective as an instrument for getting countries to collaborate among themselves in international health matters and to develop their own health capabilities."[13] In fact, one of the major problems facing the Organization according to WHO personnel is the frequent inability (and at times, perhaps unwillingness) of the individual members to enact programs that have been agreed upon collectively by the World Health Assembly. As described by WHO's chief of coordination, Dr.

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[12] *Everyone's United Nations, op. cit.*, p. 361.

[13] *Executive Briefing* for Americans on the World Health Organization, "The Ultimate Value of WHO," in Sec. 5 (WHO/ADMIN/1982), p. 50.

G. L. Mutalik, "It's the gap between collective responsibility and resultant individual actions."[14]

Changes Over Time

In important respects, WHO's approach to health has changed over the years. In the late 1940s and early 1950s, the major focus was on technical health issues: establishing a nomenclature system for drugs, achieving international agreement on appropriate research methods, and working toward achieving international standardization of diagnostic, prophylactic, and therapeutic substances. Then, beginning in the mid-1950s and extending through the 1960s, WHO shifted focus toward mobilization of medical resources for concerted attacks on major sources of epidemics: tuberculosis, malaria, and smallpox. Over the past decade, the Organization has devoted greater attention to the establishment of indigenous health resources, manpower, and institutions—particularly in the Third World. Along with this new emphasis has come a rejection of "the concept of 'technical assistance,' whereby aid was provided by so-called 'donors' to 'recipients.'"[15]

The new emphasis, in practice, stems from two realities: first, with the eradication of many of the killing diseases, WHO began to direct more effort toward disease prevention strategies, such as increased attention to broader social-environmental causes of illness; second, the explosion of Third World membership throughout the U.N. system has necessitated more attention to specifically Third World problems, including those relevant to health.

Under the direction of Dr. Halfdan Mahler, WHO is calling for more participation on the part of developing countries. Since the Health for All strategy was launched in the late 1970s, Mahler has urged the developing nations to organize behind a minimal program of self-help measures—which should enable the Organization's more affluent (healthier) members to target assistance to them.

WHO has largely fulfilled, then, its orginal tasks. With success, however, has come a new challenge, reflected in the "Health for All By the Year 2000" strategy.

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[14] Discussion at WHO headquarters, Geneva, Switzerland, September 26, 1983.

[15] Resolution of the WHO: Thirty-Sixth World Health Assembly (May 22, 1983), p. 1.

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Toward Health For All

In numerous late 1983 discussions in New York and Geneva, WHO representatives emphasized that the health needs of the Organization's members have changed a great deal from the time when its functions were technical-medical. Explained Jack Ling, director of WHO's information department: "In the past, our concerns were narrowly focused. Increasingly, however, we are recognizing that progress on the global health front depends on our capacity to address broader, socio-economic development issues."[16] In part, of course, WHO's policy evolution mirrors the U.N.'s call for a "New International Economic Order" (NIEO). WHO's increased emphasis on what it calls developmental aspects of health (reductions in human exposure to hazardous environmental agents, new initiatives to ensure food safety, the delivery of comprehensive health care) places it within the broader framework of the NIEO.

This shift—away from specifically technical-medical issues toward a broad and questionable socioeconomic emphasis—is captured in the following mid-1970s WHO statement:

> WHO's role as an international forum encourages debate on health issues of moment in an atmosphere uncluttered by constraints. The emphasis is now shifting towards issues of such vital importance as the poverty-malnutrition-infection syndrome; malnutrition as an expression of an imbalance between production, distribution, and organization at the village level as a prerequisite for rural and health development . . . and the injustices and waste inherent in the maldistribution of national health resources. These are different *types* of subjects from those tackled in the past . . . The implications for countries and WHO of such a change are profound.[17]

A Mandate for Health for All

Then, in 1977, the World Health Assembly transformed these words into a long-term program, designed to bring about some of the changes alluded to in the above passage. Entitled "Health for All by the Year 2000," the

[16] Interview, WHO liaison office, New York City, August 30, 1983.
[17] *Introducing WHO* (Geneva: World Health Organization, 1976), pp. 80, 81.

strategy calls for "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."[18] To this was added a more precise program focus in the following year when the World Health Organization announced that the HFA strategy would be carried out through a long-term program of "primary health care."

From the beginning, the guiding influence behind HFA has been WHO Director-General Dr. Halfdan Mahler, long known as a passionate supporter of initiatives to improve health prospects in Third World countries. Well-placed sources characterize Mahler's commitment to developing countries as verging on a personal crusade; some suggest, however, that the zeal with which he pursues this goal has dimmed somewhat in the last few years. As the Director-General sees it, WHO has played a vital part in helping those countries improve their health care systems. But he remains dissatisfied with the pace of progress. As he wrote in the *World Health Forum* in 1981: "Globally, there has been in recent years some improvement in the world's health. Statistics prove it. Yet a newborn child in some African countries has only a 50-50 chance of surviving through adolescence, four-fifths of the world's population have no access to any permanent form of health care, and only one in three persons in developing countries has reasonable access to safe water and adequate sanitation."[19]

Combining HFA with the Organization's primary health care program is to be the means of ameliorating those conditions in Mahler's view. But what is the precise meaning of Mahler's ambitious strategy, and how does he intend—through WHO auspices—to carry it out?

From its inception, the "Health for All by the Year 2000" strategy has been clothed in semantic ambiguity. Advocates of the New International Economic Order see HFA as one important aspect of a larger redistributive effort orchestrated by WHO to provide the "poor" South with a more "equitable" share of the assets of the "rich" North. Until recently, Mahler gave lip service to this goal. Commenting on WHO's essential drug program several years ago, he explained: ". . . we are now moving straight into technology production, patents, trademarks—all the elements of a new international economic order in the widest possible sense."[20] "WHO," the Director General then continued, "has set the scene, and other bodies like the U.N. Conference on Trade and Development, the U.N. Industrial Development Organization and the World Bank should now play their parts."[21]

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[18] In Halfdan Mahler, "The Meaning of 'Health for All by the Year 2000,'" in *World Health Forum* 2 (1), 1982, pp. 5-22, a general overview of what the HFA strategy means.
[19] *Ibid.*, p. 5.
[20] Taken from James R. Phelps, "The New International Economic Order and the Pharmaceutical Industry," *Food Drug Cosmetic Journal*, April 1982, p. 207.
[21] *Ibid.*

Yet a careful look at the specific content of the Health for All Program prompts the question whether the Director General's enthusiasm for linking his program with the NIEO was more the result of temporary confusion about the broader aims of the U.N. than the consequence of a carefully developed plan of action, designed to wed the two ideas. As Mahler has been at pains to emphasize, Health for All by the Year 2000 is "essentially a guide to countries" who wish to enact programs that flow from his strategy. This emphasis is at one with WHO's traditional mandate, as contained in Article 2(c) of the Organization's Constitution to "assist Governments, upon request, in strengthening health services." Similar statements have been made by the Director General's closest advisers. Those of Dr. Joshua Cohen, an Israeli expert on health care administration, deserve special attention.

Cohen enjoys the reputation of someone who, in the view of one well-informed observer, has "few specific tasks but a tremendous amount of authority." He is, according to one former WHO official, Mahler's right-hand man and the most influential person in the day-to-day running of WHO. In practical terms, Cohen is the salesman of the Health for All strategy. As he sees it, WHO's main responsibility is to "help assist people in a variety of coordinated endeavors, focusing on promotion of primary health care—that if carried out successfully will result in a country far better able to shoulder its major health responsibilities."[22] Cohen and others at WHO emphasize that the long-term aim of the strategy is to promote an indigenous approach, which encourages "individuals to take responsibility for themselves; in preference to leaving such decisions to central government authorities."[23]

Integral to the HFA strategy is promotion of primary health care, especially in Third World countries. "Most developing countries have to start from scratch," as Mahler sees it. Building on that foundation, the Director General, along with Cohen and other associates, believes that between now and the end of the century, WHO's responsibility is to galvanize—occasionally goad—the membership behind a plan of action designed to achieve the following:

- training of a cadre of primary health care workers,
- establishment of indigenous health research capacities,
- promotion of family health care practices,
- provision of essential drugs to local communities,
- immunization program to inoculate children against the six most common infectious childhood diseases, in countries that need it.

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[22] Interview, September 27, 1983, WHO headquarters, Geneva, Switzerland.
[23] *Ibid.*

One of the supplements to this plan was the Essential Drug List (EDL), which was formulated by WHO's expert committee on the selection of essential drugs in the late 1970s. The EDL is designed to provide countries, particularly in the Third World, with a working list of low-priced drugs that can meet the health needs of the majority of the population. As part of the Health for All by the Year 2000 strategy, EDL is geared to attack specific named diseases, which occur in Third World countries. The list consists of about 200 active substances, running the gamut from anesthetics, analgesics, antidotes, antimigraine drugs, diuretics, immunologicals, and psychotherapeutic drugs. Each country is expected by WHO to formulate a list suitable for its own needs in conformance with WHO standards.

Enactment of the HFA strategy depends on the willingness of U.N. members to cooperate in the program for primary health care, enunciated at the joint WHO-UNICEF conference held in Alma-Ata, USSR, September 6-12, 1978. According to well-informed sources, the Alma-Ata conference resulted in a major propaganda victory for Western countries—principally the United States—who support the principles of self-help and decentralized medicine. "When the Soviet Union originally agreed to host the conference," explained a well-placed source, "I thought that a coup d'etat had been registered. In fact, the outcome of the Alma-Ata conference was a political disaster for the USSR, resulting in the forced resignation of at least one high-ranking Soviet health official in its aftermath."[24]

There is a direct relationship between the Alma-Ata regime and the Health for All strategy. For like HFA, the primary health care focus calls for the extension of health services to those U.N. member countries, especially in the Third World, which need them. As a document from the Alma-Ata conference states, those programs include: "promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of local endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries."[25]

Implementation of HFA

How is HFA to be implemented? WHO devotes a good deal of time to answering that question and has published a number of short statements to provide its membership with appropriate guidelines. They include: Health Programme Evaluation; Managerial Process for National Health Develop-

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[24] Interview in Geneva, Switzerland, September 26, 1983.

[25] *Primary Health Care*, a joint report by the Director-General of the World Health Organization and the Executive Director of the United Nations Children's Fund, Geneva and New York, 1978, p. 2.

ment; Development of Indicators for Monitoring Progess toward Health for All; Formulating Strategies for Health for All; Plan of Action for Implementing the Global Strategy for Health for All.[26] The Seventh General Programme of Work (1984-1989), for instance, calls upon members to have national strategies in place by 1984, with implementation measures completed the following year. By the end of this decade, Geneva headquarters expects that the various national health plans will "be at an advanced stage of implementation."[27]

Neither the Work Programme nor the guidelines provide much insight into how WHO members are to actually accomplish the ambitious HFA by the year 2000 mandate. Formulating Strategies for Health for All, for instance, is long on action statements (including sections addressing how members should pursue national, regional, and global HFA strategies), but short on specific suggestions for individual countries.

How successful has WHO been in galvanizing membership support for the HFA strategy? For the record at least, its representatives are optimistic. One WHO offical bravely predicts: "The subsequent development of national and regional strategies and the recent adoption by the Thirty-Fourth World Health Assembly [held in 1981] of a Global Strategy to reach this goal are certainly encouraging signs that the world health situation can and will improve during the period of the Seventh General Programme of Work."[28] Mahler himself is candid about the obstacles, however. Consider, for instance, his remarks before the Thirty-Sixth World Health Assembly (May 3, 1983). While generally praising the membership for its support of the Health for All strategy, the newly reelected Director-General also had some complaints. He charged a number of unnamed members with neglecting to build up their health infrastructures "based on primary health care." WHO officials are careful not to identify specific countries with whose policies the Organization finds itself in disagreement. But it is possible that Mahler's concerns in this instance were directed toward some of the more affluent and independent advanced developing countries. If these negative developments continue, he warned, "valuable energy will be wasted, and you will be deflected from your path."[29] "Remember," he concluded, "the Strategy for Health for All and the Plan of Action implementing it have been arrived at through extensive and intensive work over many years. They are based on the collective wisdom and agreement of governments representing almost the whole of humanity. So, if you are

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[26] These various documents are distributed by WHO.

[27] Taken from *Seventh General Programme of Work* (Geneva: World Health Organization, 1982), p. 46.

[28] *Ibid.*

[29] Address by Dr. Halfdan Mahler to the Thirty-Sixth World Health Assembly, Geneva, Switzerland, May 3, 1983, p. 5.

seized with *positive* impatience to implement them-yes! *Negative* impatience-no!"[30]

The Health for All strategy seems to enjoy the support of WHO's diverse membership, including the United States. Why? First, because the HFA concept is broad enough to include various health initiatives. Second, HFA in practice emphasizes relatively costless programs—notably training of indigenous health personnel by WHO technical personnel—which even the poorest of Third World countries can afford. Finally, and as a result of the above considerations, the Health for All strategy represents an implicit challenge to the more far-reaching components of the New International Economic Order. Yet even in its present guise, it could be asked whether HFA is too ambitious; whether its thrust is in fact weakening traditional programs, and at the same time reinforcing concerns on the part of the Reagan Administration that the new emphases in WHO are designed to push private enterprise out of Third World health care.

Is HFA Too Ambitious?

The 161 members of the World Health Organization are committed to working together toward Health for All by the Year 2000. While there is an overall strategy for achieving this ambitious goal, each country is expected to implement it in its own way using its own financial, human, and technical resources to reach for an agreed upon outcome. Notably lacking at the 1983 meeting of the World Health Assembly was any public suggestion that adhering to the 1977 strategy decision was beyond the capacity of any member state. Notable was the unanimous support that HFA enjoyed among member countries.

Nevertheless, there are grounds for concern about the ambitious scope of the Health for All strategy. "Critics," explains one source, "say that by embarking on what they call a quixotic quest, WHO is straying too far from more traditional categorical programs that target a single disease. In 1970, WHO spent nearly 37 percent of its budget on such programs. This year (1982-1983), that percentage dropped to 15.5."[31] No one would argue—including Mahler—that the HFA strategy is not ambitious. It endeavors to provide primary health care to the estimated 6.1 billion people who will be living on this planet in less than two decades. Mahler, nevertheless, rejects the criticism out of hand. "If health for all meant medical repairs by doctors and nurses for everybody in the world for all their existing ailments . . . it would certainly not be a realistic proposition," he acknowledges. "But," he points out, "it does not mean that. Nor does it mean that nobody will be sick or disabled. It means a different approach by which health is

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[30] *Ibid.*

[31] Kathleen S. Mirin, "Who says health for all is just around the corner," *The Interdependent*, March/April 1983, p. 7.

considered in the broader context of its contribution to, and promotion by, social and economic development."[32]

Mahler has not silenced the skeptics. "I don't think there is any prospect in the world that there's going to be health for all in the year 2000," maintains Dr. Donald A. Henderson, Dean of Johns Hopkins University School of Public Health and the former director of WHO's successful smallpox eradication program.[33] Adds Dr. Aubrey S. Outschoorn, a senior scientist at the U.S. Pharmacopoeia and a former WHO staffer: "The Health for All strategy doesn't add up to anything concrete. What the Organization needs is a precise plan of action, replete with tested hard criteria. HFA lacks such specificity."[34]

As for the related criticism that WHO's pursuit of HFA robs traditional programs of scarce funds and personnel, one program, which may be losing out, is pharmaceutical testing. Observers of this program point out that Third World countries desperately need timely, accurate information on the medical and pharmacological effects of drugs being brought onto the market today. "Unfortunately, WHO's information gathering and analytic strengths have been weakened because of the budgetary demands of other departments which are directly tied into the HFA strategy," confided one knowledgeable source.[35]

For all that, the majority of HFA's members appear satisfied with Mahler's strategy. Explained Dr. Abdul Khalid Bin Sahan, Malaysia's delegate to the Fifth Plenary Meeting of the Thirty-Sixth World Health Assembly in May 1983:

> With the adoption of the Global Strategy of health for all by the year 2000 many of us would have by now started to reappraise our present situation and to take steps to ensure that we can achieve what we have politically committed ourselves to carry out. For some of us it is a question of effecting better distribution of resources between urban and rural areas, or between therapy and prevention. For others it means that a greater proportion of the national income needs to be spent on health. For yet others, health for all by the year 2000 means more equitable sharing of scant resources, more efficient and effective planning, organization and operation of health programmes. . . .[36]

And yet, it would seem possible that Mahler's public concern about "negative impatience" on the part of some members is a direct result of confusion as to what, in fact, HFA means for them?[37] WHO representatives

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[32] *Ibid.*
[33] *Ibid.*, p. 9.
[34] Conversation in Washington, D.C., October 27, 1983.
[35] Interview, Geneva, Switzerland, September 26, 1983.
[36] Fifth Plenary Meeting, May 4, 1983, WHO headquarters, Geneva, Switzerland, p. 14.
[37] Presumably this is not at issue since the membership voted to institute the HFA strategy in the first place.

seem confident that the Health for All strategy will mobilize individual countries behind programs that are carefully designed to improve health conditions in many Third World countries. Perhaps such confidence is justified. But the continuing vagueness of the HFA idea could encourage another result—spreading member confusion, which might lead individual countries to stray outside the guidelines of HFA.

In the meantime, a fundamental concern of Western countries is how HFA relates itself to the role of private enterprise in developing areas.

3

WHO and Private Enterprise

WHO spokesmen have expended considerable effort to repair relations with the United States in the aftermath of the infant formula controversy. And most experts believe that the Organization has made some progress. Mahler himself (reportedly at advisor Dr. Joshua Cohen's urging) has played a key part in attempting to reassure the Reagan Administration that WHO's global health programs are in line with the principles of private enterprise, especially those of pharmaceutical firms. As Mahler declared before a meeting of the International Federation of Pharmaceutical Manufacturers Association (IFPMA) in June 1982:

> The field of cooperation is wide open to all those who are ready to act along the lines of the policies and programs that have been agreed upon collectively by WHO's Member States. So, under these circumstances, it is wide open to other multilateral organizations, to bilateral agencies, to non-governmental organizations, and, of course, and particularly to the pharmaceutical industry.[38]

Mahler then went on to praise the IFPMA's membership for the development of a number of drugs directly related to the health problems of Third World countries: leprosy, schistosomiasis, onchocerciasis, and malaria. The Director-General also emphasized that he was pleased with the "increased interest" of the pharmaceutical industry in WHO programs.

And yet, there remain grounds for U.S. concern. To begin with, a number of observers point out that individual U.N. agencies are engaged in long-term efforts that could control the activities of pharmaceutical firms, especially in Third World countries. Consider the following:

- The U.N. Industrial Development Organization is calling for weakened patent and trademark protection laws, which, if enacted, could significantly affect pharmaceutical companies. Explains Harry Schwartz, formerly with the *New York Times* and a recognized expert on international health: "Brand names and trademarks establish a

[38] Papers Presented at the Eleventh IFPMA Assembly (Washington, D.C.: June 7-8, 1982), p. 68.

manufacturer's responsibility for its products and assure customers of quality. . . . To the foes of transnational companies, however, trademarks are simply a device for giving firms intolerable market power."[39] But weakening patent and trademark protection laws most probably would blunt the incentives that would attract entrepreneurs to investing in developing countries. Patent protection provides drug companies with a guarantee that their innovations will not be routinely passed on to less competitive firms or government marketing agencies—who would, in effect, derive all of the marketing and sales advantages of the originator without having had to undertake the entrepreneurial risks.

- The U.N. Center for Transnational Corporations has been engaged for several years in creating a Code of Conduct for TNCs. This could, of course, apply to the activities of many private companies; but pharmaceutical concerns might be especially affected given their high exposure throughout the Third World. Such a code, if enacted, could discourage firms, including pharmaceutical ones, from investing in developing countries.
- The U.N. Conference on Trade and Development has turned out a number of studies critical of pharmaceutical companies. A November 1980 examination, for instance, discussed the need for a "regulatory framework for transfer of pharmaceutical technology."
- WHO support for a Code of Marketing of Breast-Milk Substitutes (passed by the World Health Assembly in 1981) and its consideration of a Marketing Code for pharmaceuticals has given rise to concern throughout the Western private enterprise sector that the Organization is embarked on an anti-free market campaign, which could seriously undermine its support in the industrial world—especially the United States.

It need not lead to that. And WHO representatives emphasize their determination to ensure the professional integrity of their Organization. But the political momentum—generated by the U.N.'s call for a New International Economic Order—behind efforts to control the operations of pharmaceutical companies is strong enough to justify continued private sector concern.

WHO Health Philosophy

Over the past decade, the World Health Organization has embraced policies and programs that are in line with the U.N.'s call for a New International Economic Order. The World Health Assembly's promulgation of the Health for All strategy in 1977 confirms the Organization's support

[39] Harry Schwartz, "The U.N. System's War on the Drug Industry," *Regulation*, July/August 1982, p. 22.

for the broader U.N. agenda. In fact it would be a mistake to conclude that the WHO's earlier undertakings were merely technical, as from the moment its Constitution was adopted by the International Health Conference in New York in June-July 1946, WHO has been directly involved with matters that touch on socioeconomic conditions. Its preamble is clear on this point:

> The States Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:
>
> - Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,
> - The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,
> - The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States,
> - The achievement of any State in the promotion and protection of health is of value to all,
> - Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger,
> - Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development,
> - The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health,
> - Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people,
> - Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.[40]

Curiously enough, with the important exception of Article 21, the WHO Constitution lacks follow-up statements, delineating more precisely how the Organization is to realize its lofty goals. But Article 21 is a major statement for such matters. It defines the regulatory aspirations of WHO:

> The Health Assembly shall have authority to adopt regulations concerning:
> (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

[40] WHO-Basic Documents (Geneva: World Health Organization, 1983), 33rd Edition, p. 1.

(b) nomenclatures with respect to diseases, causes of death and public health practices;
(c) standards with respect to diagnostic procedures for international use;
(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
(e) advertising and labeling of biological, pharmaceutical and similar products moving in international commerce.[41]

Together, the preamble to the Constitution and regulatory Article 21 established the legal basis for much of the Organization's activity. Only since the 1970s, however, has this broad mandate has been transformed into an action program.

Today the health care philosophy of WHO is one that generally supports the U.N.'s call for more "equal" economic relations between the industrial North and the nonindustrial South. Commenting on the rationale behind the Health for All strategy, for instance, WHO representatives routinely say that its adoption in 1977 was a matter of "simple decency."

Moreover, unlike other United Nations agencies whose claim to justice is subject to understandable skepticism by Western countries, WHO's admirable health care record and former strict adherence to technical matters in practice eschew redistribution rhetoric while advancing more workable self-help measures. As a result, the Organization is in a strong position to make a respectable case for improving world health conditions by calling upon the membership to undertake joint actions—especially by the rich on behalf of the truly poor.

The vehicle for HFA is WHO's primary health care program, which was initiated jointly with UNICEF in 1978 at Alma-Ata, USSR. Significant policy differences separated the various approaches to ensuring health among the conference's participants. As some WHO representatives take pains to point out, a number of statements in the primary health care program reflect Western values, in their emphasis on self-reliance and self-help along with community participation in both local and national health care initiatives. But the Alma-Ata program also mirrors broader U.N. assertions that the prevailing relationship between rich and poor nations is an inequitable one that should somehow be righted. As the program document summarily concludes: "In view of the magnitude of health problems and the inadequate and inequitable distribution of health resources between and within countries, and believing that health is a fundamental human right and worldwide social goal, the Conference called for a new approach to health and health care, to close the gap between the 'haves' and 'have-nots,' achieve more equitable distribution of health

[41] *Ibid.*, p. 7.

resources, and attain a level of health for all the citizens of the world that will permit them to lead a socially and economically productive life."[42]

These emphases continue to define the WHO health philosophy in the early 1980s. And yet it is clear that the Organization wants to do all that it can to avoid political confrontation with Western countries—notably the United States—which could easily undermine the ability of WHO to carry out even its noncontroversial programs. Mahler hinted as much when he delivered these remarks before the Sixth Plenary Meeting of the World Health Assembly on May 5, 1983. Though he spoke in oblique terms (by refusing to mention specifics), his message was clear:

> We have been singularly successful until now in guiding our Organization between the minefields of international political and economic turmoil. I consider it essential that we continue to follow that route—a route for health for all that we have mapped out together . . . If we allow ourselves to be lured astray into fields beyond our constitutional competence, I am afraid we will find ourselves in these very minefields that we have been trying so hard to avoid, in the interest first and foremost of the health of the deprived peoples living in the Third World. None of us, I am sure, would want to blow up our Organization.[43]

For the time being, it is reasonable to conclude that WHO's new spirit of caution and political pragmatism will continue to coexist with the rhetoric of redistribution. And yet an important determinant in WHO's ultimate definition of its philosophy will be its relationship with private pharmaceutical companies.

WHO and the Western Pharmaceutical Industry

WHO personnel (including several former pharmaceutical company officials) are intimately aware of the role played by pharmaceutical companies in the world health picture. Mahler, who in times past has accused them of engaging in "drug colonialism," now increasingly emphasizes that Western pharmaceutical companies' readiness to assist WHO is prerequisite to the success of Health for All. As the London *Economist* explains, "contrary to popular prejudice," Third World countries, "need the drug multinationals more than the multinationals need them."[44] But in spite of a seeming spirit of cooperation, there still remains a certain tension in the relationship between the pharmaceutical firms and WHO and the United Nations in general.

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[42] *Alma-Ata: Primary Health Care* (Geneva: World Health Organization-U.N. Children's Fund, 1983), p. 16.
[43] Sixth Plenary Meeting (Geneva: World Health Organization, May 5, 1983), p. 6.
[44] *Economist*, March 12, 1983, p. 90.

These tensions are caused partly by the tendency of U.N. agencies and their members to criticize private enterprise, while praising the alleged achievements of state socialism. Ironically, some are from Western countries, and they make no secret of their objections to the role played by multinational enterprises in Third World countries. They are, as the eminent development expert P. T. Bauer, of the London School of Economics and Political Science, puts it, victims of a "guilt complex." "Acceptance of emphatic routine allegations that the West is responsible for Third World poverty reflects and reinforces Western feelings of guilt. It has enfeebled Western diplomacy, both toward the ideologically much more aggressive Soviet bloc and also toward the Third World. And the West has come to abase itself before countries with negligible resources and no real power."[45]

Such guilt feelings are particularly easy to mobilize and exploit in the United Nations when the subject at hand is pharmaceuticals. For these products strikingly reflect the double-bind facing Western countries vis-à-vis the Third World: the undoubted superiority of private firms in the research/development and marketing of the most vital drugs held to be necessary for health throughout the Third World; the conviction held by members of both advanced and developing countries that nobody should make a profit from ill health. This conflict is exploited by Soviet bloc members in the U.N. and creates an overly intense atmosphere in U.N. debates about international pharmaceutical matters.

None of this is made easier by the organization of anti-drug company coalitions, which have been able to stoke the fires of Third World anger in U.N. specialized agencies, including WHO. In the words of S. Michael Peretz, Executive Vice President of the International Federation of Pharmaceutical Manufacturers Association (IFPMA): "Much of the recent criticism that has appeared in the media and elsewhere has . . . resulted from a well-orchestrated campaign mounted by various self-described public interest groups such as the International Organization of Consumers Unions (IOCU), Oxfam, Social Audit (in the U.K.), BUKO (in West Germany), WEMOS (in the Netherlands) and the Interfaith Centre of Corporate Responsibilities (ICCR) variously and loosely held together under the banner of Health Action International."[46]

Health Action International (HAI), based in Penang, Malaysia, has indeed taken an adversarial position toward pharmaceutical companies and has mounted a considerable effort to influence appropriate U.N. policies. Among its proposals are:

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[45] P. T. Bauer, *Equality, the Third World, and Economic Delusion* (Cambridge, Massachusetts: Harvard University Press, 1981), p. 66.

[46] "Changing the Public Image of the Pharmaceutical Industry," paper delivered by S. M. Peretz, at the MCF Conference, "Pharma 83," Zurich, Switzerland, June 10, 1983, p. 2.

- An end to the commercial anarchy of prescription drug competition (for instance in India, there are some 15,000 branded drugs on sale—compared with just 225 'essential drugs' identified by the WHO).
- An end to patent protection for essential drugs. The 'essential drugs' identified by WHO 'are too important to be left in a monopoly domain.'
- The progressive replacement of proprietary . . . brands with generic drugs—which usually cost many times less.
- The 'decommercialization of essential drugs'—assuring that people who need drugs get them.
- Regional or national production and bulk-buying arrangements to reduce to an absolute minimum the cost of essential drugs.[47]

HAI, created only in 1981 in the wake of the WHO baby food code, and other such groups have tried to place the activities of drug firms in an unfavorable light. Industry representatives reject the charges of Health Action International, believing them to be wide of the mark—if not outright fallacious. Indeed, pharmaceutical companies—including the heads of the U.S.-based Pharmaceutical Manufacturers Association and the IFPMA—are attempting to broaden their cooperation with countries in the Third World who depend on a reliable supply of safe and effective drugs. The industry is also placing greater emphasis on improving its relationship with WHO. Peretz, for instance, emphasizes industry's need to demonstrate enlightened self-interest by supporting and, where possible, cooperating with the Organization.[48] And such efforts are bearing fruit.

Western pharmaceutical firms have responded to WHO's requests for assistance. In the best known instance, a number of these companies are participating in the Organization's Action Programme for Essential Drugs. Redefined in 1981 (it was originally promulgated in the mid-1970s), the Action Programme endeavors: "to ensure the regular supply to all people of safe and effective drugs of acceptable quality and lowest possible cost, in order to reach the overall objective of health for all by the year 2000 through health systems based on primary health care."[49] Through IFPMA's auspices, a large number of companies agreed to provide about 140 drugs and vaccines, which are included in the WHO's model list of essential drugs, at concessionary prices. Some fifteen of these firms have offered to supply experts to WHO for logistics, distribution, and procurement assistance. In the United States, the Pharmaceutical Manufacturers Association has organized a group of ten American firms (Bristol Myers, Eli Lilly & Company, Johnson & Johnson, Merck Sharp & Dohme, Pfizer Incorpo-

[47] See James R. Phelps, "The NIEO and the Pharmaceutical Industry," in *Food Drug Cosmetic Journal*, April 1982, p. 209.
[48] S. M. Peretz, *op. cit.*, p. 4.
[49] WHO, 1982, p. 5.

rated, Schering-Plough Corporation, Searle Pharmaceuticals, SmithKline Corporation, Sterling Drug, and Syntex Corporation) to finance an effort in Gambia, begun in spring 1982, to improve pharmaceutical management by introducing an effective supply system and adequate storage facilities. The U.S. group has also agreed to supply the Gambians with the necessary essential drugs.[50] Three Swiss pharmaceutical firms have provided similar assistance to Burundi.

Whether such efforts will bring improved relations between pharmaceutical companies and the United Nations, particularly WHO, is being asked with increasing frequency. "The world needs a research-based pharmaceutical industry," explains IFPMA's Peretz. "And," he continues, "that research can only be undertaken by firms whose drug prices cover research costs."[51] In other words, the world needs the contributions that only a market-oriented industry can provide. Industry experts point out that these firms generate a good deal of research that goes into the production of low-priced drugs for Third World countries. They further point out that public pharmaceutical companies in the Soviet bloc—which uses the U.N. to excoriate the commercial activities of the "drug multis"—contribute virtually nothing to the field of original research.

While pharmaceutical firms are demonstrating their readiness to cooperate with WHO and individual governments in creating a more effective and economical drug procurement system, they are also beginning to warn the international community that recourse to political control will inevitably shut off the source of innovation and capital upon which Third World countries depend. In Peretz's words: "The private sector pharmaceutical industry has the technological resources, the plant capacities and the skilled manpower to respond to these needs, but it can neither be forced to do so by some government edict nor will it be willing to do so if it is going to have an adverse effect on its economic viability. And it can be in nobody's interest to drive such companies out of business."[52] "Yet," continues Lewis A. Engman, President of the PMA, "the pharmaceutical industry is constantly under assault." "Once our facilities are in place," he explained before a group of specialists in mid-1983, "developing nations often pursue policies both in their own countries and through such groups as UNCTAD which have the effect of undermining the preconditions for democratic capitalism, and thus ensure that future direct investment in their economies will not be made."[53]

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[50] Brief descriptions of both projects provided by S. M. Peretz in "Pharmaceuticals in the Third World," *Tropical Doctor*, January 1983, p. 3.

[51] Interview, Zurich, Switzerland, September 23, 1983.

[52] S. M. Peretz, "Pharmaceutical and Health Problems of the Least Developed Countries," *Pharmacy International*, February 1981, p. 5.

[53] Lewis A. Engman, President Pharmaceutical Manufacturers Association, remarks to Drug Information Association Annual Meeting, Washington, D.C., July 28, 1983, p. 9.

Third World countries, and the U.N. as a whole, have choices available to them, just as pharmaceutical companies do. One of these will be whether they are capable of organizing their three-sided relationship in a manner that strengthens private enterprise's vital role in the provision and distribution of drugs. The World Health Organization promises to be a major influence in determining the content of that relationship.

Private Enterprise and WHO

Can the World Health Organization achieve its 1977 goal of Health for All by the year 2000 without alienating a vital partner—the pharmaceutical companies—in the process? And on the other hand, what are the incentives to pharmaceutical companies for working with the Organization in pursuit of that goal? An answer to the first question depends on an answer to the second—and vice versa. For it is at least questionable that the Health for All strategy can be successfully pursued without the support of pharmaceutical companies; and at the same time, those companies have a major interest in ensuring that the HFA strategy succeeds, at least in part.

If partnership between pharmaceutical firms and WHO is required for the well-being of both, significant efforts must be made to prevent needless political confrontations between them. Such a confrontation occurred in the spring of 1981. And even now its repercussions are felt.

The Infant Formula Controversy

Although most pharmaceutical firms were not directly affected, the World Health Assembly's decision to promulgate an "International Code of Marketing of Breast-milk Substitutes" threw them into panic. If WHO were able to push through such a code on one product—with the lone dissenting vote cast by the United States—what would prevent it from initiating more far-reaching actions in the future? In retrospect, both WHO and private sector personnel believe that the World Health Assembly's 1981 action has turned out to be an isolated instance: an instance that neither Mahler nor his closest associates in the WHO Secretariat want to see repeated. As one well-placed WHO official expressed it: "The Code on infant formula was rubbish! What do people want us to be—a police force?!"[54] The infant formula code bears the WHO's seal of approval, nonetheless.

Many factors prompted the World Health Organization to take action on infant formula, a manufactured breast-milk substitute that has been on the market for many years. In 1974, the Twenty-Seventh World Health Assembly "noted the general decline in breast-feeding in many parts of the world," as a WHO document puts it. The decline seemed due to so-

[54] Interview, Geneva, Switzerland, September 27, 1983.

ciocultural factors that encouraged (or required) ever increasing numbers of women to abandon breast-feeding. One of those factors was the marketing of manufactured breast milk substitutes in the Third World.

In May 1978, the issue of breast-feeding was again raised at the World Health Assembly. One of the Assembly's recommendations was that member states "should give priority to preventing malnutrition in infants and young children by, *inter alia*, supporting and promoting breast-feeding, taking legislative and social action to facilitate breast-feeding, taking legislative and social action to facilitate breast-feeding by working mothers, and 'regulating inappropriate sales promotion of infant foods that can be used to replace breast milk.'"[55] Over the next few years, momentum developed in favor of getting WHO and the United Nations Children's Fund (UNICEF) to draft an infant formula code, in no small measure because of the heavy lobbying by consumer groups. In January 1981, the WHO Executive Board endorsed and unanimously recommended a joint UNICEF/CODE to regulate the marketing of infant formula. This was followed by the vote in the World Health Assembly on May 21, 1981, to adopt the code by 118 yes, 1 no, and 3 abstentions.

What did the vote mean? In practical terms, the World Health Organization put itself on record in support of a marketing code with teeth, although the document ("International Code of Marketing of Breast-Milk Substitutes") is put forward as a recommendation, not a regulation. The most important articles are 9 and 11, which address the labeling of products and implementation and monitoring of breast-milk substitutes.

Article 9 states that "labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breast-feeding." Furthermore, these labels are to include the following written points: "(a) the words 'Important Notice' or their equivalent; (b) a statement of the superiority of breast-feeding; (c) a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use; (d) instructions for appropriate preparation."

Article 11 states that "Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system." Other vital parts of this Article include provisions for monitoring of the code by national governments "acting individually, and collectively through the World Health Organization"; and a provision calling upon "manufacturers and distributors of products within

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[55] *International Code of Marketing of Breast-milk Substitutes* (Geneva: World Health Organization, 1981), pp. 5-6.

the scope of this Code" to "regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them."[56] (A number of national governments are implementing the Code in both the spirit and letter of these and other Articles.)

Repercussions of the Infant Formula Code

The infant formula vote degenerated into an oversimplified, mud-slinging, domestic debate over the Reagan Administration's position on the Code. As one observer describes it: "The issue had generally been presented by the [American] media as a simple matter of right versus wrong. Churches, charities, concerned scientists, and the vast majority of the world's governments were depicted as anxious to prevent one million infant deaths caused by the unscrupulous promotion methods of infant formula companies, whereas the Reagan Administration was portrayed as preoccupied with defending the 'free enterprise' of multinational corporations against international bureaucratic regulation."[57]

One result of the politicization of the infant formula issue, however, has been the growing interest in the United States in determining whether WHO's prohibition against marketing of breast-milk substitutes is based on rigorously developed scientific evidence. A number of American experts are convinced that the answer is "no." They note, for instance, that while use of infant formula can lead to high infant mortality, it can also be used safely to promote infant health. In 1971, the *British Journal of Nutrition*, for instance, reported on a study of 250 infants from lower-income urban families in Kuala Lumpur, Malaysia. The study showed that bottle-fed infants gained weight as rapidly as breast-fed infants in the early weeks; after 20 weeks, artificially fed infants gained significantly more weight than breast-fed infants. Such findings, to be sure, do not prove conclusively that breast-milk substitutes can be used safely by mothers. But in terms of the United States' relationship with WHO, debating the scientific merits would seem a salutary approach.

Two questions surround the present International Code of Marketing of Breast-milk Substitutes: Will it be implemented by national governments? Will it in either event provide industry critics with a political wedge that can be used to campaign for more inclusive regulations against pharmaceutical companies?

Implementation of the Code was the subject of a March 1983 WHO report on "Infant and Young Child Nutrition." According to the report, it appeared that a number of WHO members are moving to ban the advertising of infant formula, without specifically enacting legislation to prevent its

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[56] *Ibid.*, pp. 20-22.
[57] Carol Adelman, *op. cit.*, p. 107.

sale. As the WHO report states: "In Gabon an interministerial committee has been created to coordinate action to be taken in adapting the International Code to local circumstances. As a preliminary step to the adoption of overall measures, the Government has prohibited the advertising of breast-milk substitutes to the general public." Likewise, in the Ivory Coast, the advertising of breast-milk substitutes has ceased. In other instances, governments allow limited advertisements that promote infant formula, but make it abundantly clear that they oppose its use. In Yugoslavia, for instance, "Breast-milk substitutes are produced in Yugoslavia by a single manufacturer in accordance with the recently adopted Code on the Safety of Marketable Dietetic Foods, and are sold exclusively through pharmacies. There is no direct contact between the manufacturer and mothers for sales purposes, nor are the products advertised through the mass media."[58] With strictures such as these, implementation of the WHO code may not be an important consideration.

Will the infant formula code provide critics with an opening wedge for a larger assault on Western enterprises? WHO personnel play down such a possibility. Moreover, they insist that they did not realize what they were getting into when the matter was originally raised in the early 1970s. But there are those who believe that the infant formula code has created a decisive political beachhead for activist groups to push forward on a broader, anti-free enterprise front. Explains Fred D. Miller, Professor of Philosophy at Bowling Green State University and author of "Out of the Mouths of Babes: The Infant Formula Controversy":

> Indeed, at first sight it is hard to see the global importance of an imbroglio over baby food. But, in fact, the infant formula controversy has far-reaching implications, for it is being used as a driving wedge by the international consumerist movement. This point is made explicitly by Anwar Fazal, president of the International Organization of Consumer Unions, in a recent interview: 'Who would have thought, five years ago, that you could have got the whole infant formula industry to stop advertising their particular product and that consumers could initiate the whole process of *demarketing* that is now going on at different levels?' Fazal exclaimed.[59]

Still, Miller's dire predictions may be premature. Nevertheless, pharmaceutical companies have taken the infant formula controversy as a serious warning that they ignore at their peril.[60] Nestlé, S.A., a multinational corporation with headquarters in Switzerland, was the lead "villain"

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[58] All quotes from WHO, No. 36/7, March 15, 1983.

[59] Fred D. Miller, Editorial Commentary, *Barron's*, September 26, 1983, p. 11. Demarketing is defined by Miller as "the removal of a product like infant formula from the free market, thus placing its production and distribution under strict government control."

[60] The Code was revised in October 1982, but Article 11's provisions remain unchanged.

in the WHO debate over infant formula—and it has been the most immediately affected by the code. In order to hinder potential government action to forestall and monitor the sale and distribution of infant formula in WHO member countries (Article 11 of the code, Sec. 11.1, specifically provides for it), Nestle set up its own independent Infant Formula Audit Commission in Washington. Its primary function is to respond to complaints made by the "Infant Formula Action Coalition," a group established to monitor the activities of infant formula companies, particularly Nestle.

Industry Actions

More generally, Western pharmaceutical companies have initiated preemptive actions to discourage WHO and other U.N. agencies from undertaking more ambitious actions against them. Even before the World Health Assembly vote in support of the infant formula code, the International Federation of Pharmaceutical Manufacturers Association in Spring 1981 proposed a "Code of Pharmaceutical Marketing Practices," which undoubtedly was instigated by the specter of a U.N. code.

The IFPMA Code of of Pharmaceutical Marketing Practices is an effort to allay WHO concerns about the ability and willingness of pharmaceutical firms to adhere to explicit ethical and commercial principles in their export practices. The professional obligations, as spelled out in the Code, are to:

- ensure that all products made available for prescription purposes to the public are backed by the fullest technological service and have full regard for the needs of public health;
- produce pharmaceutical products under adequate procedures and strict quality assurance;
- base the claims for substances and formulations on valid scientific evidence, thus determining the therapeutic indications and conditions of use;
- provide scientific information with objectivity and good taste, with scrupulous regard for truth, and with clear statements with respect to indications, contraindications, tolerance and toxicity;
- to use complete candor in dealings with public health officials, health care professionals and the public.

In addition, the IFPMA's code articulated several key principles, of which the most pertinent seem to be:

(2) Information on pharmaceutical products should be accurate, fair and objective, and presented in such a way as to conform not only to legal requirements but also to ethical standards and to standards of good taste.

(5) Statements on promotional communications should be based upon substantial scientific evidence or other responsible medical opinion. Claims should not be stronger than such evidence warrants. Every effort should be made to avoid ambiguity.

(6) Particular care should be taken that essential information as to pharmaceutical products' safety, contraindications and side effects or toxic hazards is appropriately and consistently communicated subject to the legal, regulatory and medical practices of each nation. The word "safe" must be used without qualification.[61]

These principles reflect the IFPMA's desire to respond to the specific charges made against pharmaceutical and other firms in their marketing of infant formula. Yet consumer groups remain unimpressed with the IFPMA's voluntary code of marketing conduct. In the immediate aftermath of its publication, Health Action International (HAI) charged that the industry proposal omitted three essential ingredients: *specificity* ("almost all of the suggested provisions . . . are very general—and their significance in practice must therefore very largely depend on how they are interpreted and by whom"); *monitoring* ("What assurance is there that what pharmaceutical companies do in practice will comply with the provisions of the IFPMA Code?"); *enforcement* ("what happens when and if there is *prima facie* evidence that the Code has been violated?").[62]

But Director General Mahler has expressed WHO support for this undertaking. He declared before an IFPMA gathering in 1982: "I consider this a very good beginning to raising ethical standards in drug promotion and marketing. Just as maximum self-care is part of primary health care, so maximum self-monitoring should be one of the principles of the pharmaceutical industry."[63]

The infant formula controversy also has contributed to a more sober, constructive, and collaborative dialogue between private industry and WHO. Industry representatives are aware that some of the activities of their companies require correction. As one source close to the industry explained: "In instances, drug firms have counterfeited their pills to make people think they are designed to help treat rare bone diseases. In fact, these pills induce premature sexual changes in children: such behavior amounts to outrageous criminality," he insists.[64] There have been instances where firms carelessly marketed potent medicines. In other cases, companies have charged higher prices for their medicines than their cost of production and marketing would seem to justify. But such practices are rare and hardly justify the harsh indictment that has been leveled at the pharmaceutical industry.

Moreover, pharmaceutical companies are beginning to discuss candidly the areas where they are vulnerable in the eyes of their critics. A back-

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[61] IFPMA Code of Pharmaceutical Marketing Practices (Zurich: IFPMA, 1981), 4th printing, pp. 5-6.
[62] HAI Discussion Document (no date), pp. 3-5.
[63] Papers Presented at the Eleventh IFPMA Assembly (Washington, D.C.: June 7-8, 1982), p. 68.
[64] Interview, Geneva, Switzerland, September 26, 1983.

ground memorandum of the Pharmaceutical Manufacturers Association states: "While our efforts with the WHO are essential in our struggle with the critics, there is another area where independent action is needed and has been taking place . . . pharmaceutical product information."

In late 1983, the IFPMA took action on this matter by introducing a proposal to improve and strengthen the WHO Certification Scheme for drugs. The WHO Scheme is designed to alert countries (especially developing ones with only limited capacity to undertake drug import regulation) as to the chemical content of the drugs they are importing. The IFPMA's new proposal calls for incorporation of additional information along with the import certification on a pharmaceutical item: including dosage, contraindications (when or when not to take a dosage when other medication is being taken), precautions, and storage instructions. Industry sources maintain that the IFPMA proposal would go a long way toward solving the problems faced by Third World countries in their effort to determine the quality of the drugs they purchase from Western firms. The IFPMA proposal, like the industry's 1981 Marketing Code, is an effort to encourage voluntary compliance between pharmaceutical companies and WHO. In the words of IFPMA's Peretz, "our proposal is that the additional workload," in supplying pertinent information on drug quality, "should be borne by the industry itself as part of its responsibilities as a source of information on the products they market."[65]

The Global Perspective

On the other side, some of the pharmaceutical industry's most articulate critics are reevaluating their previous positions. Consider the case of Sanjaya Lall, Senior Research Officer at Oxford University, and an expert on the pharmaceutical industry of his home country, India. His change of heart might be symptomatic. When Lall began writing on the pharmaceutical industry in 1973, under the United Nations Conference on Trade and Development's (UNCTAD) auspices, he authored a number of studies criticizing the role of multinational corporations in the Third World. Reflecting back on his earlier thinking, he said in 1982: "The innovativeness and effectiveness" of pharmaceutical company activities was "of course, never in doubt. What was in doubt was the cost."

Along with many other students of Third World Development, Lall had insisted that the have-nots needed direct and immediate access to good, low-priced drugs. In the years since his earlier studies, however, Lall has taken a close look at the Indian pharmaceutical industry. This forced him to recant and to characterize the Indian industry "as the most severely regulated of all manufacturing industries." He excoriated the Indian government for choking off the vital sources of pharmaceutical innovation that

[65] Interview, S. M. Peretz, IFPMA headquarters, Zurich, Switzerland, September 23, 1983.

lead to the production of medically sound and inexpensive drugs. Lall, like a number of people in WHO, and even in the pharmaceutical industry, continues to believe that a certain amount of regulation is absolutely necessary today. "But," he adds, "such regulation" should not "incapacitate the competitive market system which is the basis of innovation and growth."[66]

This more constructive dialogue also opens the door for WHO and the Western pharmaceutical industry to work together. WHO's "essential drug program," for instance, is supported by most Western pharmaceutical companies, as evidenced by the IFPMA's offer to supply some 200 of those drugs to populations in the Third World under "favorable conditions." And industry—provided with the appropriate market incentives—could do a lot more to help advance the Organization's Health for All by the Year 2000 strategy.

And yet, as a lesson of the infant formula controversy, it remains the case that Western pharmaceutical companies confront severe obstacles in the effort to promote expanded cooperation with WHO and other U.N. agencies. "The heart of the matter," explains Jay Kingham, Vice President of the Pharmaceutical Manufacturers Association's International Division, "is that drug companies will not invest in countries which make it impossible for them to earn a profit."[67]

In fact a large number of Third World governments seem intent on erecting barriers that discourage entrepreneurial activities. "Why should a pharmaceutical company go into a developing country which fails to provide it with patent protection?" Kingham asks. According to the PMA, the absence of patent protection makes it easy for so-called "pirate" firms (from the Soviet bloc, for instance) to market products that have been discovered by Western firms. And they do.

The heart of the problem, according to industry sources, is that WHO's desire to improve health conditions in Third World countries, by encouraging the distribution of low-priced, essential drugs appears to miss the central point: that the major challenge facing have-not nations is not how to obtain access to Western medical resources and know-how, but how to establish viable health infrastructures, which can in turn deliver low-cost medical services. "It's fine for some Third World countries to complain about the high prices pharmaceutical firms charge for drugs," explains PMA's Kingham, "but whose fault is it when those same firms come forward with low-priced shipments of drugs, only to find out later that they've rotted at the dock?"[68] In a keynote address at the 1979 Conference

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[66] IFPMA Assembly (Washington, D.C.: June 7-8, 1982), pp. 51, 55 and 57.
[67] Conversation, October 6, 1983.
[68] *Ibid.*

on Pharmaceuticals for Developing Countries, Senator Edward M. Kennedy (D-MA) alluded to such concerns by making a broader point:

> It is a question of building a primary care infrastructure in each country. And that infrastructure must be built by the individual country, adjusted to its particular needs. It cannot be imposed from outside. This means training local people to solve local problems. It means building a new structure of health care in the only way it can be built—from the ground up by the people who live there.[69]

Similar views are being expressed by health experts from developing countries. Dr. Paulo de Almeida, former Minister of Health in Brazil, for example, maintains that many Third World governments preside over inadequate health systems, administered by people who are frequently illiterate. Of particular concern to WHO personnel and people like Almeida is the lack of basic data on deaths and sickness.[70]

Prospects for the Future

Clearly, the Third World will command increased amounts of WHO attention if Mahler's Health for All strategy is pursued. And WHO personnel know better than anyone that the collaboration of Western drug companies with the Organization and its developing world members must be enlisted. To facilitate such collaboration, however, requires more than abstract expressions of temporary goodwill on the part of Western firms and WHO. What is needed is (1) a reduction in the highly charged, anti-free enterprise rhetoric, which all too often is a substitute for careful thought on the part of critics of pharmaceutical companies; and, (2) the strengthening of positive incentives to encourage larger investments of time and energy by drug companies in Third World countries. Dr. Mark T. Hoekenga, of Merrell/Dow pharmaceutical company and an authority on tropical medicine, addressed this issue before the American Society of Tropical Medicine and Hygiene in late 1982. Among the incentives he listed were:

- the need for uniform public policy that recognizes the need for drug discovery and a central role for industry in that process;
- modification of antitrust laws that impede collaboration between United States [companies] . . . [who] should be encouraged to work together on humanitarian projects;
- strengthening of the patent system as an inducement to embark on long and costly research and development programs;

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[69] Mark T. Hoekenga, "The Role of Pharmaceuticals in the Total Health Care of Developing Countries," *American Journal of Tropical Medicine* (1983), p. 439.
[70] *Ibid.*, p, 445.

- more dialogue between pharmaceutical firms and United Nations agencies. . . .[71]

Such proposals, of course, are not substitutes for action—by either pharmaceutical firms or WHO. Nor can proposals of this nature be undertaken in the kind of climate that generated the controversy of May 1981 over infant formula. A case for and a case against infant formula can be made.[72] What is now required is more collaboration and less polemic between WHO and Western firms. There are strong indications that WHO is seriously committed to that proposition. In the aftermath of Mahler's conciliatory address before the IFPMA in Washington, D.C., three high-ranking WHO officials visited a number of pharmaceutical companies in the United States. In Hoekenga's view, "The results of such dialogue," launched by that visit, "have been nothing short of spectacular."[73]

Such expressions of enthusiasm may be premature. Though WHO personnel emphasize that pursuit of Health for All strategies can result in new marketing opportunities for Western pharmaceutical companies, Mahler's own view toward these firms remains unclear. He wants to improve WHO relations with drug companies; but he stands by the larger U.N. system, which remains deeply skeptical about the commercial motivations and practices of pharmaceutical companies. As a result, WHO can be expected to work toward cautious accommodation with drug firms, pushing them to support its programs, but endeavoring to avoid future confrontations with them. A proposed marketing code has been vigorously pushed by consumer groups, but as is frequently heard at Geneva headquarters these days, "you can forget about that idea—we aren't about to support any other codes."

Over the long term, of course, attractive opportunities may exist for private pharmaceutical firms to go into Third World countries—under WHO auspices—to help them develop their medical infrastructures. The idea is not far-fetched: expanded sales in developing countries need not be made at the expense of WHO programs any more than the pursuit of profit and good health are contradictions in terms.

1. It is not only the IFPMA that talks about the lamentable condition of medical infrastructures in the Third World as a prime source of their health difficulties. At the May 1983 World Health Assembly meeting in Geneva, Kenya's Minister of Health, Dr. Mukasa Mango confirmed this: "One of the major constraints in the health care delivery system is the procurement and distribution of drugs to our rural health facilities. The problem has

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[71] *Ibid.*

[72] WHO's Code of Marketing Breast-milk Substitutes provides the rationale for the World Health Assembly's action; most "counter-arguments" are not about the inherent virtues of infant formula but are "agnostic" appeals for us to reexamine the scientific basis behind the WHO decision. See, for example, Carol Adelman, *op. cit.*, pp. 107-126.

[73] Hoekenga, *op. cit.*, p. 445.

existed for a long time, and is caused by shortage of financial resources and the cumbersome procurement policy which often led to unavailability of drugs in rural health centers."[74]

The PMA's Lewis Engman expands upon this particular difficulty and supplies a partial solution to it:

> One of the most serious health care problems developing countries face is the logistics of drug delivery. In many countries there is one central warehouse for medical supplies. Scarcely any records are kept of what comes in, or what goes out. No one can tell you how long any particular product has been on the shelf. No one can tell you without making a count what the national supply of any given drug might be. And no one—even having made the count—can tell you whether the number of containers found represents a one month's supply, or a one year's supply. In such countries it is not uncommon for the government to hold huge stocks of some products while it is completely out of, and awaiting shipment, of others.
>
> The distribution system that radiates outward from this warehouse runs downhill all the way. At the local dispensary level, the would-be consumer of medicines is lucky if his trek in search of help nets him more than a one day supply of an antibiotic that is useless taken by itself. He is equally likely to find, like Old Mother Hubbard, that the cupboard is bare.
>
> *We can do nothing about problems of this sort.* Last year, at the request of—and in partnership with—the Gambian government, a number of our companies funded a demonstration project. With the help of a group called Africare, a team of experts were sent to Banjul to work with the Gambian health authorities to try to improve their central purchasing system and to try to ensure that the medicines the government purchased actually got delivered to the people who needed them, rather than sitting on the shelves of the central warehouse long past their expiration dates. Today, the Gambian government has been left with improvements to its health care system that are self-sustaining. And it has been able to increase the quality of medical care without any increase in its drug budget [emphasis added].[75]

2. WHO has encouraged pharmaceutical companies to sponsor countries in such joint projects as:

- Some Italian firms have established special arrangements with Somalia and are providing this African nation with low-priced drugs and technical assistance.
- Several Swiss companies are engaged in a pilot project to provide technical assistance in Burundi.

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[74] *Thirty-Sixth World Health Assembly* (Geneva, Switzerland: May 4, 1983), p. 25.
[75] Remarks to the Drug Information Association, Annual Meeting (Washington, D.C.: July 28, 1983), p. 7.

Neither example should lead to the conclusion that pharmaceutical firms are able, or willing, to shoulder the responsibility of WHO and other international agencies to provide technical expertise in the establishment of indigenous health care systems. But from the sidelines, these companies could play a valuable supporting role in helping Third World countries grapple with this important challenge.

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U.S. Interest in WHO

Is the United Nations, to quote former U.S. Ambassador Daniel P. Moynihan, "a dangerous place" for the United States? It seems to be, although there are some encouraging signs. The U.N. General Secretary, for instance, now worries about the amount of time routinely wasted in General Assembly debates, believing—for all too obvious reasons—that useless resolutions against the U.S. and other scapegoats erode the legitimacy of a vital institution. But denunciation of U.S. actions, both real and more often imagined, continues to permeate the political culture of the United Nations.

Even worse is the influence of the General Assembly and the Secretariat on the operation of the allegedly independent U.N. agencies. This has certainly been the situation at the World Health Organization, albeit WHO has enjoyed a comeback of sorts in the United States of late. In the words of William C. Bartley, Health Attache for the United States in Geneva, this comeback is the result of one fact: "You get better performance from WHO because it is less politicized than other agencies, and is more interested in solving technical issues."[76] And according to the man reputed to be WHO's *eminence grise*, Joshua Cohen: "We are a 'techno-corporation'."[77] Similar views of WHO today are held by private industry people. PMA's Kingham, for example, believes that the World Health Organization is "now on track, and is successfully moving away from supporting divisive issues in order to get on with the professional mandate that it has to contribute to the improvement of global health conditions."[78]

While America's contribution to the WHO budget is the highest, U.S. nationals are, if anything, overrepresented. Moreover, cooperation between the American health sector and WHO remains broad-based and beneficial to the U.S. In fact, even WHO's toughest critics acknowledge that the United States derives considerable benefit from the Organization. Warren Furth, U.S. national and Assistant Director-General, points out, for instance, that one third of WHO's total annual purchases of medical supplies

[76] Interview, U.S. Mission, Geneva, Switzerland, September 27, 1983.
[77] Interview, WHO Headquarters, Geneva, Switzerland, September 27, 1983.
[78] Conversation, October 6, 1983.

are bought in the United States. And he believes that relations between the Organization and U.S. pharmaceutical companies are on sound footing.[79] Upjohn Company, for instance, routinely tests compounds for WHO. If the compound ends up being something that the Organization can use in the field, Upjohn gives up its right to market the compound and turns it over to WHO.

In general, WHO benefits to the United States include: epidemiological surveillance of diseases; promulgation of international health regulations—that provide rapid notification to WHO and epidemiological reporting by members on diseases subject to the regulations, including cholera, plague, yellow fever, and until its eradication, smallpox; international classification for procedures in medicine and impairments and disabilities; and dissemination of statistical information on health.

Special importance is placed on the Program for Research and Training in Tropical Disease (TDR). Established in 1976, it is supported through the WHO Voluntary Fund for Health Promotion (one component of the Organization's extrabudgetary resources). Cosponsored by the United Nations Development Program and the World Bank, the program supports research and development of new and improved tools for control of six tropical diseases: malaria, schistosomiasis, filariasis, trypanosomiasis, leishmaniasis, and leprosy (still endemic in Hawaii). Among the specific benefits of this program for the U.S. are:

- Work sponsored by the program which focuses attention on genetic engineering approaches to the search for a malaria vaccine, which in turn could be valuable to U.S. manufacturers of vaccine.
- Facilitation of cooperative drug research between U.S. companies and medical institutions with their counterparts in other developed and developing countries.
- The generation of grants to U.S. institutions. Between 1976-1980, the program expended direct grants of $10,800,000 to those institutions, while the U.S. contributed but $4,400,000 to its activities. At present, the Program has negotiated twenty-two research/development contracts with fifteen pharmaceutical companies.

The United States enjoys broader, philosophical gains as well from its membership in WHO. While the Organization's increasingly conciliatory stance toward private enterprise does not mean all the political obstacles have disappeared, the U.S. nevertheless has a valuable opportunity to put its own approaches to socioeconomic development to work within WHO. And despite some justified concerns on the part of the United States about the underlying assumptions of the Health for All strategy, the Reagan Administration seems committed to supporting it. In speaking before the

[79] Interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.

Spring 1983 World Health Assembly, Margaret Heckler, Secretary of the Health and Human Services (HHS) Department, characterized America's belief in the value of a "partnership between government and the private sector in compassion and caring," and underlined the U.S. stake in the WHO. She reports, for instance, that more than fifty institutes and laboratories in the U.S. now serve as WHO collaboration centers—of which the Center for Disease Control in Atlanta, Georgia, plays an especially important role (for instance, by lending numerous professionals to WHO).

There remain important issues that need to be addressed by the United States as it attempts to build a closer, more pragmatic relationship with the World Health Organization. The politicization of the U.N. agenda is not as far advanced at WHO as it is in other agencies. But it exists.

At the May 1983 meeting of the World Health Assembly, for instance, the air was thick with political declarations that had little to do with the major health challenges facing the 161 members. One delegate called for WHO to provide "Assistance to Namibia and national liberation movements in South Africa [that] are recognized by the Organization of African Unity."[80] The delegates were asked to support this struggle because it had been backed in "many resolutions of the United Nations, the Organization of African Unity, the movement of nonaligned countries and other international institutions and organizations that call for the immediate and unconditional withdrawal of South Africa's illegal government from Namibia."[81] The intended recipients of such aid, of course, would have been the terrorist South West Africa People's Organization and the African National Congress.

Similarly, the delegates were asked to back a Soviet bloc initiative to recognize "the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all."[82]

Not surprisingly, it was commonplace to hear some delegates making political points at the expense of others during the course of the 1983 World Health Assembly meeting. But high-ranking WHO personnel insist that this level of politicization is relatively harmless. "A number of us grit our teeth and bear it during the first couple of days of WHO meetings when the delegates feel the need to push forward their views on politics," is the way one Secretariat member puts it. "Besides," he adds, "there's no earthly way that you can ever seal off such rhetoric—even at WHO." And they insist that the professional integrity of the Organization has not been impaired by this annual ritual. "I challenge anyone to show me how our

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[80] Second Plenary Meeting (Geneva, Switzerland: World Health Organization, May 3, 1983), p. 19.
[81] *Thirty-Sixth World Health Assembly*, May 2-16, 1983, *op. cit.*, p. 21.
[82] *Ibid.*, p. 25.

operations or the overall quality of our programs have been negatively affected by such statements," says Assistant Director General Warren Furth.[83] Yet rhetoric, particularly of an anti-U.S., anti-Western kind, has become a part of the U.N. total reality over the past few years. Such rhetoric may not negatively affect WHO operation today. But an accumulation of ideologically loaded slogans could have a detrimental influence, even on the actions of the World Health Organization.

A related, more precise issue engendering U.S. concern about WHO is the role played by the Soviet Union. The USSR is able to routinely influence the political course of U.N. General Assembly deliberations in ways that are held to be detrimental to Western interests. WHO representatives nevertheless insist that the Soviets play a rather modest role in the Organization. Observes a member of the Secretariat: "The Soviets act pretty responsibly in the Organization. For instance, we have a number of supervisory panels that are designed to screen candidates put forward by their countries for work here. The Soviets usually play it straight, tending to judge prospective applicants on the basis of their professional qualifications."[84] This is hardly intended to suggest that the Soviets do not attempt to work against U.S. interests in the WHO. Indeed they do.

One favorite Soviet strategy is to maneuver the United States into embarrassing positions, which play to the demands of advocates who want to impose regulations on multinational enterprise through the WHO. In the aftermath of the May 1981 World Health Assembly vote approving the infant formula code, for instance, Kenneth L. Adelman described how the Soviet Union attempted to capitalize on it (Henry Kissinger refers to such behavior on the Soviets' part as analogous to scuffling on the floor for loose change):

> Last November [1981], for example, the Moscow Medical Workers' Union paid round-trip airfare to Moscow as well as hotel bills for representatives of 200 trade unions and organizations from fifty-seven countries. They met to organize labor against multinational drug companies, and specifically to push WHO into adopting a code of conduct to regulate the companies' marketing practices. Needless to say, the conferees blasted the West in general and praised the Soviet Union.[85]

As U.S. Health Attaché William Bartley explains: "We keep a pretty close tab on the political activities of the Soviet bloc. And on most occasions we are able to head them off. But they keep at it—and in the process the Organization is prevented from focusing its attention on the really significant technical medical issues."[86]

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[83] Interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.
[84] Interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.
[85] Kenneth L. Adelman, *op. cit.*, p. 18.
[86] Interview, U.S. Mission, Geneva, Switzerland, September 22, 1983.

5

The Future of WHO

For the Third World—that loose collection of more than 120 developing nations—the 1970s and early 1980s produced some unanticipated and cruel developments. For example, Althea Duersten and Arpad von Lazar, of the World Bank and the Fletcher School of Diplomacy, respectively, point out that the Organization of Petroleum Exporting Countries price increases of 1979 cost the Oil Importing Less Developed Countries $35 billion.[87] Furthermore, the financial stability in these developing countries has deteriorated to the point that, by the end of 1983, the Third World owed Western financial institutions an astounding $810 billion, and most of these nations lack the wherewithal to pay it back. In the United Nations, the Third World demand for a New International Economic Order has been met with a stony silence, not only by most Western countries, but also by the Soviet bloc, which had supported those demands rhetorically as long as they were spared from helping pay the bill.

Current Status of World Health

Reality in the vital area of health has also been cruel to most—though not all—developing countries. As the WHO reported in 1982:

> Nearly one thousand million people are trapped in the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity and limits their ability to plan for the future. The depth of their deprivation can be expressed by a few statistics. Whereas the average life expectance at birth is about 72 years in the developed countries, it is about 57 in the developing countries; in Africa it is only about 50 and in southern Asia about 54. Whereas only between 10 and 20 out of every 1000 infants born in the developed countries die during their first year, the infant mortality rate in most developing countries ranges from nearly 100 to more than 200. Whereas the death rate for children between one and five is only about one per 1000 in most developed countries, it averages about 20 in many developing countries and more than 30 in Africa south of the Sahara.

[87] Althea Duersten and Arpad von Lazar, in Yergin/Hillenbrand, eds., *Global Insecurity* (Boston: Houghton Mifflin, 1983), p. 271.

> Maternal mortality rates in many areas of developing countries, though not well documented, are known to be from 100 to 200 times greater than in developed countries.[88]

So where does this leave the WHO Health for All By the Year 2000 strategy? Closer to the painful beginning than its Director General wants it to be. For in fact, the World Health Organization's effort to improve medical conditions is being compromised by a number of seemingly intractable problems. To begin, there is the extraordinary imbalance between health care and defense expenditures in many Third World countries. Explains Dr. Mark T. Hoekenga:

> As a matter of fact, governments of most developing countries spend far less on health than on defense. In a recent year, for example, Bangladesh spent 2.5 percent of its budget on health and 7 percent on defense; Ethiopia, 4 percent on health, 17 percent on defense; India, 3 percent on health, 12 percent on defense; Brazil, 1 percent on health, 14 percent on defense. It is also of interest that many countries spend as much or more on alcohol and tobacco as on pharmaceuticals. India, for instance, spends 70 percent more on tobacco than on pharmaceuticals.[89]

Moreover, it appears that a goodly number of Third World countries have eschewed the modest goals of the HFA strategy—to build up primary health infrastructures, in order to provide low-cost medical services to local populations—in favor of more grandiose schemes which, in Mahler's view, needlessly drain away already scarce resources from strained domestic budgets. In practice this means country "X" building an expensive hospital when it would be better advised to implement a system of low-cost clinics. In fact, WHO personnel in Geneva cite as a basic frustration the frequent inability (or unwillingness) of national health ministers to translate commitments they have made at Assembly gatherings into concrete policies at home. "Part of the difficulty," acknowledges one source, "is that in the domestic political hierarchy, health ministers rank next to the bottom—if not at the bottom—of the ladder."[90] In the heady atmosphere of Geneva, it is easy to pay lip service to Health for All's basic goals. Caught in the dynamics of domestic political struggles, however, member states frequently experience difficulty following through.

The World Health Organization itself has come in for some criticism. Relates one employee of the Secretariat: "All too often, you find yourself wondering how WHO is going to move from slogan to action." In the cast of management, the surface impression is that Geneva headquarters and its six regional offices are managed well. High-ranking WHO personnel speak

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[88] *Seventh General Programme of Work* (Geneva: WHO, 1982), p. 17.
[89] Hoekenga, *op. cit.*, p. 438.
[90] Off-the-record interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.

glowingly of the new "managerial framework," which is designed to provide an ongoing intensive evaluation of all the health care programs carried out by the Organization. There is even a booklet on *Managerial Process*, designed to assist members in the implementation of medical programs—including a "Master Plan of Action," specifying the national health policies to be followed; the objectives to be attained; and the use of financial resources during various phases of the program implementation process.[91] In reality, WHO's administrators in Geneva and in the six regional offices have been criticized for pushing forward a whole series of uncoordinated programs with little regard for how they relate to the whole.

At bottom are two reasons why WHO's pragmatic approach may be undermined: potential disillusion over the prospects for realizing HFA through the primary health care route; inadequate funding.

The primary health care approach—articulated at the 1978 Alma Ata Conference—appeals to a general sense of basic priorities, especially in the Third World where the most rudimentary health care systems are frequently inadequate, if not completely lacking. WHO's primary health care emphasis on training local people to administer basic low-cost care is attractive in eschewing the unnecessary, high-tech "frills" that rapidly diminish the modest health care budgets of many Third World countries. As WHO's top policy advisor Joshua Cohen explains the relationship between primary health care and the provision of low-cost drugs: "Most of the basic health needs of people can be addressed by a number of drugs. In Kenya, for instance, $1.00 a year just about does it."[92] And yet there are skeptics. Reports one of them:

> Recent evidence indicates that primary health care, which became popular in the 1970s, may not be the panacea that it was initially hoped to be. A 1982 report by the American Public Health Association . . . evaluating 52 primary care projects sponsored by the Agency for International Development . . . found some successes but many failures. For example, the report said that village health management committees had apparently 'disappeared' by 1980 in the Sine Saloum project launched in 1977 in Senegal. Similarly, APHA reported that six months after selection of health workers for a project in Afghanistan, no active committees can be found.[93]

Disillusionment over the wisdom of the primary health care approach is deepened by the fact that most WHO officials are highly trained specialists; most Third World doctors at WHO were trained in Western hospitals. Hence, primary health care is both distant from their own experience and is viewed by some as going against their years of specialized training.

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[91] *Managerial Process for National Health Development* (Geneva: World Health Organization, 1981).
[92] Interview, WHO headquarters, Geneva, Switzerland, September 27, 1983.
[93] Kathleen Mirin, *op. cit.*, p. 7.

Moreover, WHO's budgetary resources are strained, at least in terms of the ambitious goals that it has set for itself. WHO's regular two-year budget, to which each member contributes a fixed amount, is set at $520 million for 1984-1985. And it is expected that extrabudgetary sources (voluntary giving and participation by government and nongovernment organizations) will reach about $460 million. This means that the Organization could have less than $500 million available on an annual basis to fund fifteen separate programs.

Can HFA be achieved in view of existing budgetary stringencies? Mahler believes it can. But there are indications that some of the important aspects of the strategy may not be realized within the strict time frame established by the World Health Assembly. The Expanded Program of Immunization was initiated in 1977 to assist developing countries in establishing immunization delivery systems that can be administered by local health care workers who have been trained by WHO technical personnel. The goal is to immunize all the world's children against six major tropical diseases by 1990. As of late 1983, however, it was operating behind schedule.

Domestic outlays for health are either not growing or actually being cut back. The WHO budget represents a slight real decrease of 0.31 percent as compared with the 1982-1983 figure. At some time in the future, Mahler may be forced to reevaluate some of his HFA program goals. If he fails to do this, the membership might initiate political shortcuts, resorting to Article 21's regulatory provisions to achieve many of the goals that the Health for All strategy is attempting to achieve through nonregulatory means.

Finally, WHO's more pragmatic posture could be undermined by its own membership, a number of whom come from the Third World. As one high-ranking member confessed: "In many instances, the political leaders of those countries are simply cheap: they don't want to spend the money on health when they are unable to gauge the short term effect."[94] Indeed, a number of developing nations have cut their health expenditures: Egypt was spending 5 percent of its budget on health in 1975-1976, but by 1980-1981, health spending had dropped to 3.6 percent. Nepal put 6.6 percent of its budget into health care in 1975-1976, and only 4.3 percent in 1979-1980. Mahler's criticism of a number of unnamed countries who allegedly engage in uneconomic health projects may make him vulnerable to the charge of "big brotherism." Nevertheless, WHO's concern about the waste of health monies in member countries (developed and developing) cannot be lightly dismissed.

Third World countries might be encouraged to cooperate more effectively by pooling scarce medical expertise. Kenya's Health Minister, Dr. Mukasa Mango, makes this point: "While we continue to receive financial

[94] Off-the-record interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.

assistance from developed countries—for which we are grateful—we are convinced that we would make more impact in our endeavors if developing countries had more cooperation among themselves. We have to combine forces in order to reach greater heights of socioeconomic standards and better health for all our people."[95]

In sum, the Organization's members, especially the have-not countries, must be prepared for the long haul. Short cuts—designed to bring about rapid changes at little cost—are guaranteed to fail, as have many elements of the broader NIEO program. Currently, however, WHO is demonstrating the political shrewdness and basic common sense (including a sense of what is realistically feasible) that could make the HFA strategy successful. This strategy reflects many values congenial to the West: the emphasis on national (versus international) solutions to domestic health problems, the mobilization of indigenous human and technical resources, and the strong belief that each country must ultimately adopt its own unique approach to health policy. "Our goal," explains Joshua Cohen, "is to assist people in building their own health systems: how they do it is up to them."[96]

Western Support

The World Health Organization continues to depend on the industrial West for financial support. The thirteen Western free market nations that belong to the Organization (including Canada, the United States, Japan, and the European Community) contribute nearly 70 percent of WHO's income. For humanitarian as well as for wholly pragmatic reasons, the West should keep up its budgetary support. The West's readiness to engage in international health projects designed to help poverty in the Third World (especially through the auspices of WHO) is but one aspect of what the IFPMA's S. M. Peretz calls "enlightened self-interest." This includes, of course, the commercial benefit that the United States and other Western countries derive from sales to Third World countries with the wherewithal to pay for them.

The West also has a political responsibility to WHO: to quietly and persistently insist that the Organization adhere to its technical mandate. This will not be easy for an agency that exists within a larger U.N. system that has rarely distinguished itself for adherence to its various professional mandates. But institutional vulnerabilities notwithstanding—the degree to which other United Nations agencies might be able to influence the Organization's policies—it possesses some impressive strengths: a technical-professional cadre, which seems increasingly committed to a pragmatic partnership with private enterprise and to programs that all countries, including the United States, can easily support. The West, and specifically

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[95] Thirty-Sixth World Health Assembly, Geneva, May 4, 1983, p. 25.
[96] Interview, WHO headquarters, Geneva, Switzerland, September 26, 1983.

the United States, should help WHO create mechanisms whereby corporations can make their views known to the organization and work with it when possible.

In comparison with the political situation in the spring of 1981, in the aftermath of the World Health Assembly's vote on the infant formula code, the relationship between Washington and Geneva has improved considerably. This derives in no small measure from the renewed commitment of both sides to WHO's technical agenda, which has in the past contributed to the improvement of health the world over. The advantage of the more traditional programs of disease prevention and control is that they were conceived and implemented before the new emphasis caught on—they are working whereas Health for All needs to get off the ground.

Another program that enjoys a sound reputation is the Pharmaceuticals Office, which provides information to member countries and other U.N. bodies on drugs. According to some sources, this office should be doing more than it is, but cannot, because of the shift in priorities associated with the primary health care program.

Other WHO programs are accorded low marks. The Human Reproduction Program—to promote family training in birth control through the use of contraceptives and the spacing of children—for instance, is regarded as an initiative that has gone nowhere.

More generally, it is argued that if the Health for All strategy were to bog down, WHO should reexamine carefully the long-term effectiveness of specific programs.

The opportunity exists now for WHO to consider how to combine its pluses and minuses in order to progress. Western drug companies have proved their desire and ability to cooperate with WHO programs. Secretary-General Mahler has opened the door, and WHO technical skills are available. It is up to WHO to reconcile the efforts of the three sides (the Third World, WHO, the West), as Dr. Mark Hoekenga has suggested, and through expanded dialogue, work out a program in which the Third World recognizes the needs of, and shares responsibility with, the West, whether the focus is Health for All or a reemphasis on the older mandates. For therein lies the mechanism for helping the Third World to help itself—to good health.

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U.N. Studies

The World Health Organization

The United States has been leading the multilateral global effort to create a healthier planet since the end of World War II. As such, it has been the most generous and strongest backer of the World Health Organization. Since WHO's inception in 1948, the U.S. has contributed nearly $800 million to the Organization. In 1984 alone, the U.S. gave over $61 million.

In recent years, however, WHO's activities and purposes have begun to worry the U.S. American health experts have feared that WHO, like many other United Nations agencies, was about to focus mainly on political issues at the expense of those for which the Organization was founded. A vote in 1981 to recommend an international code regulating the promotion and use of infant formula, for instance, signalled a major break with WHO's non-political and non-ideological tradition. American observers have begun to wonder whether this was but a first step toward more restrictive codes regulating the activities of multinational enterprises. Has the WHO, it is being asked, been captured by advocates of the radical New International Economic Order?

In this volume, political scientist John Starrels addresses this question. He searched through WHO documents, assessed WHO programs, and went to WHO headquarters in Geneva to talk to WHO officials and staffers. His finding are generally reassuring. WHO technical personnel seem to have learned the hard lesson of the infant formula episode and the criticisms that it triggered. They now are on record supporting policies reaffirming WHO's original mandate. WHO staff are said now to see ideological campaigns as counterproductive. WHO is determined to concentrate, say its staffers, on world health problems, not on furthering a questionable political agenda advocated by radical Third World nations.

Because of this, concludes Starrels, the U.S. and the West should continue supporting WHO — for humanitarian reasons, to insure that the Organization adheres to its technical mandate, and to demonstrate that U.N. agencies, unlike UNESCO, which resist becoming politicized can count on U.S. backing. The WHO has contributed impressively toward improving health the world over. The U.S. must work to see that WHO continues at what it does best.

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