

## NON STATE ACTORS IN THE GLOBAL HEALTH WORLD

### Introduction

A global health world based on non-state actors has been evolving for as long as the state system and this is a process continuing towards an ever-more advanced form of global governance since it is a policy area that starkly exposes the limitations of sovereignty. The inappropriateness of the traditional high politics – low politics distinction in international relations, that prioritizes state military and economic interests over other human needs, is most clearly apparent when considering health issues. Recognition of this can be dated back to the 1940s when David Mitrany, building on the writings of Leonard Woolf during the First World War, developed the theory of Functionalism, prescribing and predicting a future post-Westphalian world order in which peoples needs would be met by functional International Non Governmental Organizations rather than by states (Mitrany 1975, Woolf 1916).

Mitrany considered the growth of functional international organizations, performing tasks like standardizing international postal rates or facilitating cross-border telegram transmissions since the late nineteenth century, to have been a boon to ordinary peoples lives and something around which to build a new, better post war world. The international system of states was alien to the needs of people since it artificially divided humanity into competitive units which overemphasized high politics at the expense of health and welfare. Hence the Functionalists advocated the growth of international organizations run not by government delegates but by internationalists specializing in the particular function concerned. The belief was not that this would happen overnight but that, gradually and inexorably, people would come to see that their interests were better served by such organizations and switch their loyalties away from their own governments. Thus a world revolution would occur quietly and slowly by a process referred to as ‘spillover’, as the functions of government transferred to a more appropriate polity. The fact that many health issues could satisfactorily only be tackled at a global level was already well apparent at this time. The influenza pandemic that emerged from the ashes of the First World War claimed more lives than history’s greatest military disaster to that date and was the latest in a long line of diseases that had rendered sovereign frontiers redundant.

This chapter examines the growth and evolution of non-state actors concerned with global health issues and contends that spillover in this world has persisted since the time of Mitrany and the birth of the World Health Organization (WHO) and that, driven by globalization, this phenomenon is set to continue.

### The Evolution of the Global Health World

The transnational threat posed by infectious diseases has long been apparent but counter-measures were slow to develop owing to an absence of any real scientific understanding of contagious diseases not spread directly by human to human (such as leprosy). The first systematic political measures to contain the international spread of non-human transmitted disease can be dated back to fourteenth century Venice and the origins of imposing a *quarantine* (the Latin for ‘forty days’) on people arriving back on ships returning from ports known to be afflicted with the Black Death. Quarantine was replicated by other states but coordinated international action to combat the spread of disease did not occur until the mid nineteenth century, when the unprecedented growth in international trade prompted the ‘Concert of Europe’ powers to consider a response.

Prior to the emergence of international policy the first non-state actors with a health focus had emerged in the 17<sup>th</sup> Century in the form of Christian religious orders carrying out humanitarian

missions, such as the establishment of nursing homes, in Africa, Latin America and the Middle East. Recognized by the Union of International Associations as the oldest international non-state health actor is the order The Sisters of St John de Lyon established in 1650, two years after the Treaty of Westphalia signaled the birth of sovereign statehood. Other charitable missions similarly emerged over the course of the next three centuries, such as the Sisters of Nazareth and the Franciscan Clarist Congregation, and it has been estimated that over 80% of all non-state actors with a role in international health before 1900 were religious orders (UIA 1999, Inoue & Drori 2006).

International organizations seeking to coordinate health measures on an international scale emerged in the mid 19<sup>th</sup> Century. In 1851 the first of a series of International Sanitary Conferences was held but failed to agree on a Convention to establish harmonized quarantine practices for cholera, plague and yellow fever. These diseases had ravaged Europe and much of the world in recent decades but little progress was made in an era when barriers to free trade and navigation were anathema to the great naval and commercial powers. The British, as the world's leading trading and naval power of the day, were particularly obstructive to global policy, to the point of even disputing the new science of contagion, in a display of hegemonic bloody-mindedness comparable to the US stance over global warming in recent years (Woolf 1916: 230-234). A breakthrough, however, occurred at the seventh International Sanitation Conference in 1892 when an International Sanitary Convention for cholera was agreed upon by most of the European maritime powers. This and three other Conventions on cholera and the plague were merged into a single International Sanitary Convention at the eleventh International Sanitary Conference in Paris in 1903. This then became the keystone of international legal measures on health in the proceeding decades as it was subsequently augmented by measures dealing with other diseases such as smallpox and typhus. Though international, it is worth noting that these agreements were regional, US-European initiatives rather than global since the explicit focus of the provisions was the protection of the developed world from 'Asiatic diseases' (Fidler 1999 : 30-32)

The International Sanitary Convention also prompted the creation of a permanent body to coordinate international action in the form of L'Office Internationale d'Hygiene Publique (OIHP) in 1907. The OIHP was a fully fledged intergovernmental organization with a Parisian headquarters, permanent staff and decision making body made up of (eventually) representatives of over fifty governments and colonial administrations. Its chief work was in disseminating medical information as well as codifying quarantine agreements and expanding the scope of the International Sanitary Convention. Whilst the agreement to set up a permanent organization with a broad international reach can be seen as a great step forward for the development of global health politics, the OIHP was not charitably inspired in the way of earlier non state actors in the global health world and was more driven by defensive self-interest rather than altruism. The first President of the Permanent Committee of the OIHP, Professor Rocco Santoliquido, made this explicit in an early speech that declared that their principal aim was to publicize information on exotic diseases which "are or may become a permanent threat to civilized states" (WHO 1958 :18).

Prior to the creation of the OIHP, and a year before the International Sanitary Convention, the seeds of today's global health polity were sown with the emergence of the International Sanitary Bureau launched by the US in 1902 in coordination with several North and South American states. Again, there can be little doubt that the Bureau was motivated more by economic interests than public health as is clear from its own stated chief aim; "that disease may be eliminated and that commerce between said Republics may be facilitated" (First General International Sanitary

Convention of the American Republics 1902 article VII). The International Sanitary Bureau could only be very loosely described as an international organization since it was run by two people, the US Surgeon General and one of his staff from Washington (Howard-Jones 1981) but in 1923 it was transformed into the Pan American Health Organization (PAHO). As the PAHO its role was expanded beyond disseminating information on disease outbreaks with a greater budget and staff leading it to publish a regular bulletin and launch initiatives to improve local health systems in the poorer Latin American states.

The means of transmitting information had greatly advanced through the 19<sup>th</sup> Century communications technology revolution and modern epidemiological research, based on the compilation of data on the spread of diseases, had also emerged at the forefront of medical science. The PAHO and OIHP hence represented a continuation of the trend established in the late 19<sup>th</sup> Century for the great powers to set up functional Intergovernmental Organizations, like the Universal Postal Union and International Telegraph Organization, to harmonize standards and reap mutual commercial rewards.

The OIHP continued to function despite the creation of a new global health organization as part of the League of Nations system established after the First World War; the Health Organization of the League of Nations (HOLN). The OIHP continued to have authority over the International Sanitary Convention whilst the HOLN focused on advising particular countries on containing the spread of epidemics and set up specialist commissions of experts to coordinate information and advise governments to in dealing with particular diseases, such as malaria. The role of the HOLN evolved rapidly in its short history from the fire-fighting operations against influenza and typhus in the aftermath of the First World War to a more preventative strategy by the late 1920s focused on mass vaccination campaigns and coordinating technical public health assistance to poorer countries. A pivotal figure in this development was the HOLNs Director, the Polish Idealist Ludwik Rajchmann, who often courted the displeasure of the League's Great Powers for his Marxist sympathies but, nevertheless, used Rockefeller and other private funds to boost campaigns (Dubin 1995). After the Second World War Rajchmann went on to be a key player in the foundation of the WHO, and became the first President of the United Nations Fund for Children (UNICEF) (Balinksa 1995). The HOLN vanished along with the League on the outbreak of World War Two, but its legacy was ensured by a successful campaign against typhus and the fostering of an international 'epistemic community' of health specialists who came to form the bedrock of the global health world of the future.

During the Second World War a new international body was set up to offer humanitarian assistance to countries on the cessation of fighting. The United Nations Relief and Rehabilitation Administration (UNRRA) started operations ahead of the rest of the planned United Nations system set to replace the League of Nations at the full conclusion of the war. From 1944 to 1946 UNRRA supplied food, drugs and medics to countries where fighting had stopped and also assumed control from the OIHP (which continued to exist until officially absorbed by the WHO) for administering the International Sanitary Convention.

The 1945 San Francisco Conference which founded the United Nations system did not envisage a direct successor organization to the HOLN since UNRRA, together with the newly-established Health, Nutrition and Population Division of the World Bank and UNICEF were considered to have taken on the stewardship of international health policy. A resolution of the first UN General Assembly in 1946, however, drafted by the delegates of China and Brazil, argued that a permanent health organization would still be necessary once UNRRA had completed its mandate

of fire-fighting post-war epidemics. The resolution gathered sufficient support to pave the way for the creation of the WHO in 1948 (Lee 2008: 12-13).

A WHO Interim Commission came into operation in 1946 prior to the establishment of the WHO proper and had a notable success in controlling a 1947 cholera epidemic in Egypt. From the start the organization was marked by an independent streak and it was agreed that the term 'United Nations' should not feature in its official title and that it would have a far more decentralized structure than any other UN Specialized Agency. The decision to devolve a great deal of the work of the WHO to six regions (Africa, the Americas, Europe, Eastern Mediterranean, South East Asia and Western Pacific) was partly a practical decision as it facilitated the continuation of PAHO as the American arm of the new global body.

### **World Health Organization**

The WHO is very much the central actor in today's global health world even though it has suffered several setbacks in its history and has been joined on the world stage by many other non-state actors.

Centrally, the work of WHO is directed by an annual World Health Assembly (WHA), held in Geneva, at which delegates of its 193 Member governments vote on budgetary matters and overall policy. The WHA elect a geographically-balanced thirty-four member Executive Board to oversee the implementation of policy. The Executive Board members are intended to be public health specialists rather than government delegates although the six Regional Committees are made up of health ministers. The WHO Director-General is elected by the WHA, on the recommendation of the Executive Board and serves a five year term at the Geneva headquarters supported by around a third of the WHO's 8,000 strong secretariat (WHO 2009). The WHO is financed by two distinct budgets. A regular budget, made up of assessed government contributions, finances the central institutions whilst extrabudgetary funds can be additionally contributed from governments, other UN agencies (particularly the World Bank) and private sources and targeted at specific programmes at the donors request.

The high point in the history of the WHO was the global eradication of smallpox, declared in 1978 after a vast immunization campaign. This momentous effort, which had to overcome obstacles such as a cultural reluctance to accept injections in some parts of India, saw many millions of people vaccinated and, consequently, around two million lives a year saved. Other notable achievements include bringing *yaws* and *Poliomyelitis* close to eradication through antibiotic and vaccination campaigns. Fuelled by scientific advances of the 1940s which saw the inventions of antibiotics like penicillin and organochlorine pesticides like DDT, the WHO's stated aim of the 'attainment by all peoples of the highest possible level of health' appeared to be a realizable dream. Ultimately, however, this goal has proved a more difficult task than at first imagined and a replication of the smallpox victory has proved elusive. The biggest eradication campaign in history failed to eradicate malaria which by the 1990s had resurged and was claiming around 1.5 million lives a year worldwide, with the disease gaining resistance to drugs such as chloroquine and the *anopholes* mosquito becoming increasingly resistant to DDT. In 1998, abandoning all aspirations to eradicate the disease, the WHO instead launched the far more conservative "Roll Back Malaria" campaign which declared as its aim the halving of malaria cases by 2010. This was to be achieved by improving access to treatment and increasing the use of insecticide-laden nets to deter rather than eliminate the mosquitoes.

The WHO also came to suffer a downturn in fortunes for political as well as technical reasons when in the 1980s it, along with other specialized agencies under the UN umbrella, became the

target of criticism for being over-bureaucratic and inefficient. The Neo-Liberal philosophy led by Reagan and Thatcher sought to challenge what it considered to be complacency in global public bodies in the same way as it had done for state bureaucracies in the US and UK. The WHO provided an easy target for such attacks since its Secretary General from 1988 to 1998, Nakajima, was widely vilified for running the organization like a personal fiefdom in which nepotism, discrimination and vote-buying were alleged to have occurred.

The election of the former Norwegian premier Dr Gro Harlem Brundtland in 1998 heralded a reform of the structure of the WHO aiming to streamline bureaucratic procedures and incorporate greater financial accountability by utilizing private managerial expertise. Greater business funds were attracted in a way that was reminiscent of Rajchman and the HOLN and, in order to “make the WHO one and not more than fifty”, (Brundtland 1999) its myriad and diverse programmes were consolidated into nine ‘clusters’ each headed by an Executive Director. These Executive Directors now together form a cabinet which meets weekly to discuss policy with the Director General.

Like the HOLN, the history of the WHO can be understood in terms of an evolution in its overall strategy and philosophy. The role of the WHO in the 1950s and ‘60s can be characterized as *vertical* in that the emphasis of its work was on targeting specific diseases for eradication campaigns. At this stage the role of WHO was essentially non-political since its approach of applying new technical fixes to problems was universally accepted as effective and appropriate. However, once it became evident that insect and microbe resistance to antibiotics and pesticides made combating the spread of disease more complicated than had at first been anticipated *horizontal* strategies- tackling underlying problems that exacerbate the effects of disease- came to be advocated more strongly and, as a result, global health became politicized. At its World Health Assembly of 1977 the WHO proclaimed as its principal aim ‘Health for all by the year 2000’, to be secured by a focus on primary health care strategies of improving sanitation and access to medical help throughout the world. The following year the WHO, together with UNICEF, organized the landmark International Conference on Primary Health Care at Alma Ata in the Soviet Union which boldly asserted that access to health services was an entitlement of all the world’s people.

The WHO’s horizontal strategy steered it into troubled waters by challenging the orthodoxy on economic development by seeming to favour greater independence and local empowerment for developing states over a focus on investment from MNCs from the Global North. This was most clearly demonstrated in the ‘essential drugs’ campaign, launched in 1977, which promoted the domestic development of pharmaceuticals in the Third World over their import from the First World. A contributory factor here was that the WHO, like the UN General Assembly, had become radicalized by the arrival of new member-states from Africa and Asia, keen to vent their frustrations against their past and present dominators and able to do so through its egalitarian voting system. The US, as the state most supportive of the spread of MNC influence, became increasingly exasperated with the new, bolder WHO. A humiliating 118-1 vote at the 1981 World Health Assembly, on adopting an international code to curb the export of infant milk substitutes to LDCs, and a long running disagreement over the essential drugs programme was a trigger for the 1980s US-led backlash against the WHO and other UN agencies.

The horizontal approach to global health has also met resistance from some states because technical quick-fixes remain popular in spite of some notable setbacks. Disasters trigger responses from the international community better than ‘routine’ suffering and tackling epidemics head on seems still to be the reflexive intergovernmental political response. The

extra-budgetary funds allocated to the WHO, which finance the disease-specific programmes, have grown since the late 1970s relative to the regular budget and this has been more pronounced since the Brundtland reforms. For many this has had the effect of counter-acting the horizontal ethos and served to undermine the advancement of health for all. Corporations involved, at least partially, for public relations purposes may be keen to focus resources on projects likely to succeed or attract attention rather than those that are the most deserving. Acute respiratory infections, for example, account for 26% of the burden of communicable diseases but attract only 2.5% of the funds allocated to global health campaigns (De Maeseneer 2008). Garrett contends that the international community's emphasis on HIV / AIDS has actually worsened the overall health of many countries particularly blighted with the infection because HIV medics are often segregated from other health workers and money has been diverted out of public health budgets (Garrett 2007).

Hence, entering the twenty-first century, the WHO found itself criticized on two fronts and its overall direction caught between that advocated by vertical 'eradicationists' (Godlee 1995) and horizontal proponents of public health. Brundtland's stewardship saw the WHO become more open and cost-efficient, to the satisfaction of the US and other major donor states, but it, nonetheless, also regained some of its radicalism and became less afraid to court corporate displeasure. This was evident in the revamping of the anti-tobacco campaign, from a weak agreement intimidated by the cigarette lobby in the 1990s to the 2005 entry into force of the far bolder Framework Convention on Tobacco Control, which has prompted stricter cigarette advertising and labeling standards to be implemented in many countries. Renewed radicalism was also evident in a campaign in support of the 'essential drugs' programme which spawned a major legal victory in 2001 when several pharmaceutical firms and the US government were persuaded to drop legal challenges preventing South African and Brazilian firms from marketing cheaper versions of generic HIV drugs. The legal cases had sought to uphold WTO Trade Related Intellectual Property Rights (TRIPS) but global public outcry over the cases prompted a backdown and marked a significant victory for human over business interests. Campaigns in recent years targeting 'lifestyle illnesses', like obesity and diabetes, have also irritated corporations and some powerful governments. The WHO's twin funding mechanism may attract criticism from two directions, but it does allow the organization to continue to attract public and private monies for high profile vertical campaigns, whilst persisting with a more socially-oriented functionalist political direction driven by the organization itself.

### **Other UN Agencies in the Global Health World**

*The World Bank* from the outset was intended to play a role in the global health world through its Health, Nutrition and Population division (HNP) although it was not until the 1970s, when its role shifted towards development from post-war reconstruction, that it granted any loans via this arm of its organization (Abbasi 1999). By the 1990s, however, the HNP was outstripping the WHO in its outlay on projects. Structural Adjustment Policies, implemented in conjunction with the International Monetary Fund (IMF) as a condition of many such loans, are, though, widely held to have often had negative health effects by encouraging cuts in expenditure from recipient governments. The Bank has become more reformist since the 1970s and 80s and its 1993 World Development Report 'Investing in Health' heralded a new direction inspired by a desire to be more socially-conscious in its development projects. Hence the World Bank, together with the IMF and WHO, has put its name to the UN's Millennium Development Goals which include several health pledges including greatly improving sanitation standards in the Global South. Nevertheless, given the

role of the organization, the World Bank is always going to have a selective rather than global approach to health issues.

*UNICEF* was established by the UN General Assembly in 1946 before the creation of the WHO with the aim of providing emergency food and health care to children affected by World War Two. It became a permanent agency in 1953 and by 2010 had a staff of 5,600 based in New York with 8 regional offices around the world (UNICEF 2009). UNICEF is widely seen as having shifted over the last quarter of a century from a horizontal approach to global health, in line with the WHO, to a more selective, vertical strategy (Werner 2001, Koivusalo & Ollila 1997: 209). From standing shoulder to shoulder with the WHO at Alma Ata in 1978 when the 'Health for All' crusade was launched, by the mid 1990s UNICEF had moved closer to the World Bank in focussing on the implementation of specific projects rather than the gradualist advancement of Primary Health Care. Werner considers this not to be a shift in ideology by the organization but, rather, the effect of UNICEF being a voluntary fund and so constrained by the preference of its donors for programmes of vaccinations over education and structural improvement (Werner 2001).

*UNAIDS* was set up as a programme of the WHO in 1986 in response to the spread of the new disease along similar lines to its other disease fighting arms. In 1996, however, it became a programme in its own right co-sponsored by ten UN agencies including the WHO, World Bank and UNICEF. This reflected the scale of the threat posed by AIDS but also, according to some, a lack of faith in the WHO to lead such a venture (Godlee 1994 : 1494-5). UNAIDS is based in Geneva with a secretariat of over 900, divided between its headquarters and 81 country offices (UNAIDS 2009). It was the first UN organ to include pressure group representatives in its executive, although voting rights in the Programme Coordinating Board are restricted to the twenty-two government representatives, elected by ECOSOC according to geographical quotas. The ten co-sponsors also have permanent representation on the board without voting right and many of their field workers carry out UNAIDS work in developing countries. UNAIDS' annual budget has grown rapidly from a modest \$60 million in 2001-2 to \$469 million for 2008-9 and it has been widely lauded for raising the profile of HIV/AIDS on the international stage and attracting significant funds to global campaigns. Horizontalists in the global health world have, however, voiced concerns that UNAIDS has failed to address underlying problems in many of the countries most affected by the disease, such as the criminalization of homosexuality and neglect in treating drug users and prostitutes. Coordinating ten sponsors with distinct credos and keeping private investors on board also makes it hard for UNAIDS to take intellectual leadership of the 'global AIDS world' and led some to suggest that the organization should be disbanded and responsibility handed back directly to the WHO (England 2008, Das & Samarsekera 2008).

### **Non-Governmental Organizations**

NGOs have been part of the global health world since the 19<sup>th</sup> Century, when their emergence augmented the humanitarian work of religious orders, but their role has become more significant over the last sixty years as they have enhanced global governance by working in conjunction with UN agencies and developing the discourse on global health.

The Red Cross was initiated in 1863 as a charitable organization mustering volunteers to go to conflict zones to provide relief to the wounded and ill. Save the Children similarly started out as a campaign to target humanitarian relief to children affected by war. Both organizations have continued with this original function but also come to have a global focus in advocating and implementing international law, such as the Geneva Conventions on War and the UN

Convention on the Rights of the Child. Recent years have seen a significant deepening of NGO activity in the health world by both assisting and lobbying the WHO. A new breed of groups use advanced communications technology to assist medics in the Global South, such as SatelLife, who utilize of satellites to link medics in the South to their developed world counterparts. The medical profession itself increasingly lobbies at the global level. MedAct is a group comprising health professionals which campaigns for government's to give greater consideration to the health impact of their policies in areas such as military security and economic development; a more overtly political stance than the traditional neutrality of groups such as the Red Cross. The radicalization of NGOs, in public health and in international relations in general, is best characterized by the work of the group Medecin Sans Frontiers (MSF). MSF consciously choose to ignore the constraints of sovereignty in their operations, sending in medical teams to countries without being specifically requested to enter by the government and making overtly political statements on the right of individual people to receive medical attention: a global 'right to life'.

It is the global civil society of the health world that has been the foremost advocates of the horizontal public health approach to global policy. NGOs and medics were a strong presence at Alma Ata in 1978 and, when the WHO appeared to waver from the course of primary health care in the 1980s and '90s, it was these actors who sought to steer it back on course. A network of pressure groups, grassroots activists and individual medics formed the 'People's Health Assembly', essentially mirroring the WHO, in 2000 in protest at the neglect of the Health for all ethos (Narayan 2008).

### **MNCs**

There is a long history of big business influencing the global health world through a mixture of philanthropism and the desire to enhance medical marketing opportunities. The Rockefeller Foundation's International Board, set up in 1913, cooperated with the US government in operations linked to the International Sanitary Board and PAHO in Latin America and later helped bankroll the HOLN. Such ventures have continued since then, particularly emanating from the US where the government has long offered tax breaks to corporations performing such tasks.

Today MNC activities in the global health world are mainly coordinated with the WHO, since Brundtland encouraged the partial outsourcing of some of its vertical operations into 'Global Public and Private Partnerships' (GPPPs) (Buse & Walt 2000). Corporations including the Rockefeller Foundation and [Bill] Gates Foundation have been encouraged to pump funds into a range of enterprises such as the Global Fund to Eradicate Filiarisis and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In this way MNCs have brought in substantial extrabudgetary funds, whilst retaining links with the WHO as only one of a number of 'partner' institutions.

Many voices are cynical about the whole concept of directly involving industry in global public health ventures. OXFAM's response to the development of partnerships between the UN and manufacturers of HIV-retroviral drugs was particularly sceptical. '(C)orporations in the pharmaceutical sector are offering islands of philanthropy, while promoting a global patents system which would enhance their profitability, but which could also consign millions to unnecessary suffering (Oxfam 2002: 8).' The governance of the GPPPs, however, is not as skewed in the direction of donors and corporations as might be imagined and efforts have been made to achieve a balance of stakeholders on the governing Boards, in a similar manner to that long employed on WHO programmes and Expert Groups. The Executive Boards



of the GPPPs consist of a mix of donor and recipient governments, UN agencies and Pressure Groups alongside the corporate representatives.

### **Assessing the Contemporary Global Health World**

Despite the diversification of actors in the global health world the WHO undoubtedly remains at its centre and the Functionalist logic of spillover persists. Functionalism can be viewed as over-utopian since the state system is still with us and global governance via non-governmental organizations does not appear much more likely than it did in the 1940s but it is still apparent in the health world. The WHO is an intergovernmental rather than a true non-governmental functional organization of the sort espoused by Mittrany, but it has developed an independent and global perspective from its epistemic community of experts and serving medics. It has frequently been criticized by both Functionalists and intergovernmentalists for not being fully in either of these camps, but its track record in the provision of the global good of public health is unprecedented in human history. It is inconceivable that the charitable cooperation of some governments and NGOs could have achieved the eradication of smallpox and so saved the lives of two million people a year. The logistics of mounting a genuinely global vaccination campaign, which had to overcome political and cultural obstacles to the intervention of foreign doctors, could only be dealt with by a body representing the whole world, rather than a powerful subset of it. In spite of its setbacks, the WHO has presided over a period of unprecedented improvements in human health. Life expectancies in the Global South have improved markedly despite the fact that these countries continue to bear the brunt of health problems. World life expectancy (at birth) in the first fifty years of the WHO increased from 46.5 to 64.3, an increase of 38% (WHO 1999). Whilst some of this can be attributed to economic growth, the greatest improvements have occurred in parts of the world where economic development and modernization has not significantly advanced.

Despite having to scale back its aims since the 'Health for All' declaration, the WHO has been empowered by contemporary globalization both in terms of the new opportunities and threats that it has brought. Recent IT advances have served to strengthen the WHO's central function of being able to detect and respond to disease outbreaks at the global level. Despite concerns over the dilution of its political leadership in global health the WHO, with its near universal membership and epistemic leadership, has been able to put itself at the forefront of this development and give greater authority to existing global rules on disease notification and open the way for the development of further ones. An Outbreak Verification System was initiated in 1997, to improve upon the previous system of relying on official state notifications to the WHO of significant disease outbreaks. Some governments can be coy about releasing such information whilst some might lack the capacity to do so effectively. Part of this system is the Global Public Health Intelligence Network (GPHIN), which routinely scans media sources for epidemiological information and passes it on to the WHO to verify and inform relevant authorities in an early warning system. Hence in 2003 the notoriously secretive Chinese government was quickly forced into coming clean after initially attempting to downplay the outbreak of Severe Acute Respiratory Syndrome (SARS). China is estimated to have lost \$1000 billion due to the SARS outbreak but, when the second wave of the disease struck the following year, the government reported it immediately and fired the officials deemed responsible for covering up the facts in the original outbreak (Upton 2004: 76).

In addition globalization has made apparent to both governments and the general population the worth of having a globally-acting focus of medical authority. The standing of the WHO was evident during the SARS outbreak when governments and the general public interpreted

their recommendations not to travel to the affected cities of Beijing and Toronto as authoritative 'bans' and they again became the source of global authority when the swine flu pandemic caused panic in 2009. Governments increasingly recognize that domestic health policies can only do so much in the face of pandemics in the contemporary world in which people and foodstuffs cross borders at an unprecedented rate. It has been estimated, for example, that, due to migration patterns, it would be more cost effective for the British government to vaccinate the entire population of Bangladesh rather than the UK's if they wished to safeguard their own population against hepatitis C (Benatar, Daar & Singer 2003). In the face of such conundrums state utilitarian logic must dictate that public health is a global concern requiring global solutions.

Sociologists Inoue and Drori, in an empirical analysis of the proliferation and maturation of non-state actors concerned with global health, observe that this has prompted the discourse of this world to evolve in a process of 'discursive sedimentation' (Inoue & Drori 2006:211). Organizations in the 17<sup>th</sup> and 18<sup>th</sup> Centuries initiated charitable health interventions in parts of the world particularly blighted by disease in a sporadic fashion. 19<sup>th</sup> Century industrialization and globalization prompted the emergence of intergovernmental organizations driven by professionalism and commercial interest to document diseases and standardize medical responses to them. From the 1940s global public health was largely subsumed within the new paradigm of development as charity and self-interest shifted towards economic empowerment. Since the 1980s this has evolved further with the growth of NGOs, internationally-oriented medics and the persistence of the WHO formulating a culture in which the dominant discourse of the global health is now based on the right to health. Charity, commercialism and development persist as values underpinning actors in the global health world but they have gradually built upon each other and a rights based approach is now the foremost culture, with the WHO very much centre stage.

The epistemic community for global public health is an influential one since its opinions are generally seen as inspired by the provision of a public good rather than any sectional interest. The increased prominence of MNCs in global health programmes has brought with it fears that policy could be transformed from the 'Health for All' approach to a more uneven charitable approach. Similar fears were expressed when developed democracies began undergoing a 'welfare backlash' from the mid 1970s. Then the cost of state support began to spiral due to ageing populations and higher levels of unemployment causing more people than ever envisaged to fall into the welfare safety net. Developed states responded, to varying degrees, by incorporating private solutions to public health but the wholesale dismantling of welfare state provision has not happened anywhere despite economic and political arguments favouring this, partly because public opinion considers state health provision a right and partly because public health practitioners have powerfully resisted this. Medics in many countries are increasingly developing a more internationalist focus, with global health now a mainstream part of many medical degrees, and they now provide a powerful global lobby in favour of maintaining a horizontal strategy. The 'People's Charter for Health' has mobilized support for a public health approach to global policy and appears to have succeeded in getting the WHO to reaffirm its commitment to this with a new rhetoric becoming evident since Director General Margaret Chan succeeded to the position in 2006.

Hence we are witnessing the maturation of the global health world in which the notion of a human right to health and a political duty to provide this is globalizing and Mitranian vision of Functionalist world revolution slowly coming to reality.

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