A GLOBAL APPROACH TO DISEASE: COORDINATING THROUGH THE WORLD HEALTH ORGANIZATION

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Summary

High mortality rates from communicable diseases in the nineteenth century brought countries together in Europe and the Americas to discuss ways to set and implement international standards for their control. Conventions were adopted and organizations established to support and implement public health regulations. The League of Nations set up a centralized health organization, which monitored health crises and gave aid to war-affected areas. Following the Second World War, UN member states agreed to establish and support the World Health Organization (WHO) to coordinate global health care. Reaching goals for setting and meeting public health standards worldwide were

thwarted by international tensions, low budgets, and the impact of wars, famines, and other man-made and natural disasters, plus the reluctance in some regions to forego cultural and social practices. WHO provides, through its six regions, information and technical help about disease control and optimal health care for six regions and has conducted action programs in response to their health needs. Its leadership was criticized as inadequate to meet the rising AIDS crisis in the 1980s and 1990s; a new organization was established, UNAIDS, to deal with it. The loss of life in Africa and its latent pandemic danger should be the occasion for an intensive evaluation of global governance in public health. A new consensus is needed to respond to HIV/AIDS and other diseases with improved programs and adequate funding.

1. Introduction

1.1 An Historical Perspective

From the early days of the nineteenth century, it was apparent that the threat of serious contagious diseases required international action. Successful treatment for an epidemic of cholera or plague within one country could be thwarted by contaminated produce brought in from another. As international trade became more vigorous, so, it seemed, did communicable diseases. The first international public health conference was held in 1851, in response to severe cholera epidemics of the 1830s and 1840s. Several European governments sent representatives to a meeting in Paris to seek agreement on sanitary regulations to control transboundary contagion.

These and subsequent meetings tended to follow the same pattern. Along with medical doctors and scientists came government ministry officials. The former pondered questions of disease control, while the latter were present to protect national commercial interests from the possible ill effects of health regulations. Quarantine of ports with a high incidence of plague, cholera, or yellow fever, would obviously impact on merchant profits. During the decades that followed, public hygiene measures were frequently weakened by concern for commerce and trade. Despite the inevitable conflict, international health conferences were held and conventions adopted in the latter part of the nineteenth and the early twentieth century, setting some positive precedents for transboundary cooperation in the treatment and prevention of communicable and other diseases.

The battle against particularly virulent contagious diseases such as cholera, plague, smallpox, and typhus led to the creation of two organizations early in the twentieth century, one in Europe in Paris, the Office International d'Hygiene (OIHP) and the Pan American Sanitary Bureau (PASB), in Washington. Both organizations established and, to a degree implemented, transboundary health standards. The OIHP worked alongside the League of Nations Health Organization until the beginning of the Second World War. As medical epidemiology developed preventive and treatment guidelines, they were added to international sanitary convention provisions. The League organization was severely challenged by pandemics of typhus and influenza in the immediate post-war years. It worked with special teams in the war-torn areas and continued to try to improve and implement public health standards until late in 1938.

1.2 Meeting Post-Second World War Challenges

There was a clear and immediate need for a re-vitalized international health organization at the end of the second world war. The 1945 UN Conference on International Organizations in San Francisco unanimously approved a proposal to establish the World Health Organization (WHO) in 1946. Its constitution was adopted that year and went into force on April 7, 1948 when the 26th of 61 signatory states ratified it. The first World Health Assembly was held in Geneva the same year, with delegations from 53 member governments. The new organization faced three major challenges. On the political side its decision making was affected by continued international tensions, in particular the outbreak of the Cold War. There were serious public health questions from contagious diseases, some old and some new. And there was a third significant challenge especially for the physicians and medical researchers: how to make the best use of and continue to improve the multiple scientific resources developed during the war years.

Political conflicts among member states within the WHO reflected those in the UN Security Council and the General Assembly. The Soviet Union and the eastern bloc countries left the WHO shortly after its organization despite the fact that they were receiving a substantial part of its aid budget. They returned after the death of Stalin in 1953. Tensions between the industrialized countries of the north and the new post-colonial states of the south increased during the 1970s and remain a factor in negotiations. Key to continued problems is the one-vote one-state WHO assembly policy, which in the view of some developed countries upset the balance of power in favor of the south. Health issues were of increasing concern in all countries. Budgets, the WHO's included, became politically controversial as new problems created by sexually transmitted diseases and rising cancer rates demanded a greater share of each country's resources.

As an independent agency, WHO has found it hard to maintain a steady pace in fulfilling its global health goals. Its output for the most part has been support for occasional studies and investigations and to provide statistical information, technical assistance, and training programs to its member states through its six regional offices. As this article shows, WHO has had to defend itself against accusations of poor leadership and use of its limited resources, in particular as it chose to handle the pandemic problems of AIDS (acquired immune deficiency syndrome). The role of the UN public health system is in need of a serious evaluation from its rationale to its organization and accomplishments.

2. The WHO: its Goals and Programs

2.1 Guiding Principles

The WHO was established as a special agency under Article 57 of the UN Charter. It is defined by its constitution as the directing and coordinating authority on international health work, its aim "the attainment by all peoples of the highest possible level of health." A number of principles support this goal, including recognition that all people should receive information essential to their health and that all governments should

provide adequate medical and humanitarian care. Its health goals include the eradication of epidemic, endemic, and other diseases as well as the improvement of nutrition, housing, sanitation, and other aspects of environmental hygiene.

	All member states	**Africa**	**Americas**	**Eastern Med.**	**Europe**	**South East Asia**	**Western Pacific**
Population							
Total population (thousands)							
1998	5 884 576	601 783	802 811	473 644	870 128	1 485 056	1 651 154
Number member states, territories	191	47	34	22	51	10	27
Annual growth rate (%)							
1978–1998	1.6	2.8	1.5	2.8	0.5	1.9	1.3
Total fertility rate							
1978	3.9	6.7	3.3	6.5	2.2	4.9	3.3
1998	2.7	5.4	2.4	4.4	1.6	2.9	1.9
Mortality rates							
Infant mortality rate (per 1000)							
1978	87	121	56	118	35	121	53
1998	57	91	28	69	21	68	38
Probability of dying (per 1000)							
under age 5 years							
Males 1998	83	172	39	107	30	87	43
Females 1998	83	154	31	102	23	97	50
age 15–59							
Males 1998	225	477	197	214	217	237	162
Females 1998	156	429	109	172	95	190	100
Maternal mortality ratio (per 100 000)							
1990	430	940	140	440	59	610	120
Social and economic indicators							
Life expectancy at birth (years)							
Males							
1978	60	46	65	53	67	53	64
1998	65	49	69	63	69	62	68
Females							
1978	63	49	71	55	74	53	67
1998	69	51	76	65	77	64	73
GDP per cap pp* in 1985 US$							
1992	4123	1261	9997	2139	10 189	1558	2959
Annual growth rate (%)							
1962–1992	2.7	0.9	1.9	2.2	2.6	2.2	4
1982–1992	2.5	–1.9	0.8	1.3	2	3.3	4.1
Ave. years education for aged 25+							
Females 1990	4.3	1.9	7.8	1.7	6.9	2.4	4.4
Males excess over females	2.1	1.5	0.6	2.2	0.8	2.3	3

Health expenditures							
Total (% GDP) ©1995	5.2	3.2	8.6	3.6	7.1	4.7	4.2
Public sector (% GDP) ©1995	2.6	1.7	4.1	1.6	5.2	1.1	2.3
Public sector (% total) ©1995	48	50	47	38	78	27	54

*The term PPP$ is defined by the UN Human Development Report as "real GDP per capita", or the GDP per capita of a country converted into US dollars on the basis of the purchasing power parity exchange rate.

Table 1. Basic health, Socioeconomic Indicators, by WHO Region

As its primary mission, the WHO coordinates international public health measures, in collaboration with its member states. More specifically, it may develop, establish, and promote international standards, with respect to food, biological, pharmaceutical, and similar products. It establishes and revises international nomenclatures of diseases, causes of death, and of public health practices. It also may standardize diagnostic procedures. It promotes cooperation among scientific and professional groups, proposes international conventions and agreements on health matters, and may itself promote and conduct research in the field of health. It assists in the development of an informed public opinion among all people on matters of health.

2.2 Structure

Decentralization has been a guiding principle for WHO since its inception. The constitution provides for regional organizations, which are responsible for the conduct of intra-regional programs. Each has a regional director and staff. There are now six regions: Africa, the Americas, South-East Asia, Europe, Eastern Mediterranean, and Western Pacific. Each has its own director and staff and a committee which represents the member states and associates of the region. The committees help to formulate policies, make budget recommendations, and carry out WHA and Board decisions. The constitution calls for cooperation with nongovernmental organizations (NGOs) at the regional and national level.

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Biographical Sketch

Dr. Irene Lyons Murphy is an author and policy analyst who specializes in national and international policy issues, emphasizing the relationship of the scientific management of health and environmental issues to government policies. She has most recently been a faculty affiliate at Colorado State University and previously was an adjunct professor at George Washington University. She was for several years a senior adviser on water resource and environmental issues in the office of the secretary of the US Department of the Interior. She has most recently participated in workshops on the use of electronic networks for the protection of international resources in Lisbon, Portugal; Amman, Jordan, and at a meeting of the Balkan countries in Thessaloniki, Greece. She is the author of *The Danube: a River Basin in Transition*, Kluwer, 1997, the editor of *Protecting Danube Resources: Ensuring Access to Environmental Data and Information*, Kluwer, 1997, and *Transboundary Water Resources in the Balkans*, Kluwer, 2000 and has published a number of articles and monographs on international issues. She has a Masters and Ph.D. degree in Political Science from Columbia University and is a graduate of Barnard College. She presently works as an independent consultant in Washington, DC.