Gómez, Octavio
International Health in the 20th Century: Agenda, Negotiations and Agreements
Instituto Nacional de Salud Pública
Cuernavaca, México

Available in: http://www.redalyc.org/articulo.oa?id=10645412
GLOBALIZATION – THE RAPID GROWTH of international commerce, the increasing ease of travel, and the communications revolution– has eroded national borders, encouraging the movement of goods, services, people, ideas, and lifestyles from one country to another. One of the side effects of this new world dynamic is that health risks and diseases are no longer a local phenomenon. National health systems, particularly in the developing world, already burdened by internal challenges – such as maintaining hygiene and providing adequate health care for the sick – must now worry about health threats from outside their borders. States and their health care institutions and organizations cannot handle these new threats alone. Indeed, as Lincoln C. Chen has pointed out, we are entering “an era of global ‘health interdependence,’ the health parallel to economic interdependence.”

This new era of global health interdependence is accompanied by a new understanding of the part that health plays in economic and social development. No longer is improving health conditions simply a humanitarian issue. In recent years, there has been increasing appreciation of the vicious cycle of illness and poverty – poor national health leads to poverty, and poverty in turn leads to ever worsening health. In addition, globalization has intensified fears that the spread of certain diseases may actually threaten international peace and security.

Because of the shift in the focus on health from the humanitarian level to the economic and political plane, the actors who traditionally dominated the global health arena – national governments, the World Health Organization (WHO), and various NGOs – have been joined by development banks, aid agencies, and other private sector groups who wish to shape the response to the threat of disease. However, this increasing and welcome attention on the transfer of health risks and the control of diseases, with the profusion of actors and ideas and agendas, has rendered the coordination and implementation of health policy an extremely complicated proposition.

Initiatives to tackle international health problems have evolved in the 20th century from simple sets of measures and actors devoted to controlling the regional spread of some diseases to a complex global regime with an increasing number of objectives, functions, institutional arrangements, and players. This international health regime has unfolded along two main lines. First is the development of technical functions (epidemiological surveillance, design of norms and standards, and the spread of knowledge and information) and the implementation of initiatives around regional and global needs. Second is the development of programs geared towards specific health needs and problems in the developing world. International initiatives to treat health problems in developing countries have often been motivated by humanitarian and developmental concerns, but security, economic, political, and military interests have also weighed heavily at times.

More generally since the late 1920s, two schools of thought have competed for attention on how to address global health challenges. On the one side are those who support the development of general health services to control all major health threats. On the other side are those who favor the control of specific diseases. Those who favor more comprehensive approaches...
–heirs to the European social reformers of the nineteenth century– have argued that ill health is not due to specific ailments but to a coming together of circumstances that result from poverty, dirt, and ignorance. Those who favor focused interventions argue that without the control of specific diseases, no development is possible.

There is no doubt that without improvements in overall living conditions (access to clean water, sanitation, good nutrition, and education) and effective health systems, no long-term solution to the vast majority of health problems can be envisaged. This should be the emphasis of strategic approaches to health threats in developing countries. Some specific disease initiatives, however, have acted as opening wedges for more comprehensive health care, and some others have produced spillover benefits to health systems development in general.

In this essay, we will discuss the nature of global health threats -primarily those involving communicable diseases and developing countries- and examine the international responses to them in the period since World War I, with particular attention to the work of the WHO. We then look at six case studies that best illustrate the changing concerns and approaches of the international regime: the malaria control program, the smallpox eradication campaign, the expanded program on immunization, the infant formula debate, the action program on essential drugs, and the fight against AIDS. We also describe the current state of affairs in the field of international health: the increasing role of new actors, most notably development banks; the institutional and leadership crisis of WHO; and the debate about the core functions of international health agencies.

The case studies provide the groundwork for the main focus of this paper: the lessons learned about what makes for successful approaches to managing global health. We explore the challenges of balancing donor and recipient priorities during the agenda-setting process; the challenges of negotiation among the increasing number of actors (bilateral and multilateral agencies, private foundations, academic institutions, development banks, NGOS) involved in shaping international initiatives; the difficulties of implementing the initiatives and ensuring compliance; and the ways of responding to noncompliance.

Nature of the problem

The 20th century was a period of tremendous progress in health and health care worldwide. Infant mortality rates declined, life expectancy increased, and the gap in life expectancy between rich and poor nations narrowed (from 25 years in 1955 to 13 years in 1995). This was mainly due to improvements in income and living conditions and advances in disease control. However, more than one billion people remain untouched by this progress. They suffer from malnutrition and succumb to common infections and reproductive problems for which relatively cheap and effective remedies are available. Pneumonia, diarrhea, and measles –easily overcome in the developed world– remain major causes of death in many poor countries, which also have to cope with new, virulent infections such as the Ebola virus and HIV-AIDS. To this grim picture we should add the appearance of new variants of old diseases such as cholera, malaria, and tuberculosis (TB).

Among the communicable diseases that pose a global threat, HIV-AIDS is probably the most prominent. More than 34 million people are living with HIV-AIDS, 70 percent of whom reside in Sub-Saharan Africa. Infection rates in the former Soviet Union, Eastern Europe, and Central Asia are also on the rise. Since the early 1980s, close to 20 million people have been killed and more than 13 million children have been orphaned by this disease. By 2010, it is expected that in Africa alone some 40 million children will have lost one or both parents to HIV-AIDS. The implications of this epidemic for social and economic development are staggering, yet policy makers around the world have only just begun to face the problem.

HIV-AIDS is by no means the only peril. TB, once thought to be under control, is making a spectacular comeback. Each year, TB kills almost two million people. It is estimated that between 2000 and 2020, nearly one billion people will become infected with the bacteria that causes TB, 200 million will develop the disease, and 35 million will die. Southeast Asia is
hit particularly hard, with nearly three million new cases each year. Drug-resistant TB, caused by inconsistent or partial medical treatment, is climbing at alarming rates in Russia and other former Soviet republics. According to Hans Kluge, regional coordinator for TB Programs for Médecins Sans Frontiers, TB is set to become the principal epidemic of the twenty-first century.5

There is no doubt that the threat of infectious disease is growing—the last ten years have seen the emergence of no fewer than thirty new pathogens—, but noncommunicable diseases are beginning to make up an increasing proportion of the global disease burden. This is in large part due to the effects of globalization and economic development. People in poorer countries are living longer and consuming more, and much of what they are consuming—fast foods, tobacco products—are not good for them. Chronic diseases prevalent in the developed world—like certain cancers, diabetes, heart disease, stroke, and pulmonary diseases—are now on the rise in the developing world. Worldwide, noncommunicable diseases account for nearly 60 percent of deaths and are the main drivers of demand for health resources.6 WHO has estimated that by 2020 noncommunicable afflictions will account for 73 percent of the disease burden worldwide, as opposed to 43 percent in 1998.7

The health challenges described above impose enormous burdens on health care systems. Wealthy countries face an explosion in demand for health care services from an aging population and skyrocketing costs resulting from physician dependence on advanced medical technology. In fact, in 1994, 90 percent of all health care spending was done in the industrialized countries.8 For developing countries, the challenge is more daunting. Most poor nations lack adequate health care infrastructures, and government investment in basic medical services is almost nonexistent. Multinational programs to help stem the tide of disease may founder because poor domestic conditions make it difficult to implement them.

The search for rational responses to these challenges has resulted in the formation of a global health care reform movement.9 Although the main challenges and reasons for reform vary across countries, some of the proposals are remarkably similar. Among the most prominent of these common proposals are the following:

• separate the basic functions of the healthcare system—regulation, financing, and delivery—in order to establish incentive structures that promote competition and accountability;
• establish mechanisms to evaluate the cost and effectiveness of health interventions and to define priorities;
• create mechanisms that ensure the proper use of health technologies;
• develop programs that assure the continuous improvement in health care quality and responsiveness to patients’ needs; and
• promote the participation of the public in the development and implementation of health care policy.

Despite the recognition of the need for health care reform, no consensus exists regarding the role of markets and government intervention in health care. Many countries are considering “turning to the market to put things right,” and some policy makers would like to limit the participation of governments in health care to the design and implementation of regulations.10 Others believe that governments should finance health care themselves. The latter view is shared by Gro Harlem Brundtland, the new Director-General of the WHO. She wrote:

Our values cannot support market-oriented approaches that ration health services to those with the ability to pay. Not only do market-oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well. Market mechanisms have enormous utility in many sectors and have underpinned rapid economic growth for over a century in Europe and elsewhere. But the very countries that have relied on market mechanisms to achieve the high incomes they enjoy today are the same countries that rely most heavily on governments to finance health services.11
It is clear that the increasing complexity of regional and global health threats demands more innovation and cooperation between national governments and multinational organizations that make up the international health regime. In this process the record of previous international efforts in this field should be taken into account.

**Track record of international efforts to control health threats**

International efforts to control health risks date back to the second century, when traveling healers from China, Japan, and Korea spread their knowledge all over the Far East. In the 14th century, in an attempt to control the spread of the Black Death, the city-states of northern Italy set up Public Health Councils, and similar bodies were established within the Ottoman Empire. In the early 19th century, inspection and quarantine policies were designed to protect international trade in the Mediterranean and the Black seas from the spread of cholera, yellow fever, and plague. By the end of the nineteenth century, the control of infectious diseases had become a staple of international diplomacy.\(^{12}\) At this time international health activities also began to have a more multilateral and institutional character.

The International Sanitary Conferences convened between 1851 and 1907 stimulated the development of international health surveillance systems based on notification and control. That said, it was not until the 20th century that permanent international health organizations were established.

The Pan American Sanitary Bureau was the product of the Second International Conference of American States, held in Mexico City in 1901. The purpose of this organization was to act as an information clearinghouse through which the countries of the region could keep one another informed regarding epidemics of international importance. The bureau was also involved, upon the request of national governments, in developing studies and assistance programs to combat outbreaks of infection or to improve sanitation.

The Office International d’Hygiène Publique (OIHP), the first worldwide international health organization, was set up in Paris in 1907 as a technical commission for the study of epidemic diseases, a permanent body for the administration of international conventions, and a center for the exchange of epidemiological data. Information was required on cholera, plague, yellow fever, typhus, and relapsing fever, diseases “that Western European countries, which dominated the creation of the health regime, feared would spread from Asia, Latin America and Eastern Europe.”\(^{13}\)

In 1920, the League of Nations called for the reexamination of international cooperation in all fields and created its own health organization. The rationale was that there was a need for broader surveillance and more active disease control based on well-organized national health services.

To many, the coexistence of several permanent international health organizations made no sense. In fact, efforts were developed to place the OIHP under the authority of the League of Nations. But these efforts were opposed by France, which did not want to lose control of what it considered its organization, and the United States, which was not a member of the League of Nations. Not surprisingly, there was considerable overlap in the programs of the OIHP and the League’s health organization.

Much of the information distributed by these international organizations was superfluous. Indeed, the European powers knew a great deal about health conditions in their colonies and had first-hand access to local epidemiological information. The same was true for the United States in Latin America. Moreover, the increasing availability of sanitation facilities and clean water in Europe and North America; the development of new drugs, vaccines, and insecticides; and the improved understanding of the mechanisms of disease transmission reduced the fear of the spread of tropical diseases.

Probably as a consequence of this decreasing fear, after World War II and during the creation of the United Nations, health was overlooked at first as a matter of global concern. It was eventually recognized, however, as a field in which the United Nations should be involved. In 1946
the International Health Conference convened in New York and adopted the constitution of the future WHO, which was officially established in September 1948.

The new organization absorbed and unified all the existing health organizations into a single worldwide intergovernmental body with broad responsibilities and the power to adopt conventions, agreements, and international regulations. At least formally, WHO was not going to limit itself to controlling the international spread of infectious diseases but was now responsible for “the attainment by all peoples of the highest possible level of health” through the development of at least 22 functions specified in Chapter 11 of its constitution.

Much of the initial work of WHO would be influenced by the progress made during and after World War II in the field of communicable diseases, including the development of insecticides, improvements in the production and application of vaccines, and the development of antibiotics. The Interim Commission of WHO, in fact, placed malaria first on its list of priorities, a decision that was ratified by the first World Health Assembly, which agreed on the immediate implementation of action plans for malaria, TB, and venereal diseases.

This emphasis on communicable disease was strengthened during the 1950s and 1960s. In the early 1950s, after the introduction of sulphone therapy, leprosy was included in the list of priorities of international health. In 1955 WHO accepted a resolution to eradicate malaria. Mass penicillin campaigns against yaws, pint, and bejel were also implemented in the 1950s. Finally, the late 1960s was dominated by the campaign against smallpox and the Expanded Program on Immunization (EPI).

In the early 1970s, decolonization and the worldwide focus on development lead to a broadening of the international health agenda. Under the leadership of Halfdan Mahler, Director-General of WHO from 1973 to 1988, WHO began to adopt a comprehensive, primary-care approach designed to improve the population’s overall health profile rather than just eradicate a certain disease. Early successful experiments in comprehensive health care include the development of a network of health care units in Kenya and Indonesia in the 1950s and the idea of integrated health care systems in the Philippines in the early 1960s. Yet, the efforts to advance this kind of approach failed due to the lack of a clear strategy, limited resources, and strong opposition from major donor agencies on the grounds that scarce resources should be spent on those interventions that yielded the highest return per unit of investment.

The 1980s and early 1990s were dominated by top-down programs including the EPI, the UN Children’s Fund (UNICEF) GOBI (growth surveillance, oral rehydration, breastfeeding, and immunization) initiative, and the World Bank’s Safe Motherhood program. However, these strategies were eventually overshadowed by the development of the health system reform movement, WHO’s recent concern for “effective health systems,” and, most notably, the World Bank’s “sectorwide approach” to health.

This World Bank initiative marked its intellectual and policy leadership in international health governance, as it emerged as the largest external financier of health activities in low- and middle-income countries and a major player in health policy debates and research. According to Kent Buse and Catherine Gwin, “By the end of 1996, the cumulative HNP [health, nutrition, and population] portfolio [of the World Bank] had reached US$13.5 billion (in 1996 dollars), encompassing 155 active projects in 82 countries and an additional 70 completed projects.”

The evolution of the international health regime in the second half of the twentieth century and the lessons learned in the process, however, can be better appreciated through the six case studies that follow.

Malaria Eradication Program

In 1955, WHO resolved to eradicate malaria. This idea was strongly prompted by Fred Soper, director-to-be of the Pan American Health Organization (PAHO), who had done extensive work for the International Health Division of the Rockefeller Foundation and prided himself as almost single-handedly having resurrected the idea of eradication as an attainable goal. Almost one-
The third of the world population was then living in malarious areas, and the yearly number of cases of this disease was reaching 300 million.

The idea was based on the efficacy of the insecticide DDT—proven through the eradication of malaria from British Guyana, Ceylon, Greece, Italy, Puerto Rico, Sardinia, and Venezuela—and the new synthetic antimalarial drugs developed by the British and the Americans during World War II. The U.S. government donated $1 billion to the effort between 1958 and 1963. The WHO itself earmarked one-third of its regular budget during these years to the malaria campaign.

In addition to the humanitarian reasons behind the effort to eradicate malaria were the ideological concerns of the Cold War period. In a 1955 report, the International Development Advisory Board of the United States argued:

> American support for malaria control could be received throughout the world only as a humanitarian action on the part of the people of the United States and their government toward their fellow human beings. This would do much to counteract the anti-United States sentiments, which have been aroused by subversive methods in these countries. If properly carried out, programs like these will challenge the Russian approach.17

By the mid-1960s malaria had been eliminated from the United States, Western and Eastern Europe, most of the Soviet Union, and some developing countries, and global incidence had been reduced to around 120 million cases per year.

However, by the late 1960s, the program began to lose momentum—and, eventually, support from donor countries—when the effectiveness of DDT and antimalarials started to diminish. In 1969, India reported 349,000 cases, up from only 62,000 in 1962. In Pakistan, the number of cases reached 108,000 in 1971, up from only 9,500 in 1968. Increases were also registered in Afghanistan, Bangladesh, Burma, Costa Rica, El Salvador, Haiti, Honduras, Indonesia, Nepal, Sri Lanka, and Thailand.

The global campaign came to an end in 1969, when it was decided that eradication could not be achieved. This declaration signaled the exclusion of malaria from the scientific, media, and political agenda, for nearly 3 years.

As malaria deaths continued to rise through the 1990s, efforts to combat malaria made a comeback. The Roll Back Malaria initiative—a partnership among WHO, UNICEF, the UN Development Program (UNDP), and the World Bank—attempts to build on the lessons learned from the failures of past initiatives. A WHO press release announcing the initiative stated:

> Roll Back Malaria (RBM) is different from previous efforts to fight malaria. RBM will work not only through new tools for controlling malaria but also by strengthening the health services to affected populations. RBM will implement its activities through partnerships with international organizations, governments in endemic and non-endemic countries, academic institutions, the private sector and nongovernmental organizations. Above all it will be a united effort by the four international agencies concerned with malaria and its effects on health and economic development.18

The focus on partnerships at the global, regional, and national levels is aimed at fostering sustained international interest in combating malaria. The RBM initiative also devises a new mode for combating malaria, the Medicines for Malaria Venture (MMV). MMV brings together the knowledge and expertise in drug discovery and development of the pharmaceutical industry and the policy and field studies expertise of the public sector. The mission of MMV is to raise capital for the discovery, development, and distribution of antimalarial drugs that are affordable to populations most afflicted with the disease.

**Eradication of Smallpox**

While the attention of the world health regime was focused on the eradicating malaria, a parallel debate was taking place about the possible eradication of smallpox, a deadly disease that afflic-
ted between 10 and 15 million people worldwide in the 1960s. Proponents of smallpox eradication were encouraged by the elimination of the disease from North America and Europe in the 1940s, and by the initial success of the campaign to eliminate it from the Americas in the 1960s. In 1966, the World Health Assembly voted a special budget of $2.5 million annually for an intensive program to eradicate smallpox by 1976.

The technical rationales for the eradication were that an effective and simple vaccine was readily available, the disease was easy to diagnose, had a short period of infectiosity, no animal reservoir, and provided complete natural immunity. However, memories of the failed antimalaria campaign still rankled, and there was much resistance to the idea that any disease could be eradicated. As a result, cash support from industrialized countries was extremely scarce. Fortunately, donors began to extend in-kind support. In the initial phases of the program, more than 140 million doses of vaccine were provided by the Soviet Union and 40 million more by the United States. Eventually, donations were received from more than 20 countries and vaccine production in developing countries increased considerably. By 1970, seven of the 12 most endemic countries of the world were rendered free of smallpox; Brazil and the Americas followed in 1971; Indonesia eliminated the infection in 1972; and India saw its last case in 1975. On May 8, 1980, the 33rd World Health Assembly declared: “The world and all its peoples have won freedom from smallpox... [and] calls this unprecedented achievement in the history of public health to the attention of all nations, which by their collective action have freed mankind of this ancient scourge.”

Expanded Program on Immunization

The success of the smallpox eradication program strengthened the leadership of WHO and prompted extensive international work in immunizations. In 1974, after a historic conference held at the Rockefeller Foundation Center in Bellagio, Italy, WHO and UNICEF launched the Expanded Program on Immunization (EPI), aimed at eradicating poliomyelitis— a goal supported by a $400 million grant from Rotary International— and immunizing 80 percent of the world’s children against measles, tetanus, pertussis, diphtheria, and TB.

By the early 1990s, vaccinations prevented more than three million deaths from measles, neonatal tetanus, and pertussis each year. Globally, the reported incidence of poliomyelitis declined by over 80 percent since 1988 and was eliminated in the Americas by 1991. In addition, better surveillance systems were put in place, new paradigms for community participation in public health emerged, and national immunization days, identified as efficient means for vaccine delivery, were established on a regular basis worldwide.

These results gave UNICEF the necessary leverage to negotiate ambitious goals with national health authorities— not only for immunizations but also for reductions in infant and maternal mortality rates— and allowed it to expand its presence in the health field. This move was welcomed by those who were concerned that WHO could not adequately exercise the world’s mandate for health by itself. However, this also fueled a rivalry between WHO and UNICEF that would last for several years.

However, despite the strong leadership UNICEF provided to pull various global actors together to improve immunization rates in developing countries in the 1970s and 1980s, immunization rates faltered by the 1990s. Inadequate local health care infrastructure, donor fatigue, insufficient information about the disease burden and vaccine effectiveness, and the high costs of vaccines plagued efforts at immunization. Also, operational problems related to the use of vaccines in the field (heat sensitivity, sterilization problems, and waste disposal) persisted in several places. By 1995, six of the world’s most populous developing countries reported coverage levels below 70 percent and 12 African nations reported figures below 50 percent.” Today at least two million children die from diseases preventable through relatively inexpensive immunizations.

In the late 1990s a new immunization effort was introduced: the Global Alliance for Vaccines and Immunization (GAVI). This 1999 initiative is an international coalition of national govern-
ments; international organizations such as UNICEF, WHO, and the World Bank; philanthropic institutions such as the Bill and Melinda Gates Foundation; the private sector; and private research institutions. Central to the initiative is the Global Fund for Children’s Vaccines, created with a $750 million grant from the Gates Foundation.

As in the past, poor domestic health infrastructure remains a significant obstacle. Despite the very low price of the older vaccines, the lack of transportation networks and trained medical personnel keeps immunization rates low in many areas.

Infant Formula Controversy

The controversy over the use of infant formula underscores the importance of NGOs in the international health arena and remains one of the best examples of international mobilization against practices detrimental to public health. By the 1970s NGOs and some health and development experts became increasingly concerned that infant morbidity and mortality in developing countries could be aggravated by the infant formula industry’s aggressive promotion of breast milk substitutes and the decline of breastfeeding. Several studies had suggested a direct relationship between diarrhea and malnutrition and bottle-feeding when carried out amid the poverty hazards of developing countries, including the use of contaminated water for preparation of the formula. The industry, however, claimed that no sound evidence supported the hypothesis that marketing practices for infant formulas had actually contributed to the decline of breastfeeding in poor nations or elsewhere.

By the end of the decade, several coalitions of consumer groups—most prominently, the Infant Formula Action Coalition (INFACT) and the National Council of Churches’ Interfaith Center on Corporate Responsibility—were lobbying for a highly restrictive international regulatory code. The controversy became extremely political because it involved substantial economic interests ($1.5 billion in sales annually in developing nations).

The matter was eventually taken to WHO with the expectation that an international code, satisfactory to all parties, could be developed. In May 1981, the International Code of Marketing of Breast Milk Substitutes, drafted by the WHO, UNICEF, several NGOs, and representatives from the food industry, was adopted. The code had originally been proposed as a regulation, which would have become binding on all member states once adopted by the World Health Assembly, but in final form it took on the quality of a recommendation and left to each country the choice of how to implement it. The WHO Executive Board, before presenting the code to the assembly, “agreed that the moral force of a unanimous recommendation could be such that it would be more persuasive than a regulation that had gained less than unanimous support.”

One hundred and eighteen nations voted to approve the code. The United States alone voted against it, with abstentions from Argentina, Japan, and Korea. Supporters of the code argued that the United States had capitulated to the lobbying pressures from the industry, and that its vote against the code should serve as a signal to the rest of the world that the United States would favor the protection of corporate profits above the health and welfare of children. Opponents of the code argued that its endorsement infringed upon trade and constituted an attempt at international regulation by WHO.

In 1996, support for the code was reaffirmed by 191 member states of the World Health Assembly. Its translation into national laws, however, has been relatively slow. In fact, a recent report by the Interagency Group on Breastfeeding Monitoring—a coalition of NGOs, churches, academic institutions, the British Medical Association, and leading international agencies such as UNICEF—demonstrated that 15 years after the adoption of the code, the marketing practices of the leading infant food industries had changed very little.

Action Program on Essential Drugs and Vaccines

The pharmaceutical industry eyed the infant formula debate warily, fearing it might be a prelude to increasing scrutiny of the health care field in general. WHO’s growing efforts in the realm of prescription drugs in the late 1970s and the early 1980s confirmed these fears.
WHO’s concept of essential drugs was developed in the 1970s in response to the scarcity of medicines in poor rural and urban areas, the proliferation of ineffective drugs, and the increasing expense of drugs. In the beginning, WHO’s activity in this area consisted of compiling a list of such drugs, but in 1981 the organization established its Action Program on Essential Drugs and Vaccines, which was designed to make recommendations on the exclusive use of generic names and the purchase and distribution of drugs, suggested the establishment of quality programs, and helped set guidelines for the design of national regulations.

The program was strengthened considerably by the financing contributions of several European states and by the participation of the growing international consumer movement. In 1981, various organizations, including the International Organization of Consumers’ Unions, Social Audit, OXFAM, and BUKO collaborated to form Health Action International (HM), whose goal was: “To further the safe, rational and economic use of Pharmaceuticals worldwide, to promote the full implementation of the WHO Action Program on Essential Drugs, and to look for non-drug solutions to the problems created by impure water and poor sanitation and nutrition.”

The coalition of multilateral agencies, European governments, and international consumer groups favored the implementation of national health programs on essential drugs in countries as diverse as Bangladesh, Democratic Yemen, Mexico, Mozambique, the Philippines, Sri Lanka, Vietnam, and Zimbabwe. The depth, emphasis, and results of these drug policies, however, were uneven at best and depended mostly on the different strengths and negotiating abilities of the local officials and nonprofit groups favoring reform, on the one hand, and the pharmaceutical industry on the other. Overall, centrally planned economies were more able to introduce comprehensive policies, while mixed economies implemented just a few aspects of the essential drug policies, often limited to the public sector.

Fight Against AIDS

The decline of the idea of the comprehensive approach to health threats coincided with the appearance of a disease that became the model of emerging infections: HIV-AIDS. Just when many health specialists were stating that infectious diseases were no longer a threat in the developed world, HIV-AIDS made its appearance in the United States in 1981.

Twenty years after the beginning of this devastating epidemic, the figures are daunting: 19 million people have died of HIV-AIDS, and before the end of 2000 the number of people living with HIV-AIDS reached 35 million. In Botswana, 35 percent of adults are infected with HIV, and in South Africa this figure has reached 20 percent, up from 13 percent just two years ago. In Latin America and the Caribbean there are 20 countries in which adult prevalence of the infection is above one percent, and in Eastern Europe there were more infections registered in 1999 than in all previous years together.

The initial response to the epidemic came too late. Thousands of people had to die, including a Hollywood star, and the group initially most affected by the epidemic, the gay community, had to build an enormous political infrastructure before the medical and research establishments, the funding agencies, and the media reacted, as Randy Shilts put it, “the way they should in a time of threat.”

Once prejudice was overcome and the magnitude of the threat was established, major international initiatives were put in place. In 1986 the First Global AIDS Strategy was formed. In 1987 WHO created its Special Program on AIDS, which became the Global Program on AIDS (GPA) a year later. In six years GPA was able to gather $700 million in support, making it the largest international health program ever established.

The major achievements of the GPA were that it raised awareness about the epidemic and its eventual spread, defended the rights of those afflicted with the disease, advanced the notion that AIDS policies should be driven by evidence and not morality or politics, and promoted the idea that AIDS policies in general should be implemented on the basis of persuasion and not enforcement.
In the late 1980s and early 1990s, HIV-AIDS figures began to rise in Africa, and the epidemic spread to Asia and Eastern and Central Europe. It was then that the health officials started to acknowledge that HIV-AIDS was a major development and security issue that demanded a comprehensive response. However, a body was needed that could coordinate the work of the different—and sometimes competing—UN agencies involved in the fight against this disease. An Inter-agency Advisory Group had been created since the inception of GPA in anticipation of such coordination problems. This group did not have sufficient authority, however, and never developed the ability to resolve conflicts or coordinate activity.

In May 1993, the World Health Assembly requested the Director-General of WHO to evaluate the establishment of a joint United Nations AIDS program (UNAIDS) to provide interagency coordination. This idea was eventually endorsed by the governing councils of a number of other UN agencies and led to the creation of UNAIDS on January 1, 1996. UNAIDS—which replaced GPA—was an attempt to draw on the experience of all UN agencies in combating HIV-AIDS. UNAIDS, composed of a Secretariat and six cosponsor agencies, has coordination, guidance, and advocacy functions and is charged with developing and implementing strategic anti-AIDS plans at the country level.

The story of AIDS is far from over. The disease continues to spread, despite the fact that we now have a better understanding of the dynamics of the epidemic, that there is acceptable international and national coordination, and that successful prevention campaigns have been implemented in most developed countries.

Potent new drug combinations called ‘AIDS cocktails” have enabled doctors to delay the onset of full-blown AIDS in individuals who have contracted HIV-AIDS, and they have alleviated the symptoms of thousands more. But the hope offered by these therapies is limited mainly to patients in the developed world, where the pharmaceutical companies that developed the drugs can charge exorbitant sums for them. The average annual cost for an AIDS cocktail in the West is about $15,000 per patient. This amount is unthinkable in the poorer countries of the world.

Developing nations like Brazil and Thailand have pioneered a new approach to dealing with the high cost of AIDS drugs—they produce generic versions of the drugs locally. Although the legality of such efforts is in doubt—Brazil, for example, is a signatory to international agreements requiring it to respect Western patents—the benefit to AIDS patients in poor countries is enormous. In February 2001, an Indian drug company, Cipla, offered to supply generic versions of the cocktails to the African anti-AIDS campaign of Medecins Sans Frontieres for $350 per patient per year.26

WHO has also been working to secure cheaper drugs for AIDS victims in poor countries. Last year, several major multinational drug makers, after talks with WHO, agreed to sell AIDS drugs to developing countries at heavily discounted rates—approximately $1,000 per patient per year. But getting the agreements has been a slow and tedious process, as they must be negotiated on a country-by-country basis. Today, only Rwanda, Senegal, and Uganda have agreements. Moves like Cipla’s may be just the impetus multinational corporations need to work faster to conclude more agreements with WHO.

The U.S. government has had a mixed record in this field. In August 2000, it offered South Africa and Namibia $1 billion in loans to purchase AIDS drugs, but the offer was rejected by governments not eager to plunge themselves into more debt. But in May 2000, President Clinton issued an executive order pledging that the U.S. government would not interfere with patent violations by African countries seeking to manufacture cheap AIDS drugs. Although many African countries lack the technology to take advantage of the executive order, Brazil has expressed its willingness to share its know-how with other developing nations.

Challenges Ahead

Despite considerable achievements, the international health regime has been under increasing fire since the 1990s. Critics declare that international health activities are disparate and often uncoordinated, that priorities follow donor preferences rather than rational evaluations of problems, and that there is a leadership vacuum in the field.
Part of these problems arises from the number of actors involved. In addition to WHO and its regional offices, the health care arena is crowded with a number of other specialized UN agencies and programs— including UNAIDS, UNICEF, the UN Food and Agriculture Organization (FAO), and the UN Educational, Scientific, and Cultural Organization (UNESCO)—as well as multilateral development banks, such as the World Bank. A variety of NGOs are also an influential group of actors in the health field. Finally, there are the multi-national corporations—such as pharmaceutical companies—responsible for the worldwide production of a large percentage of health-related goods and services.

These new international health actors have often proven unable to work together to achieve common goals and now must reinvent themselves to meet the challenges of the future. The agenda for reform includes issues like redefining mandates for multilateral agencies, setting priorities and tasks, redesigning governance structures, developing efficient coordination mechanisms, and adopting reliable means of accountability. Among these issues, one of the most controversial is the identification of priorities, which must be done before any of the other challenges can be tackled. At the moment, however, there is little consensus about what the essential functions of international health organizations should be. In fact, there seems to be a broad spectrum of views with respect to the scope of responsibility that international health agencies should assume in the coming years.

At one end of the spectrum we find what might be called the “essentialist” point of view, which identifies functions in which international organizations have a comparative advantage over national entities, because it is more cost-effective for these organizations to carry them out and because these functions fall outside the sovereignty of any one nation. There are two major functions that the essentialists want to make the permanent responsibility of international agencies: (i) the production of international public goods, including conducting research and development, compiling information and databases, setting norms and standards, and building consensus on health policy issues that can help mobilize political will within each country, and (ii) the management of international health threats, such as the spread of pathogens and microbial resistance to antibiotics and of environmentally related health problems.

At the other end of the spectrum are those who desire a broader, more activist role for international health organizations. Based primarily on arguments of social justice, proponents of this view want to redistribute resources from rich to poor countries, actively advocate certain national health policies, regulate transnational corporations, and intervene in planning or implementing national health projects.

In the middle are those who identify two general types of functions for international agencies: core and supportive. Core functions are basically those proposed by the essentialists, and supportive functions, seen as temporary obligations of the international community, include the protection of the dispossessed—especially in countries where state structures are weak—and the mobilization of resources such as knowledge and money to support countries with special developmental needs.

The health regime has changed dramatically in size and complexity in the 20th century and is again poised on the brink of reform. Whatever the shape of the next incarnation of the international health system, if it is to be successful, it will have to take into account the hard lessons learned through five decades of experience.

Lessons learned

The uneven record of international attempts to meet health challenges provides several key lessons about each stage of health care governance: agenda setting, negotiation, implementation, and reactions to noncompliance.
Agenda Setting

Donors have driven the international health agenda since the inception of the regime in the late 1800s. Issues important to developing countries have always been prominent, but their growing importance in the agenda has reflected the fears and concerns of the major interest groups of Western nations. For example, the international disease surveillance activities of the early 20th century were focused mainly on those tropical diseases that could represent a real threat to the security of European nations.

Humanitarian and developmental concerns are key components of the international health agenda, but economic, commercial, security, political, and ideological interests have also been important. Economic interests, for example, guided the international health activities of several countries and firms in the early 20th century. Frederick T. Gates, who would help found the Rockefeller medical philanthropies, stated in 1905, “Our export trade is growing by leaps and bounds. Such growth would have been utterly impossible but for the commercial conquest of foreign lands under the lead of missionary endeavor.” The conquest of these lands for Western commerce, in turn, would not have been possible were its exotic diseases not kept in check. Indeed, at a joint WHO/FAO meeting on tropical diseases in 1948, Alberto Missiroli made clear the relationship between the eradication of tropical diseases and the filling of Western coffers when he pointed out that, “Africa cannot be fully exploited because of the danger of flies and mosquitoes. If we can control them, the prosperity of Europe will be enhanced.”

During the Cold War, eradicating disease was no longer just a financial matter to Western governments—battling pathogens was akin to battling communism. At a 1950 Conference on Health Problems of Industries Operating in Tropical Countries, attended by representatives of 23 multinational corporations, the dean of Harvard University’s School of Public Health, James Simmons, declared:

Powerful Communist forces are at work in this country and throughout the world, taking advantage of sick and impoverished people, exploiting their discontent and hopelessness to undermine their political beliefs. Health is one of the safeguards against this propaganda. Health is not charity, it is not missionary work, it is not merely good business—it is sheer self-preservation for us and for the way of life which we regard as decent. Through health we can prove to ourselves and to the world, the wholesomeness and rightness of Democracy. Through health we can defeat the evil threat of Communism.

Multilateral agencies, however, have helped lessen the influence of donor governments and agencies by building up awareness of health issues in the developing world. This was the role of WHO in the promotion of primary health care, immunizations, and essential drugs, for example. It is an especially important role considering the low priority that health aid tends to have in the domestic political agenda of donor governments.

But the international health agencies can only do so much. For an issue to gain traction, it must attract the interest of a major donor—if an issue does not gain such support, or if it fails to maintain it, it falls by the wayside. However, when donor agencies, foundations, and private corporations are interested in an issue, such as children’s vaccination, efforts in that arena receive a major boost. Witness the March 1999 WHO-UNICEF meeting in Bellagio, Italy, to explore the creation of a new, major vaccination program, attended by leaders of the vaccine industry and representatives of bilateral aid agencies and major foundations, and strongly influenced by the recent creation of the Bill and Melinda Gates Children’s Vaccine Program.

NGOs have also become important actors. With increasing access to the media and electronic methods of communication, NGOs are able to introduce major issues in the international health agenda. In fact, the infant formula debate and the essential drug policy program are good examples of this, with open participation not only of consumer groups but also of industry associations. NGOs have been particularly vigorous in adding their voices and concerns to the debate over the shape of international health initiatives to deal with AIDS.

NGOs are not only participating in the debate over the international health agenda, they are actually providing the forums in which much of the most important discussion of health issues
take place. Two recent examples are the Conference on Health Reform in Latin America, convened by the Forum of the Civil Society of the Americas, and the People’s Health Assembly, coordinated by the Asian Community Health Action Network, Consumers International, Health Action International, the Dag Hammarskjold Foundation, the International People’s Council, and others. Some of these organizations have been active in the international scene since the early 1980s and have successfully participated in the design and implementation of several health initiatives.

Anybody that wishes to participate in the agenda-setting process can have no more powerful weapon at its disposal than science. States, international organizations, and NGOs have consistently used scientific knowledge as a key instrument to advance health initiatives. Progress in medical knowledge and technology in this century has been so impressive that since the early 1940s, the merest suggestion by technical experts and the scientific community of an issue’s importance is enough to place it on the agenda. In fact, practically each step in the progress of international health can be linked to a scientific and technological breakthrough. The yaws and malaria campaigns, for example, were triggered by the introduction of two new technologies: an injectable, single-dose, long-acting penicillin for the treatment of yaws; and DDT, an inexpensive insecticide for use against the malaria mosquito. New oral rehydration therapy quickly became the cornerstone of anti-diarrheal programs, and immunization-related initiatives such as EPI and the Task Force for Child Survival were given successive boosts by the biotechnology breakthroughs of the 1990s, which eventually gave birth to the CVI.

In fact, until development banks and economists arrived on the scene, the international health field was dominated by people who were trained in public health and medicine, which produced “an ethos that looked at global health problems as medical-technical issues to be resolved by the application of the healing arts.” Organizations like the Rockefeller Foundation, for example, have traditionally used scientific and academic leadership to rally the international health community around new initiatives. In 1997, 100 scientists and public health experts from all over the world, summoned by the heads of the U.S. National Institutes of Health and France’s Institut Pasteur, gathered in Dakar to kick off a new program to combat malaria in Africa.

For many, health problems can be seen essentially as technological challenges and not as problems that have strong behavioral, political, and economic components. Sometimes only those health challenges that seem to lend themselves to technical solutions are included on the agenda, and, in extreme cases, problems that demand strong political mobilization or broad societal interventions are actively excluded.

Negotiation

Donor countries and agencies have dominated the negotiation process in the health field, frequently disregarding local concerns, imposing their views and priorities on the recipients, and dictating how health initiatives are to be implemented. This is a clear reflection of the conviction in the 1950s and the 1960s that Western science, technology, and managerial abilities were sufficient to transform the developing world. This attitude is particularly ascendant in the broader policy initiatives in which donor interests are at stake and in programs designed to help the least developed countries where their dependence on external aid is so high that they are forced to accept any suggestion or condition.

However, the increasing number of actors in the health arena and the lessons of the past have helped even out somewhat the balance of power between donors and recipients, allowing more local control of international initiatives, thus increasing their legitimacy. The smallpox eradication campaign, for example, was considerably more attentive to local interests and views than was the malaria program, which was rigidly imposed from abroad and neglected the opinions and concerns of local officials, technicians, and communities. A recent example is the health system reform proposal in El Salvador to be financed by an Inter-American Development Bank (IADB) loan. The proposal was submitted to a consensus exercise as a result of the pressures generated by Congress and several professional and civil society groups, such as the Na-
tional College of Physicians and the Salvadoran Foundation for Economic and Social Development.

Finally, conflicting interests between donor and recipient and the diverse values of local interest groups have often demanded a certain degree of ambiguity in the negotiation process to reach formal acceptance by different national parties or interest groups. These ambiguities are carried through in conventions and agreements, which leave to local authorities the responsibilities of the form of implementation. The result is that important issues are never really resolved, locking participants in a constant process of negotiation and redefinition. WHO’s international code on the marketing of breast milk substitutes, for example, is widely violated (or creatively interpreted) and must be constantly monitored, supported, negotiated, and redefined at international and local levels.

Implementation and Compliance

The successful implementation of disease control or eradication programs has depended on a few factors: the local health infrastructure, local capacity to implement health initiatives, and the technology involved in the initiatives, especially the efficacy of the drug chosen for disease control. The international experiences with malaria and smallpox provide a valuable comparison. The malaria program failed for several reasons: drugs and pesticides were used inconsistently, thus encouraging the emergence of resistant mosquitoes and parasites; no new research was being done; national eradication programs did not have enough money or technical know-how; basic health care services were lacking; the program was run in a hierarchical manner; and socioeconomic conditions were too poor to sustain such a program. Since that initial failure, malaria has begun to be addressed as a social and economic issue, not just a health concern.

The Roll Back Malaria initiative, for example, assumes that malaria “flourishes in situations of social and environmental crisis, weak health systems and disadvantaged communities” and makes its control dependent on the integration of disease-specific interventions with “existing primary health care activities, and the strengthening of health care services in general.”

Although malaria eradication efforts hobble along, a thorough assessment of the lessons learned from their costly failure helped lead to the successful eradication of smallpox. The malaria program illustrated the need for flexibility and for the ability to implement a program using existing health services. It also demonstrated the importance of continued research and involving local communities in eradication programs. And it demonstrated that a careful analysis of the eradication potential of the disease and the efficacy of the treatment was required. For smallpox, such analysis demonstrated that it was easier to eradicate than malaria and that the available vaccine was effective and easy to apply in adverse field conditions. Finally, the malaria failure demonstrated that strong international commitment to cooperate toward a goal was required—an attitude that has been absent in more recent health initiatives.

Often, broad disease control initiatives require that smaller local or regional experiences demonstrate their effectiveness and feasibility. The supporters of the eradication of smallpox in the 1960s pointed to regional elimination experiences in Europe, North America, the Philippines, and some countries of Central America in the 1940s and 1950s. The elimination of malaria from Cyprus, Sardinia, and Venezuela served as a strong argument for the approval of the worldwide malaria eradication campaign. The strategy for global poliomyelitis eradication was built on the initial successes of pilot programs in the Americas in the 1990s.

Even when a program to combat infectious disease fulfills all of these requirements, it still may falter. Compliance with certain international regulations is problematic. For example, providing information on outbreaks, which is required by international law, can harm commerce and tourism. The cholera outbreak in Peru in the early 1990s, for example, cost the country $800 million in lost trade and tourism. Therefore, states have an incentive not to participate or support disease control programs.

Governments and localities cannot fight vicious diseases on their own, however. Just as it is necessary to get an item on the global health agenda, sustained interest and support by donor
countries and agencies are needed for successful implementation of global health initiatives, especially those that affect significant business and economic interests. We have already seen how the lack of U.S. support for the breast milk code has meant that manufacturers of baby formula have not changed their marketing practices in developing countries, even though a large number of countries have signed onto the code.

An important and creative example of how business and national interests have met in the health field is PAHO’s Revolving Fund. Participating Latin American and Caribbean countries contribute toward the fund, a common fund used to finance the bulk purchase of vaccines and immunization-related supplies. The increased purchasing power allows the participating countries to negotiate with pharmaceutical companies to obtain lower prices. Countries are also allowed to pay for the vaccines in local currency after they are delivered, thereby eliminating two major obstacles developing countries face in the international marketplace: the lack of hard currency and the need to pay in advance.

One of the main challenges to successful implementation of health initiatives is the proliferation of and lack of coordination among the myriad independent actors in the global health arena. In the early 1990s the number of organizations involved in international health assistance in the United States alone amounted to more than 400, and the number of NGOs in developing countries working to promote people’s health was estimated at around 20,000. In most African countries, ten to fifteen major external sources of health assistance deal regularly with local health authorities. These organizations often have competing or overlapping agendas, and the recipient country must spend considerable resources to satisfy all of them. “It’s a common experience,” says Richard Feachem, former director of health, nutrition, and population at the World Bank, “to go to ministries of health in smaller countries and see most of the talented people devoting their time to servicing the needs of the donors rather than developing the policies and health services for their country."

One of the most promising recent experiments in increasing coordination is the UNAIDS program, which provides the highest visibility for the challenge of AIDS and coordinates the activities of a plethora of actors. The other is the sectorwide approach. In Bangladesh, for example, a consortium of ten donors funds around one-third of the health ministry’s budget and coordinates the activities of more than 30 multilateral and bilateral organizations.49

Reactions to Noncompliance

International organizations have limited capacity to enforce or guarantee compliance with international agreements. Several mechanisms have been tried, including reporting, external monitoring, conditioned disbursements, and periodical evaluations, with variable results. International events, such as the World Summit for Children or AIDS World Day, are also used to encourage national health authorities to commit themselves to the attainment of precise health goals in a particular period of time (for example, they are challenged to attain a certain percentage of vaccination coverage, or a specific reduction in infant mortality rates or in the number of cases of a specific disease).

The situation is different when it comes to development banks and broad policy issues. A senior World Bank economist recently made the following comment:

Policy based lending is where the Bank really has power –I mean brute force. When countries really have their backs against the wall, they can be pushed into reforming things at a broad policy level that normally in the context of projects, they can’t. The health sector can be caught up in this issue of conditionality.50

In contrast to the power of the purse of development banks, WHO and the World Health Assembly are relatively powerless. Most of the World Health Assembly’s decisions are recommendations that are legally nonbinding. This position is consistent with the public health ethos that traditionally supports the idea that disease-prevention and health-promotion activities should
depend mostly on education and persuasion. Legal experts argue that international law in the field of health is nothing more than a loose moral code because it cannot be enforced.

However, the Framework Convention on Tobacco Control, on which negotiations began in October 2000, may mark WHO’s entry into regulation of a product. Tobacco policies enacted by the World Health Assembly will become binding under Article 19 of the WHO Constitution, which states that a measure accepted by two-thirds of the votes of the World Health Assembly shall come into force for each Member state. In other words, the World Health Assembly will finally use its long-dormant power to make law.

CONCLUSION

The twenty-first century promises to bring tremendous advances in world health, but it also promises to be an era fraught with challenges. Although new technologies and breakthroughs may allow us to cure once devastating diseases, new contagions and long-dormant ones will pose new threats. And as increasingly dynamic economies lead to increased life spans and greater consumption, rich people’s diseases will become all people’s diseases: obesity, diabetes, certain cancers, and heart disease will become equal-opportunity killers.

The international health care regime must be reformed if it is to cope adequately with the challenges and promise of the new century. The reform process will require input from all relevant actors: health care professionals, multinational institutions, donors, and recipients. It will require better means of ensuring compliance without trampling on the fragile sovereignty and national pride of developing nations, and it will require a recognition on the part of wealthy nations that poor health anywhere in the world affects us all.

Any successful reform effort should be grounded in a thorough examination of what came before. During the first half of the 20th century, regional and global health challenges were few and international health activities were limited and controlled by Western countries. In the second half of the century, however, the number of global challenges increased dramatically, as did the number of actors in the health field. The creation of WHO and the emergence of NGOs gave recipients a voice, helped their concerns become part of the international health agenda, and changed the way international initiatives were negotiated and implemented at local levels. In the next century, the challenges of setting an inclusive, well-defined agenda, of conducting effective negotiations that produce results, of ensuring international compliance with agreed-upon rules, and of developing means of enforcing those rules will remain paramount. They can be met, however, if we do not forget the lessons of the past, including the importance of:

- fostering local control of health initiatives;
- taking local capabilities and concerns into account during the agenda setting process;
- coupling responses to specific diseases with efforts to improve local health infrastructure and the socioeconomic conditions that foster disease;
- using regional programs to build momentum for broader initiatives;
- coordinating the work of NGOs and multinational health organizations;
- finding ways for recipients to pool their resources and work as equals with donors; and
- continuing research into new methods.

References

4 www.who.int/health-topics/tb.htm.