

DI.2 **The World Health Organization and the Commission on the Social Determinants of Health**

This chapter is written in the belief that it is worth aspiring to an accountable and effective multilateral global health agency, driven by a desire to promote health with the understanding that the distribution of health and health care is a core marker of social justice.

For many, the World Health Organization (WHO) is emblematic of an organisation designed to enable international cooperation in pursuit of a common public good. Its constitution, written in a different era, needs to be updated to reflect current realities, but it remains a good reminder of the aspirations that have been invested in it. Among the principles governing the WHO's constitution are:

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states.
- Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

The actual state of global health indicates a reality that is more brutal, cynical and unforgiving than the WHO's constitution suggests. But for many, the hopes and ideals reflected in the constitution are worth fighting for.

As an intergovernmental organisation, the WHO is also important because it has the mandate and opportunity to establish or influence laws,

regulations and guidelines that set the foundations for international and national health policy. It is the closest thing we have to a ministry of health at the global level. Given the degree and extent of globalisation, this calls for greater public interest in and scrutiny of the WHO. Support for the WHO also reflects support for the United Nations (UN) system. For all its often-reported structural and operational failings, the UN (including the WHO) does much good and is ultimately irreplaceable and vital to human security.

Since publication of the first *GHW*, there have been significant changes at the WHO, including the election of a new director-general following the sudden death of Director-General Dr Lee Jong-wook in May 2006. Regrettably, many of the challenges facing the WHO that were identified in the first *Global Health Watch* remain, and in some cases have become more acute. The WHO is still pushed and pulled by the tidal forces of international politics; it remains underfunded, and over-reliant on so-called 'public-private partnerships'; it faces a crowded global health arena; and internally, low morale among staff and the sclerotic nature of WHO bureaucracy are still problematic.

This chapter is not a comprehensive review of the WHO over the past three years. Rather it describes a selection of issues to illustrate the challenges facing the WHO. These include:

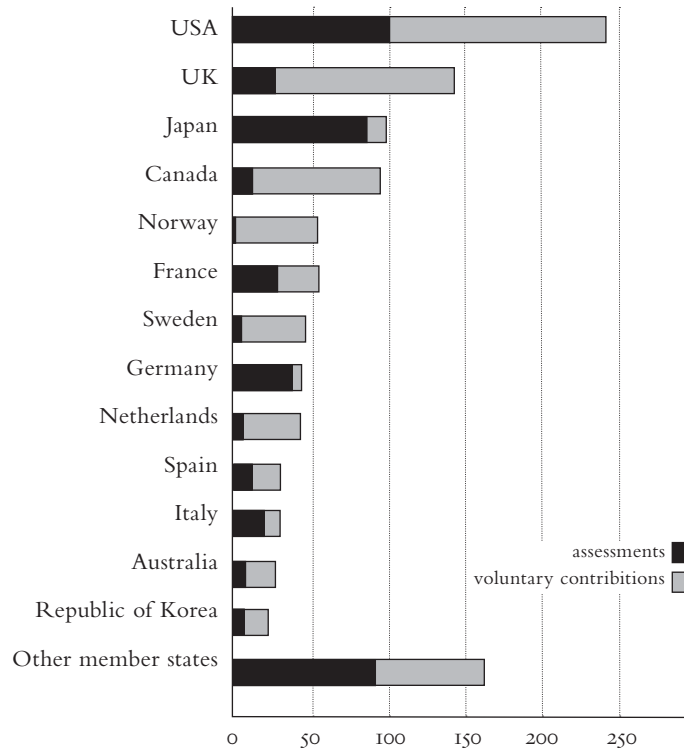
- the WHO's funding and budget for 2008/09;
- the highly contentious boundary between trade and health policy;
- international developments in global preparedness for a potential avian flu pandemic;
- progress made by the Commission on the Social Determinants of Health.

Underfunded, donor-driven and compromised?

Most of the WHO's funding comes from its member states. 'Assessed contributions' provided by member states (usually through ministries of health) form the basis for the WHO's regular budget funds (RBFs). The relative contribution of each state is calculated using a UN funding formula based on a country's population and size of economy. This results in a small number of countries providing most of the WHO's core budget. For example, the United States' assessed contribution is currently 22 per cent (it used to be 25 per cent but this was reduced following US requests). In contrast, Tuvalu contributes 0.001 per cent (WHO 2007a).

In addition to the assessed contributions, the WHO receives extra-budgetary funds (EBFs), in the form of grants or gifts. These are contributed

FIGURE DI.2.I Assessed and voluntary contributions from WHO member states in 2006



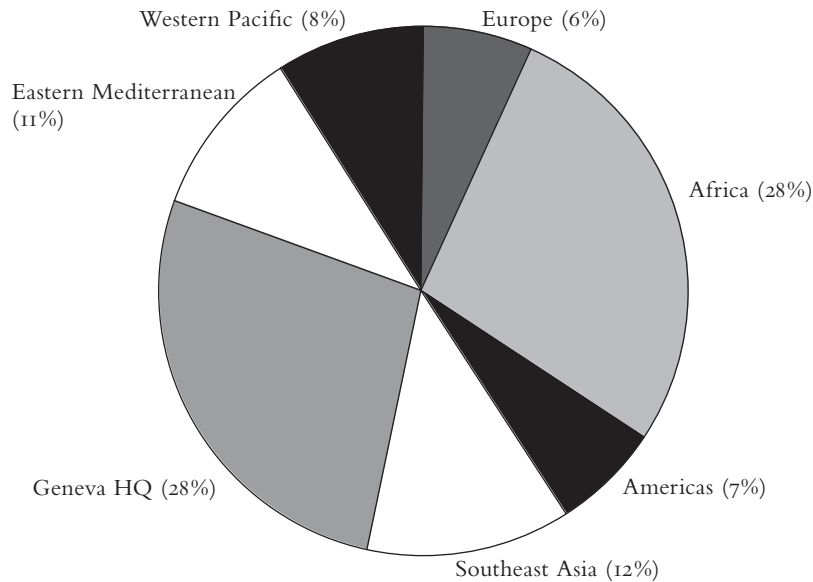
Source: WHO 2007c.

by member states (usually from their ODA budgets), other parts of the United Nations, foundations, non-governmental organisations (NGOs), charities and private companies.

The relative contribution of RBFs and EBFs has changed over time. In 1970, EBFs accounted for 20 per cent of total WHO expenditure, with over half these funds coming from other UN organisations (Lee 2008). EBFs exceeded RBFs for the first time in the 1990/91 biennium. Today, EBFs account for about three-quarters of the WHO's expenditure, most of which is sourced from member states (WHO 2007b). Unlike the RBFs, most of the voluntary contributions made to the WHO are tied to specific projects determined by the donors, although some donors provide EBFs that are not tied to specific projects.

The US was the largest contributor in terms of both assessed and voluntary contributions in 2006, followed by the UK, Japan, Canada, Norway,

FIGURE DI.2.2 Allocation of 2008/09 budget by region



Source: WHO 2007d.

France, Sweden, Germany and the Netherlands. The Gates Foundation provided voluntary contributions of \$99.4 million in 2006, which made it the third equal (with Japan) largest contributor of funding to the WHO (see Figure DI.2.1) (WHO 2007c).

The much greater reliance on EBFs reflects the preference of donors towards having greater control over the use of their money. In addition, it reflects a period of financial austerity imposed upon the UN as a whole. First, major donors introduced a policy of zero real growth in 1980 to the RBFs of all UN organisations. In part, this was a reaction to the perceived ‘politicisation’ of UN organisations, in particular UNESCO and the International Labour Organisation (ILO), but also to the WHO’s campaigns against irrational prescribing of medicines and breastmilk substitutes (Lee 2008). Then in 1993, a policy of zero nominal growth was introduced, reducing the WHO’s RBFs in real terms.

The WHO (and other UN organisations) have also had to contend with late or non-payment by member states. Non-payment by the United States has been particularly problematic. By 2001, the US had become the largest debtor to the UN, owing it US\$2 billion. Arrears to the WHO rose from around US\$20 million in 1996 to US\$35 million in 1999 (Lee 2008).

TABLE DI.2.1 **Budget for WHO strategic objectives, 2008/09**

Strategic aim	Budget		RBF	EBF
	(US\$ m)	(%)	(%)	(%)
1. Communicable diseases	894.043	21.1	9.5	90.5
2. HIV/AIDS, malaria and tuberculosis	706.932	16.7	6.9	93.1
3. Non-communicable disease, mental health, injuries and violence	158.104	3.7	28.6	71.4
4. Maternal and child health, sexual and reproductive health and healthy ageing	359.833	8.5	15.5	84.5
5. Emergencies, disasters and conflicts	218.413	5.2	8.1	91.9
6. Risk factors to health: alcohol, tobacco, other drugs, unhealthy diet, physical inactivity and unsafe sex	162.057	3.8	24.1	75.9
7. Social and economic determinants of health	65.905	1.6	21.9	78.1
8. Environmental health	130.456	3.1	25.1	74.9
9. Nutrition, food safety and food security	126.934	3.0	18.2	81.8
10. Health services	514.054	12.2	27.2	72.8
11. Medical products and technologies	134.033	3.2	23.3	76.7
12. Global health leadership	214.344	5.1	65.1	34.9
13. Organizational improvement of WHO	542.372	12.8	52.8	47.2
Total working budget	4,227.480	100.0	22.7	77.3

Source: WHO 2007e.

The problems associated with a heavy reliance on EBFs are fairly apparent. They include unhealthy competition among departments within the WHO and with NGOs and other organisations chasing donor funding, as well as limitations on the WHO's ability to plan, budget and implement its strategic aims coherently. Even projects authorised by World Health Assembly (WHA) resolutions are reliant on a chase for funding.

In theory, budget allocations are determined by the WHA and WHO Regional Committee meetings. In practice, they are set by the WHO Secretariat under the influence of donors and powerful member states. It is difficult to determine what conditions donors place on their funds and what impact this has on budget-setting by the secretariat.

The WHO's budget for the 2008/09 biennium, made up of both RBFs and EBFs, is US\$4.2 billion (WHO 2007d). This is an increase of 15 per

cent on its previous biennium. The Geneva headquarters is allocated \$1.18 billion (27.8 per cent), with the rest shared across the six regions. The Africa region receives the biggest proportion of regional funding – \$1.19 billion (see Figure D1.2.2) (WHO 2007d). Although the Western Pacific is the second largest region by population, its relatively small budget is related to the WHO's lack of presence in China.

The budget for 2008/09 is also subdivided into thirteen strategic objectives (see Table D1.2.1). What is striking about the budget is the reliance on EBFs and the high allocations to communicable diseases relative to food and nutrition; non-communicable disease; social and economic determinants of health; and environmental health.

Putting health first

With its dependence on EBFs, the WHO is particularly vulnerable to donor influence. Margaret Chan, director-general of the WHO, said that she will 'speak the truth to power', and certainly the WHO has resisted pressure from powerful interests in the past (quoted in Schuchman 2007). It did so, to some extent, when it helped establish the Framework Convention on Tobacco Control and the International Code on the marketing of breastmilk substitutes. On both occasions, civil society organisations and member state representatives also played a vital role in protecting the WHO from being bullied.

But on other occasions it has buckled under pressure. When the WHO recommended the lower consumption of free sugars and sugar-sweetened drinks, the sugar industry lashed out with a barrage of threatening letters, and appeals to the US government to intervene (which it did) (Simon 2005). By the time the WHO finalised its Global Strategy on Diet, Physical Activity and Health, it had been heavily watered down (Cannon 2004). As one WHO official noted: 'During discussions on the Global Strategy on diet, US representatives never made a mystery of the fact that they would not let WHO go beyond a sanitary, education-focused strategy' (quoted in Benkimoun 2006). Ongoing challenges to the public health responsibility and independence of the WHO are often played out in the arena of trade, as illustrated by the following recent stories.

Our man in Bangkok

Few people will have heard of William Aldis, but for a short period he was the WHO's top health adviser in Thailand. In January 2006, he published an article in the *Bangkok Post*, criticising a bilateral trade agreement that was being negotiated between the US and Thailand. Aldis was concerned

that the treaty would have negative consequences for Thailand's generic drug industry and on the cost of second and third-line HIV drugs (Aldis 2006). The US was furious. Its ambassador to the UN visited the then head of the WHO, Dr Lee, and followed this up with a letter. According to a staff member who read the letter, Lee was reminded of the need for the WHO to remain 'neutral and objective' over matters of trade (quoted in Williams 2006).

Aldis quickly found himself transferred to the WHO's New Delhi office. Although the WHO strongly denied that the decision was due to pressure from Washington, *The Lancet* was in no doubt about the real significance of Aldis's transfer: 'This action was a clear signal of US influence on WHO' (Benkimoun 2006).

The anecdote involving Aldis is part of a longer-running story of pressure from the US to prevent the WHO from taking a proactive, health-protecting stance with regard to trade negotiations and trade policy, even though the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS) have extensive and profound implications for health care across the world.

The WHO does have a unit dealing with trade and health. But it is small and underfunded. In 2006, the WHA passed Resolution 59.26 on international trade and health.¹ Although welcome at one level, the resolution was weak, vague and half-hearted.

Tripping up over TRIPS

Controversy followed the WHO back to Thailand in February 2007 when Margaret Chan visited the National Health Security Office in Bangkok. Much to the dismay of many, Chan praised the pharmaceuticals industry, promoted drug donation as a solution to the problem of poor access to medicines and suggested that the Thai government's recent issuing of three compulsory licences to import and/or produce locally generic copies of patented drugs for HIV/AIDS and heart disease was counterproductive. Chan is alleged to have said: 'I'd like to underline that we have to find a right balance for compulsory licensing. We can't be naive about this. There is no perfect solution for accessing drugs in both quality and quantity' (quoted in Third World Network 2007).

NGOs and Thai health officials were appalled. The president of AIDS Access Foundation summed up the general feeling: 'It's disappointing. The [WHO] should have supported drug access and promoted the study of quality and inexpensive drugs for the sake of the global population rather than supporting pharmaceutical giants' (Treerutkuarkul 2007). A worldwide petition followed. Chan later wrote to the Thai minister of public health

stating her deep regret that her comments had been ‘misrepresented’ in the Thai press, and for any embarrassment that this may have caused.

Censorship and the even more slippery slope of self-censorship

Conflicts between public health and commerce are nothing new. But it is important that such conflicts are played out in the open, particularly when they involve the WHO. In 2006, acting head of WHO Anders Nordstrom should have informed senior WHO staff of US opposition to a report co-written by a member of WHO staff and jointly published with the South Centre. He didn't. The report was shelved, and senior staff only found out about US complaints from a leaked memo. The publication, *The Use of Flexibilities in TRIPS by Developing Countries: Can They Promote Access to Medicines?*, had been critical of US interpretation of the WTO's TRIPS agreement. The perception was that the top brass at the WHO had bowed to US pressure (IPW 2006).

The US subsequently demanded a full review of the WHO's publication policy. At the January 2008 Executive Board meeting, it was proposed that all publications by the WHO should be subject to review and clearance by a Guidelines Review Committee and that sensitive publications should be cleared by the director-general herself. When several developing-country delegations raised concerns that the proposals were too ‘centralised’ and could result in external censorship, Margaret Chan gave the following reassurance: ‘in no situation during my tenure will I compromise editorial independence don't worry I can stand the political pressure – it is our duty to guard publications based on science and that are peer reviewed’ (Tayob 2008).

Partnerships or the privatisation of international health policy?

During the leadership of Director-General Brundtland, partnerships with the private sector became a prominent feature of the WHO. According to David Nabarro, Brundtland's senior adviser,

We certainly needed private financing. For the past decades, governments' financial contributions have dwindled. The main sources of funding are the private sector and the financial markets. And since the American economy is the world's richest, we must make the WHO attractive to the United States and the financial markets. (quoted in Motchane 2002)

The argument goes that if a financially dependent public institution such as the WHO enters into a partnership with a wealthy partner such as a major multinational, the latter will set the agenda and the former will become its stooge. The WHO is particularly sensitive to this charge. If the

WHO is perceived to have been hijacked by the private corporate sector, it will lose its authority as an impartial norm-setter on global health issues.

Has the WHO compromised itself through its partnership with the private sector? It is hard to say. But there are certainly reasons for concern. In June 2006, the WHO became embroiled in controversy again when its director of mental health and substance abuse, Benedetto Saraceno, suggested to the head of the European Parkinson's Disease Association (EPDA) that EPDA accept a donation of \$100,000 from GlaxoSmithKline on WHO's behalf (Day 2007). In an email, Saraceno wrote:

WHO cannot receive funds from the pharmaceuticals industry. Our legal office will reject the donation. WHO can only receive funds from government agencies, NGOs, foundations and scientific institutions or professional organisations. Therefore, I suggest that this money should be given to EPDA, and eventually EPDA can send the funds to WHO which will give an invoice (and acknowledge contribution) to EPDA, but not to GSK. (quoted in Day 2007)

Although Saraceno explained that his email had been 'clumsily worded', the incident demonstrates a likely side effect of the WHO's funding arrangements and the need to clarify the WHO's protocol for engaging in relationships with the private sector. There has not been a comprehensive review of WHO-private sector relations since the publication of the WHO's *Guidelines on Interaction with Commercial Enterprises to Achieve Health Outcomes* seven years ago. A report (Richter 2004) on the WHO and the private sector, which called for a public review and debate on the benefits, risks and costs of public-private interactions in health when compared to alternatives, fell on deaf ears. Half a decade on, civil society should renew pressure on the WHO to take a fresh look at WHO-corporate relationships.

The avian flu vaccine controversy

The prospect of a global flu pandemic is the subject of intense discussion and fear. World attention was further focused when the Indonesian Health Ministry announced in early 2007 that it would no longer provide avian flu viral material to the WHO's 'Global Influenza Surveillance Network' (GISN) for the purposes of assisting with surveillance and vaccine development.

The GISN is made up of the WHO, four Collaborating Centres (WHO CCs) based in Australia, Japan, the United Kingdom and the United States, and about nine WHO H₅ Reference Laboratories.² GISN's work and outputs rely on viruses being submitted every year by various country-based National Influenza Centres (NICs).

The Indonesian government discovered that avian flu viral material that it had voluntarily submitted to the GISN ended up in the hands of

pharmaceuticals companies for vaccine development, without its permission. This was contrary to WHO guidelines, which state that any further distribution of viruses beyond the WHO reference laboratories must require the permission of the originating country (WHO 2005, 2006).

When the WHO was taken to task about the breach of its own guidelines, the guidelines were removed from the WHO website. The WHO then proposed a new document³ describing best practices for sharing influenza viruses and viral sequence data. This latest offering contradicted the Convention of Biological Diversity (CBD) principle, which holds that countries have national sovereignty over their biological resources and should derive a fair share of the benefits arising from the use of them.

There has been a dramatic increase in the number of patent applications covering the influenza virus (or parts of it), as well as for actual vaccines, treatments and diagnostics, in recent years (Hammond 2007). The discovery that patents had been sought on modified versions of other viral material (and its use in vaccines) shared through GISN without the consent of the supplying countries reinforced the perception that the GISN is part of a system that begins with the free sharing of viral material, which goes through the WHO, then through public laboratories, and finally ends up with private pharmaceuticals companies having a monopoly over the end product.

The system results in a clear set of winners and losers. Commercial vaccine developers have already obtained many millions of dollars' worth of contracts from developed countries to supply vaccines, in addition to grants and subsidies for their R&D activities. Populations in developed countries have a better chance of being protected from a flu pandemic, although the taxpayer is probably paying an extremely high premium to keep the commercial companies well in profit.

Developing countries, particularly those most likely to be badly affected, face potentially astronomical bills for the purchase of vaccines and other medical supplies. As drug companies can produce only a limited amount of vaccines in a given year, many developed countries have made advance purchase orders for vaccines, limiting even further the prospects of countries like Indonesia benefiting from vaccine development (Fedson 2003).

These and related issues were raised by Indonesia, together with the support of more than twenty other developing countries, at the 2007 WHA, culminating in a resolution that sets out a series of proposals to achieve both 'the timely sharing of viruses and specimens' and the promotion of 'transparent, fair and equitable sharing of the benefits arising from the generation of information, diagnostics, medicines, vaccines and other technologies' (WHA 2007f). The resolution also recognises the sovereign right

of states over their biological resources and the right to fair and equitable sharing of benefits arising from the use of the viruses.

At the intergovernmental meeting convened in November 2007, tensions resurfaced. Indonesia reiterated the need for developing countries to have trust in a multilateral system that did not undermine their sovereign rights over biological resources (based on the CBD), nor disadvantage the health of people living in poor countries. Developed countries in turn argued that the stance taken by Indonesia was jeopardising global health security and violated the WHO's International Health Regulations (IHR), which was designed to ensure international compliance with a set of public health standards and practices aimed at preventing and mitigating global health risks. Presently, the IHR does not expressly require the sharing of biological samples (Fidler 2007). It has been suggested that even though Indonesia is not in contravention of the letter of the law, its stance is in violation of the spirit of the IHR. However, the primary sticking point is the lack of a mechanism to ensure equitable access to vaccines and technologies in preparation and in the event of a global flu pandemic.

This incident succinctly illustrates the fundamental conflict between a patent-based system of commercial vaccine production and the WHO's mission to promote and protect health worldwide. Having failed to manage properly the practices of actors within the GHSN, the WHO now has the opportunity to demonstrate its value and worth both as a technical agency and as a moral arbiter on international health policymaking.

The Commission on the Social Determinants of Health

When the WHO's Commission on Macroeconomics and Health (CMH) reported in 2001, many public health activists criticised the way that health care had been portrayed in a purely instrumental way as a requirement for economic development. The notion of health as a human right and the economic and political determinants of poor health and under-resourced health systems were largely ignored.

Thus when the WHO launched the Commission on the Social Determinants of Health (the Commission) in May 2005, many people hoped this would mark the beginning of a new programme of work that would engage with the fundamental economic, political and social determinants of health, complementing the WHO's existing focus on diseases and health services.

Michael Marmot, a British epidemiologist known for studying health inequalities, chairs the Commission. There are eighteen other commissioners, including the Nobel prizewinning economist Amartya Sen. Nine Commissioners come from rich countries, but twelve live in them. Four come

from Africa, two from Asia, and one from Latin America. As a group, the commissioners represent a broad spectrum of views, ranging from a former senior US administration official with impeccable Republican credentials, to individuals with progressive credentials such as Pascoal Mocumbi (former prime minister of Mozambique), Giovanni Berlinguer (Italian member of the European Parliament), Monique Begin (former Canadian minister of health) and Fran Baum (People's Health Movement).

The Commission consists of five workstreams (Irwin et al. 2006):

1. Nine *knowledge networks* (KNs) to inform policy proposals and action on the following topics: early childhood development; globalisation; health systems; urban settings; women and gender equity; social exclusion; employment conditions; priority public health conditions; measurement and evidence.
2. *Country-based workstreams*, involving more than ten countries at the time of writing.
3. Engagement with *civil society*, involving the inclusion of civil society representatives on the Commission and formal consultations with civil society groups.
4. Engagement with *key global actors and initiatives*.
5. *Institutional change* at WHO to advance the work of the Commission after it ends. This has mainly involved the creation of a separate KN and engagement with the regional WHO offices, of which only the Pan American Health Organization (PAHO) seems to be taking the Commission's work seriously. As for institutional change in Geneva, several hurdles appear in the way of overcoming the disproportionate influence of clinically oriented disease-based programmes that do not readily view health through a broader social and political lens.

The conceptual framework for the Commission's work is based on an understanding that ill-health and unequal health outcomes are produced through a chain of causation that starts from the underlying social stratification of societies and that interventions can be aimed at: decreasing stratification by, for example, redistributing wealth; decreasing exposure to factors that threaten health; reducing the vulnerability of people to health-damaging conditions; strengthening the community and individual level factors which promote resilience; and providing accessible, equitable and effective health care.

Representatives of civil society have attended all but one Commission meeting and made presentations to the commissioners. They have participated in the KNs and fed into the thinking of the Commission. Civil society groups have been contracted to conduct consultations in each

region of the world although there have been questions about the extent to which this engagement is real or token, and about the lack of administrative support and funding to support this work.

At this stage it is only possible to provide an interim and partial assessment of the Commission's work. In July 2007, the Commission released an Interim Statement. Among other things, it explicitly promoted health as a human right and with intrinsic value. It stressed the importance of fairness and equity, gender, and the value of social movements in achieving change. And it provided strong support for the principles of the Comprehensive Primary Health Care (PHC) Approach, calling for 'a global movement for change to improve global health and reduce health inequity'.

Compared to many recent WHO reports, the Interim Statement is much more strongly committed to equity. It doesn't explicitly criticise neoliberalism, but provides a strong voice for action to reduce inequities and goes beyond poverty reduction to consider issues of trade imbalance and net outflows from poor to rich countries. However, it was disappointing that the Interim Statement failed to draw lessons that have contemporary significance from historical analyses of population health improvement in Europe that identify, for example, the role of wealth accumulation through colonial exploitation and the agricultural and industrial revolutions, and later social reforms enacted by the state following bitter struggles by the urban poor. The final report of the CSDH, launched in August 2008 (CSDH 2008), will be important as it sets out an agenda for action on the social determinants of health and establishes the pursuit of health equity as a crucial matter of social justice.

Prospects for the future

The Commission has an opportunity to make a significant and lasting impact on the future performance of the WHO, as well as upon the broader health policy landscape. But to do this, it must resist the pressures to produce a weak, consensus report that is acceptable to all players. It must stay true to its intellectual idealism and challenge the climate of cynicism about what multilateral institutions can achieve.

Thus far, the Commission appears not powerful enough to have much influence on the major players in global health, especially given the neoliberal perspectives of some actors, and the widespread support for vertical, top-down, disease-based programmes by other actors. Pressure from civil society will be required to ensure that the progressive aspects of the Interim Statement are retained in the final report.

A crucial determinant of the Commission's impact will be whether its central messages are adopted, supported and championed by the WHO.

Dr Chan will be pivotal. She must give full support to the Commission's report through her personal endorsement and the commitment of resources to enable implementation of the recommendations. At the time of writing, the WHO seems to be adopting a wait-and-see approach. Global Health Watch must monitor the extent to which the WHO takes up the strong social justice message of the report and whether it puts bold action on the social determinants of health equity at the centre of its operations.

However, there was considerable anger at the failure of Dr Chan to support and budget for ongoing work at the 2007 World Health Assembly. Thailand's senior health official Dr Suwit Wibulpolprasert insisted that a reference to social determinants be reinserted into the WHO's budget document to indicate that the Organization will take the goals of the CSDH seriously.⁴ The Commission will now report to the World Health Assembly in May 2009.

Conclusions

This chapter has placed the WHO under the spotlight. It is intended to make uncomfortable reading.

The WHO's funding situation is unacceptable. Instead of being funded as a democratic UN agency, it is in danger of becoming an instrument to serve donor interests and yield 'quick gains' even if this may not serve the WHO's overall strategic goals. The imbalance between EBFs and RBFs must be corrected. Civil society organisations, thus far, have failed to take this up as an issue. But in the meantime, the WHO should exert stronger independence, resist the influence of donors, and demand greater support for its own strategic plan and programmes.

While the need for 'better funding' is obvious, does the WHO need 'more funding'? By common consensus, it does. The increase in the WHO's 2008/09 budget is therefore cause for optimism. But the WHO needs to do more to improve its administrative and management performance, and a good place to start would be for its regional offices – particularly in Africa – to demonstrate their value more than they currently do.

The WHO also needs to reappraise its purpose, roles, responsibilities, budget allocations and workplan, especially in light of the changing global health landscape. The emergence over the last twenty years of other actors, notably the World Bank, the Gates Foundation, GAVI and the Global Fund, as well as the public-private partnerships paradigm, has left the WHO often following an agenda, rather than setting it.

The WHO must 'speak the truth to power', as its director-general promises it will. But that means standing up to powerful industries and

being more prepared to speak out against its most powerful member state. Critically, the WHO must define a stronger role for itself in the trade arena, particularly in the face of worldwide economic liberalisation and growing corporate power. Too often, social aims and objectives are treated as secondary concerns when it comes to the way the global political economy is shaped and governed. Often, the needs and priorities of the poor are neglected in favour of those of the rich. The application of basic public health principles at the global level provides some form of protection against these trends. But the WHO needs to assert itself as the guardian of international public health. But in doing so, it must not be forced into a limited role of monitoring and controlling communicable diseases within a narrowly defined health security agenda.

Some will say that as a multilateral organisation, governed by its member states, the WHO will always be held hostage to international politics. This is true. But it is equally true that significant improvements in global health and a concurrent reduction in the gross disparities in health and access to care will only be achieved through political negotiation and international diplomacy. This should place the WHO at the centre of the stage, not as a peripheral player.

Change is possible. But for this to happen, civil society organisations must also come together around a coordinated plan to strengthen the ability of the WHO to fulfil its mandate and to act as an organisation of the people as well as of governments.

Notes

1. See www.who.int/gb/ebwha/pdf_files/WHA59-REC1/e/Resolutions-en.pdf.
2. See www.who.int/csr/disease/influenza/surveillance/en/and www.who.int/csr/disease/avian_influenza/guidelines/referencelabs/en/.
3. A60/INF.DOC./1 dated 22 March 2007.
4. See www.twinside.org.sg/title2/avian.flu/news.stories/afns.008.htm.

References

- Aldis, W. (2006). Opinion: It could be a matter of life or death. *Bangkok Post*, 9 January. Available at: www.bilaterals.org/article.php?id_article=5072.
- Benkimoun, P. (2006). How Lee Jong-wook changed WHO. *The Lancet* 367: 1806–8.
- Cannon, G. (2004). Why the Bush administration and the global sugar industry are determined to demolish the 2004 WHO global strategy on diet, physical activity and health. *Pub Health Nutr* 7: 369–80.
- CSDH (Commission on the Social Determinants of Health) (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: WHO.
- Day, M. (2007). Who's funding WHO? *British Medical Journal* 334: 338–40.

- Fedson, D.S. (2003). Pandemic influenza and the global vaccine supply. *Clin Infect Dis* 36: 1552–61.
- Fidler, D. (2007). Influenza virus samples: International law, and global health diplomacy. *Emerging Infectious Diseases* 14(1): 88–94.
- Hammond, E. (2007). 'Some intellectual property issues related to H5N1 influenza viruses, research and vaccines. www.twinside.org.sg/avian.flu_papers.htm.
- Intellectual Property Watch (IPW) (2006). Internal memo suggests shift in WHO handling of US criticism. 10 November.
- Irwin, A., et al. (2006). The Commission on Social Determinants of Health: Tackling the social roots of health inequities. *PLoS Med* 3(6). <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10%2E1371%2Fjournal%2Epmed%2E003106&ct=1>.
- Lee, K. (2008). *The World Health Organization*. London: Routledge.
- Motchane, J.L. (2002). Health for all or riches for some: WHO's responsible? *Le Monde Diplomatique*, July.
- Richter, J. (2004). Public–private partnerships and health for all: How can WHO safeguard public interests? GASPP Policy Brief. <http://gaspp.stakes.fi/NR/rdonlyres/8F169CDC-9A01-4C20-B9B6-4FDF272F00E7/0/policybrief5.pdf>.
- Schuchman, M. (2007). Improving Global Health – Margaret Chan at the WHO. *New England Journal of Medicine* 356(7): 653–6.
- Simon, M. (2005). Bush supersedes effort to weaken the World Health Organization. *International Journal of Health Services* 35(2): 405–7.
- Tayob, R. (2008). WHO publications will come under committee review. SUNS 6402, 29 January. Geneva. www.twinside.org.sg/title2/intellectual_property/info.service/2008/twn.ipr.info.080103.htm.
- Treerutkuarkul, A. (2007). WHO raps Compulsory Licence plan: Government urged to seek talks with drug firms. *Bangkok Post*, 2 February.
- TWN (Third World Network) (2007). 'WHO DG's shocking views on compulsory licensing criticised by health movements', 13 February. www.twinside.org.sg/title2/intellectual_property/info.service/twn.ipr.info.020706.htm.
- WHO (2005). Guidance for the timely sharing of influenza viruses/specimens with potential to cause human influenza pandemics. Geneva. www.sdnpsd.org/sdi/issues/health/birdflue/other/timelysharing.pdf.
- WHO (2006). Procedures for obtaining release of H5N1 sequences to the public domain. Geneva. www.who.int/csr/disease/avian_influenza/guidelines/h5n1sequences2006_08_23/en/print.html.
- WHO (2007a). Scale of assessments 2008–2009. WHA60.5. Geneva.
- WHO (2007b). *Working for health: An introduction to the World Health Organization*. Geneva. www.who.int/about/brochure_en.pdf.
- WHO (2007c). Unaudited interim financial report for the year 2006. Annex: extra-budgetary resources for programme activities A60/30 Add.1. Geneva.
- WHO (2007d). *Proposed programme budget 2008–2009*. Geneva. www.who.int/gb/ebwha/pdf_files/MTSP-PPB/en_mtspp_p5.pdf.
- WHO (2007e). Appropriation resolution for the financial period 2008–2009. WHA60.12. Geneva. www.who.int/gb/ebwha/pdf_files/WHA60/A60_R12-en.pdf.
- WHO (2007f). WHA Resolution 60.28 'Pandemic Influenza Preparedness: Sharing of influenza viruses and access to vaccines and other benefits'. Geneva. 23 May. www.who.int/gb/ebwha/pdf_files/WHA60/A60_R28-en.pdf.