THE POLITICS AND PROTEST WORKSHOP: NOTE

This paper relies on materials and arguments from a larger book project, but is intended to be a stand-alone article. In the book I look at how the World Health Organization (WHO) responded to developing countries' call for a New International Economic Order in the 1970s and compare it to the WHO's response to the spread of US-led neoliberalism in the 1990s. In the paper I introduce the general argument of the book (WHO's "strategic adaptation" to exogenous pressures) and illustrate the argument by looking at the 1990s.

This is still very much a work-in-progress and I would appreciate any substantive (but also organizational) recommendations. I apologize in advance for the length of the paper but hope you'd find the empirical materials interesting!

Thanks much for reading the paper and I'm looking forward for the workshop!

Nitsan

Neutralizing Neoliberalism at the World Health Organization

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-- DRAFT. PLEASE DO NOT CITE --

Abstract. This paper analyzes the conditions for the spread of neoliberalism at the international level by examining the far-reaching policy transformations at the World Health Organization (WHO) that started in the 1990s. Common arguments on the spread of neoliberalism, across both nation-states and international organizations, emphasize the role of exogenous pressures and suggest that governments and international organizations had no choice but to passively embrace neoliberal formulas imposed from above. In contrast, this paper shows that the WHO responded to exogenous pressures by *adapting* to them, albeit *strategically*. The WHO actively incorporated itself into the new order by "translating" the exogenous logic into policies and programs that were relatively compatible with WHO's material interests and core principles. By manipulating the exogenous formulas, the WHO has authored its own neoliberal version, which has also helped transform the neoliberal logic overall.

INTRODUCTION

The ongoing global financial crisis and current attempts to save the neoliberal political-economic system from itself have attracted renewed attention to the institutional arrangements and policies that have maintained and reproduced neoliberal reasoning. When investigating the spread of neoliberalism at the domestic level, especially in the developing world, much has been said about the role of international organizations – particularly, the World Bank, the International Monetary Fund (IMF) and the General Agreement on Tariffs and Trade / World Trade Organization (GATT/WTO) – in forcing poor countries into compliance with the new world order. But what are the origins of neoliberalism at the international level? Much less attention has been paid to the spread of neoliberal economic thinking across international organizations (IOs), particularly international organizations other than the three just mentioned.

In this paper, I look at one United Nations (UN) specialized agency, the World Health Organization (WHO), to explore the origins of the current neoliberal orientation at the international level. Back in the 1970s, the WHO advocated principles, such as primary health care and basic health needs, which were concerned with equity, and followed a redistributive logic. Since the 1990s, in contrast, the WHO has embraced economic reasoning, prioritized cost-effective programs, and accepted market-driven solutions and business-friendly arrangements. I argue that this transition from "equity" to "efficiency" was in response to the rise of neoliberal reasoning in the United States and elsewhere. In contrast to the conventional argument, however, which views neoliberalism as an exogenous imposition that targeted parties were forced to passively accept, I show that the WHO responded to exogenous neoliberal pressures by *adapting* to them

strategically. The WHO actively incorporated itself into the new order, but through a process of "translation" – in which the WHO constructed an agreeable "fit" between its programs and the external environment – the organization could still protect some of its material interests and core principles. By way of such strategic adaptation, the WHO has also contributed to the transformation of the neoliberal logic itself.

THE RISE AND IMPOSITION OF NEOLIBERALISM

The adoption of neoliberal economic theories as a dominant governing tool began in the United States, the United Kingdom, and Chile, was adopted in international organizations such as the World Bank and the IMF, and ultimately spread across the globe and was embraced by many other governments independently of their political inclinations or level of economic development (Harvey 2005, Babb 2009). Neoliberal policies are governed by a number of fundamental economic maxims, including a reliance on the efficiency of the market, suspicion at most governmental interventions (Harvey 2005: 2-3), and a tendency for conceptual reductionism of social wellbeing into economic development (Somers 2008). Economic policies based on neoliberal principles therefore supported budget cuts, tax reforms, trade liberalization, deregulation, and privatization. For the purpose of this paper, it is also important to consider the spread of neoliberal maxims into non-economic realms of governance, including health, through the imposition of economic logic on realms that had previously been relatively autonomous of it. Such neoliberal orientation led to policies that, for example, preferred market-driven solutions over governmental interventions, or that defined goals, listed priorities and measured success in pure economic terms.

What conditions led to the spread of neoliberal policies across states and international organizations? While some accounts on the rise of neoliberal economic policies give prominence to domestic factors,[1] the adoption of similar policies by a large number of countries led most scholars to focus, instead, on the role of shared exogenous factors (Simmons, Dobbin and Garrett 2006, Henisz, Zelner and Guillén 2005).

Early accounts that focused on common factors highlighted the weakened bargaining leverage of governments, as capital could now easily shift investments across states and therefore play-off one government against another in search for concessions (Sassen 1996, Ohmae 1995, Callinicos 2001, Gill and Law 1993). The neoliberal turn, according to these studies, was governments' response to structural pressures created by intensified inter-state competition over capital investment. Other accounts identified an emerging transnational capitalist class – containing multinational firms from across the globe, but clearly dominated by American capital – which was capable of forcing the reformulation of domestic and global policies to reflect its interests (Robinson and Harris 2000, Sklair 2000, van der Pijl 1998). But transnational corporations also relied on

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[1] See, for example, Pierson 1994, Valdés 1995, Harvey 2005, Krippner 2010, and Chorev 2007. Many of these accounts, however, analyze the rise of neoliberal economic policies in the United States, which not only adopted neoliberalism relatively early, but later became an active player in imposing such policies on others.

supportive governments to help them impose neoliberal policies on others, and scholars have documented the critical role of the US government in the spread of neoliberalism, especially in developing countries (Shaw 2000, Gowan 1999, Gowan 2003, McMichael 2000). It is in the case of developing countries that the mediating role of international organizations has been particularly consequential.[2] Using its vast influence on the World Bank and the IMF, the US government pressed these international financial institutions to force upon developing countries neoliberal economic reforms (Wade and Veneroso 1998, Babb 2009, Chorev and Babb 2009, *but see* Abdelal 2007).

A somewhat different stream in the literature documented how – in Latin America, Eastern Europe but also across international organizations – neoliberalism spread through intellectual and professional networks, particularly among economists. In Mexico, for example, the shift to neoliberal economic policy was influenced by the entry of US-trained economists into positions of influence in the government (Babb 2001). In Chile, the *Chicago Boys*, who had attended the University of Chicago for postgraduate studies, orchestrated a similar adoption of neoliberal policies , demonstrating a "remarkable case of ideological transfer" from the United States to Latin America (Silva 1996: 519; *see also* Dezalay and Garth 2002, Campbell 2009, Fourcade 2006). International organizations have been similarly influenced by US-trained experts who held highly-ranked positions in the organizations or served as influential advisors (Chwieroth 2008). As Harvey (2005: 54) summarizes: "The US research universities were and are training grounds for many foreigners who take what they learn back to their countries of origin… as well as into international institutions such as the IMF, the World Bank, and the UN."

There are important theoretical differences among these various arguments, but there are also two central premises they all share. First, all these accounts attribute the rise of neoliberalism to exogenous forces that use their economic dominance, political influence, or expertise to impose neoliberal principles on others. In particular, all these accounts heavily rely on the active role of Americans (the US government, US companies or US economists) in leading to the adoption of neoliberalism elsewhere. The possibility of imposition is central to narratives that focus on diffusion through economic or political means, and while the spread of neoliberalism through professional networks may not be considered coercive, it similarly implies a form of imposition, with policies traveling from the center to the periphery. The second common feature of these accounts is that the receivers of the new prescriptions often play an inactive and acquiescent role. The governments, international organizations, as well as the experts from the periphery who form part of a transnational network, are often viewed as passive recipients of neoliberal formulas developed in the United States and other core countries.

The case of the WHO certainly confirms the role of the US government, US companies, and US economists in spreading neoliberal maxims. International

[2] Intergovernmental organizations have the capacity to influence not only developing countries but developed countries as well, as demonstrated in the study of Abdelal (2007) on capital accounts liberalization across EU and OECD members.

organizations are particularly susceptible to exogenous pressures, and in the late 1980s and early 1990s, the US government managed to generate a major crisis in the entire UN system, which threatened the WHO's financial standing, its authority over health issues, and its legitimacy as a competent and trustworthy organization. To restore its position, the WHO needed to reform its ways in a manner compatible with external expectations, and it heavily relied on US experts and transformed its relations with US business in the process.

But the case of the WHO also questions the literature's second premise, that of passive embrace of exogenous pressures. While external pressures forced a change within the WHO, the contours of the subsequent changes can only be partly explained by the original demands. Rather, the WHO's experience shows that the diffusion of neoliberal policies involved, to a great extent, subjects' *manipulation* of those exogenous pressures.

The argument advanced here, which questions the ability of external imposition to serve as the sole explanation for the type of neoliberalism that emerged in different sites, is in line with the institutionalist literature on "divergence" in states' adoption of neoliberal policies. That literature has convincingly demonstrated the role of domestic institutions in shaping governments' response to exogenous neoliberal pressures and has successfully identified some of the domestic factors that lead to such divergence (Fourcade and Babb 2002, Prasad 2006, Guillén 2001). However, this literature does not take into account the conflict that is likely to emerge when domestic adaptations do not follow exogenous expectations, and it therefore fails to analyze the conditions and strategies that *enable* governments and international organizations to deviate from the original prescriptions. The purpose of my analysis here, in contrast, is to exactly identify the strategies that *minimize* this conflict and its potentially costly ramifications.

To understand the ability of international organizations to deviate from exogenous formulations without leading to overt conflicts, I draw on Christine Oliver's (1991) work on organizations' strategic response to institutional pressures (see also Pfeffer and Salancik 1978) and on a subsequent body of constructivist scholarship that has recently began to explore how international organizations respond to their environment.[3] In this literature, a number of plausible strategies available to international organizations have been explored, including: acquiescence, compromise, avoidance, defiance, manipulation, and strategic social construction (Barnett and Coleman 2005). Subsequent literature has focused largely on the strategy of avoidance, or what Weaver (2008) calls organizational hypocrisy. Barnett and Coleman (2005: 601) define avoidance as "adopting the myths and symbols of the international environment, [while] continu[ing] business as usual," which closely echoes the sociological categories of "ceremonial conformity" and "loose coupling" (Babb 2009: 34, and see Meyer and Rowan 1977). Significantly, this literature takes into consideration the risk of conflict (hence, the need for compromises, avoidance

[3] One central contribution of this constructivist view is that it grants international organizations agency, which most international relations schools of thought do not. It is only once an international organization is recognized as an actor, that we can start identifying its preferences and its strategies for achieving them.

strategies and so on). Moreover, the list of available strategies suggests a crucial move away from a dichotomy between successful imposition (acquiescence) versus failed imposition (avoidance, defiance). I will argue that in order to understand the nature of neoliberal policies as they were adopted by the World Health Organization we need to move beyond the common categories of compliance or capitulation, on the one hand, and defiance (by way of covert resistance) or decoupling (by overt "duping" of the external forces, as is the case with avoidance), on the other, and instead analyze the means by which the organization's response to exogenous pressures entailed the adoption of policies that did not completely adhere to external formulations, yet did not entirely avoid significant changes.

Concretely, I suggest that the WHO, but also other international organizations and national governments, responded to exogenous neoliberal pressures by *adapting* to them, albeit *strategically*. By *strategic* adaptation I refer to a type of adaptation that alleviates exogenous pressures and appeases those external forces demanding change by *adhering* to the new exogenous logic, *but in a way that allows the international organization to maintain some of its material interests and core principles*. I argue that this is achieved by "translating" exogenous demands into policies that are attuned to the organization's needs and orientation, while at the same time being able to convincingly maintain that such translation is compatible with the original expectations and demands.

Strategic adaptation involves three analytically distinguishable phases. When confronted with new exogenous pressures, an international organization looks for and develops *proactive strategies of incorporation* into the exogenous order. This proactive incorporation involves *creative compliance*, whereby the organization translates its interests into a language that can be accepted by the environment and/or translates the exogenous logic into statements, principles and programs that are compatible with the organization's interests. Such manipulations do *not* prevent real changes and significant sacrifices, but they enable the organization to protect some of its material interests and ideational positions. It may also potentially lead to *reverse imposition,* that is, to corresponding changes in the environment.

Proactive incorporation. For international organizations like the WHO to function properly, they have to attain sufficient financial resources from their member-states, they need to ensure that a majority of member-state representatives vote in favor of suggested plans and programs, and they need to maintain legitimate authority (Barnett and Finnemore 1999, Babb 2009, Barnett and Coleman 2005, Weaver 2009). To protect their resources, votes and legitimacy, international organizations need to respond effectively to exogenous pressures coming from member-states. This is particularly the case where these pressures come from rich countries, which contribute most of the funds and have great influence over the voting of other member states as well (Babb 2009). But international organizations take "authorship" over their response to others' demands. When in the 1980s and the 1990s the US government put pressure on the WHO by reducing its funds, questioning its legitimacy and undermining its authority, the WHO responded by proactively incorporating itself into the new hegemonic order. Drawing on Gramsci's notion of hegemony (1971), we see that rather than resist and risk coercive

measures against it, the WHO willingly incorporated itself into the historic bloc. Although such acts of incorporation are inherently defensive – necessary to avoid or overcome a crisis – they prevent a view of the WHO as a victim of exogenous impositions. They also prevent a view of the WHO as a passive recipient of concessions. Rather, proactive incorporation suggests active participation, and it is a condition for the possibility of *creative* adaptation.

Creative adaptation. In the process of proactive incorporation, organizations formulate policies and initiate activities that would allow them to be successfully accepted into the exogenous environment while maintaining, as much as possible, their material interests and core principles. In the case of the WHO, material interests included expanded funds for the organization but also expanded funds for global health more generally. The WHO's core principles are derived from its Constitution (that overlaps with the professional ethos of WHO staff who are often public health experts) and emphasize the quality of health care and equitable access to health care both within and across countries. According to the WHO Constitution, the objective of the organization is "the attainment by all peoples of the highest possible level of health." The Constitution also declares that, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition," and that, "Unequal development in different countries in the promotion of health… is a common danger." As we will see, there was a potential conflict between the WHO's material interests and core principles and the exogenous neoliberal prescriptions. It is due to this conflict that the WHO has not just simply implemented such prescriptions. Instead, proactive incorporation entailed a creative *fitting* of the organization's goals, claims and programs with the neoliberal way of thinking. This has often been achieved by translating exogenous expectations into policies that can be convincingly portrayed as compatible with the exogenous logic *and* that are reconcilable with the organization's goals. Alternately, it has been achieved through translation of WHO goals, claims and programs so that they become reconcilable with the exogenous paradigm.[4]

Such strategies clarify why thinking in binary terms of acquiescence or defiance/avoidance is insufficient, since what seems like acquiescence often involved a "defiant" reinterpretation of what compliance required. In other cases, the WHO bypassed some of the expectations for change without resorting to direct confrontation or

[4] Strategic adaptation is somewhat in line with Barnett and Coleman's (2005) "manipulation" and "strategic social construction," which refer to efforts by the international organization to *control the demands* imposed by the environment. But strategic adaptation goes beyond these strategies, for it is not only about changing the preferences of the environment, but also, and more centrally, about convincing the environment that certain acts adopted by the IO are consistent with the initial demands. This point is also made, albeit less explicitly, in the literature on "framing" (Snow et al. 1986, Benford and Snow 2000) and the literature that relies on Bruno Latour to show how actors with diverge goals may nonetheless forge a common language in which they construct their interests as common (Bockman and Eyal 2002, Fridman 2010).

strategies of avoidance, but by convincingly suggesting that those demands were in fact incompatible with the new exogenous logic and should therefore be amended. In addition, unlike strategies of defiance and avoidance, translation required significant changes in the policies and programs, and required, at times, the sacrifice of fundamental principles or goals. Creative adaptation is not about deceiving ("duping") the US government or the World Bank to think that the WHO complied with their demands while it had not. The WHO has certainly embraced many elements of the neoliberal reasoning. But rather than simple submission, in some cases the WHO turned exogenous expectations into programs that were still compatible with WHO's interests and principles, and in other cases the WHO was able to explicitly oppose disagreeable prescriptions coming from above. Through these strategies of creative adaptation, the WHO embraced neoliberalism while simultaneously also neutralizing its effects.

Reverse imposition. Creative adaptation entailed the manipulation of the dominant logic so as to make it compatible with the WHO's views. When successful, this may have also lead the originators of the neoliberal order to move away from their initial position. At times, therefore, the WHO's strategic adaptation helped transform the neoliberal order itself. Gramsci's (1971) notions of hegemony and historic blocs suggest that any hegemonic order depends on its ability to form a broad coalition. This depends on the ability of the dominant social forces to represent their interests as the *common* interests. But alliances do not necessarily rest on shared *existing* interests. Rather, interests are reframed (or translated) in order to make alliances possible. Reverse imposition suggests that the privilege of representation is not in the hands of the dominant social forces alone. The act of translation is also taken by the "subordinate" forces. There are no "active authors" and "passive recipients," as the recipients, too, are involved in the act of fitting alliances and are thereby active participants in this universalizing task.[5]

In short, while the neoliberal paradigm was imposed from above, I argue that the contours of neoliberal policies that were adopted in specific sites greatly depended on the receivers' strategic adaptation to such imposition. In what follows, I document how the WHO's proactive incorporation and creative adaptation to the neoliberal paradigm led to a radical transition in the WHO's policies and principles, but still allowed the WHO to neutralize neoliberalism so as to protect at least some of its interests and principles.

STUDYING THE WORLD HEALTH ORGANIZATION

So far, only scarce attention has been paid in the literature to the spread of neoliberalism across international organizations. The World Bank, the IMF and the WTO were central *carriers* of neoliberal prescriptions – and, as such, they were important agents in bringing change at the domestic level – but only recently has their own adherence to neoliberal prescriptions been scrutinized (Babb 2009, Weaver 2008, Abdelal

[5] Instances of *reverse imposition* further complicate our understanding of the spread of neoliberalism, for they suggest that diffusion also involves an on-going transformation of the hegemonic order itself.

2007, Chorev and Babb 2009). Other international organizations, particularly UN specialized agencies, have failed to attract a similar scholarly attention (Barnett 1997). While not as commanding as the international financial institutions, UN specialized agencies nevertheless matter greatly to developing countries, as they provide both financial support and technical assistance. Through the advocacy of policies and the initiation of programs, UN specialized agencies greatly influence many domestic policies in developing countries, including in fundamental areas such as labor, education and health (Meyer et al. 1997).

There is also reason to think that the study of UN specialized agencies could shed light on issues that investigations of the World Bank, IMF or the WTO may not. Most importantly, the study of UN agency like the WHO provides an opportunity to observe an international organization that is the *recipient*, rather than the originator or enforcer, of the new world logic. In addition, while international financial institutions have much in common with the UN specialized agencies, there are also important institutional differences, which suggests that we should not apply what we learn about the former for understanding the latter. Amongst UN specialized agencies, moreover, the WHO is of particular interest for a number of reasons. First, it is one of the largest specialized agencies, both in regard to its budget, scope of mandate, and actual intervention and programs. Second, its health mandate means that its recommendations and programs are of great interest to a number of exogenous actors – including donor countries, recipient countries, multinational corporations (e.g., pharmaceuticals) and health activists. As a result, it captures particularly complex sets of relations and offers a wide scope of possible tensions and conflicts to analyze.

For the empirical analysis, I collected primary data from the library of the WHO in Geneva and the library of the regional office of the WHO in Washington, DC, and from Presidential Libraries and the National Archives in the United States, the National Archives in the UK, and the Library and Archives Canada. In addition, I conducted a large number of interviews with WHO and governmental officials, officials of other international organizations and public-private partnerships (including the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, IAVI, MMV, DNDi), local and transnational health activists (including Médecins Sans Frontières, Consumer Project on Technology and Treatment Action Campaign), and representatives of brand-name and generic pharmaceutical companies and their associations. I observed one World Health Assembly, in May 2008. I also studied the topical minutes of the annual World Health Assemblies and biannual Executive Board meetings, and the relevant Congressional hearings, among many other official documents.

STRATEGIC ADAPTATION AT THE WHO

The WHO was established in 1948 as a specialized agency of the United Nations. Unlike with the IMF and the World Bank, WHO decision-making powers reside with the member-states, who follow the principle of one-country/one-vote independently of countries' assessed contributions. Country representatives meet once a year at the World Health Assembly (WHA), where they establish policy and decide on the organization's

programs and budget. An Executive Board (EB), whose members are elected by the WHA, meets twice a year to prepare for the Assembly and to oversee the implementation of the decisions taken by the WHA. While delegates to the Assembly are representatives of their designated states, delegates to the Executive Board are expected to act as experts, on behalf of the whole Conference. The third pillar of the organization is the Secretariat. The Secretariat is headed by the Director-General (DG), who is elected by the World Health Assembly after nomination by the Executive Board.

In the early years, the WHO functioned as a medical-technical organization that focused on technical assistance and was mostly concerned with specific diseases. Some early initiatives included programs for the vaccination against tuberculosis (1947-1951), and for the eradication of malaria (1955-1970), yaws (1955-1970) and smallpox (1967-1980). Beginning in the 1970s, however, the WHO turned into a radically different organization, one that was mostly concerned with reaching "Health for All by the Year 2000," by means of primary health care and meeting basic health needs. This transition to redistributive concerns and a logic of equity corresponded with radical changes in the exogenous environment. At the time, the UN was strongly influenced by the Third World's call for a New International Economic Order, which appealed for greater equality between the industrializing and industrial countries while seeking ways to break the dependence on Western companies.[6] But in the 1980s, primary health care was all but abandoned, and by the late 1990s the programs advocated by the WHO looked remarkably different, as an even a cursory comparison would demonstrate.

- In the 1970s, the overarching principle guiding WHO programs was that of equity, which gives precedent to programs *aiding those most in need*; since the 1990s, the governing principle has given precedent to programs that fund those who *could be helped efficiently and cost-effectively*.
- In the 1970s, health was considered a defensible fundamental goal on its own right; starting in the 1990s, investment in health has been justified mostly as means for advancing economic development and growth.
- There was a move from horizontal to vertical health interventions. To achieve the goal of "Health For All by the Year 2000," the flagship initiatives in the 1970s focused on *primary* health care: WHO programs advocated the provision of services that would grant *basic* health needs for all and would use only *appropriate* and affordable technology. In the 1990s, the WHO advocated disease-specific programs, with a focus on medical treatment and resources devoted to the development and distribution of drugs and vaccines.
- In the 1970s, in the spirit of "collective self-reliance," policies were advocated with the goal that developing countries would be able to carry some of the financial costs on their own; since the 1990s, most funds are expected to come from donations.
- Traditionally, most (albeit never all) funds provided by rich countries to the WHO were granted by way of mandatory assessments; in the 1990s,

[6] This paper is part of a larger project in which I compare WHO's response to the call for a New International Economic Order with the Organization's response to neoliberalism.

mandatory assessments were frozen, and, since then, WHO funds have come mostly from voluntary contributions. Significantly, in addition to rich countries, some voluntary funds came from private foundations, such as the Bill and Melinda Gates Foundation.

- In the 1970s, both donor and recipient countries viewed the transfer of funds as an obligation, partly linked to the colonial past of many of the recipient countries. Since the 1990s, donors have viewed these transfers as investment and/or humanitarian acts of charity.
- In the 1970s, the relations between the WHO and multinational corporations were formally hostile. In that period, the WHO tried to supervise the quality and limit the number of "inessential" medicines sold in developing countries, called for spending in rural areas rather than on hospitals in urban centers, passed a resolution regulating the marketing of infant formula, and considered regulating the marketing of pharmaceuticals. In the 1990s, the WHO developed a much closer relationship with the private sector, invited companies to become partners in WHO initiatives, and welcomed monetary, in-kind, and other contributions.

Table 1 offers a brief summary of the main differences between the 1970s and the late 1990s. This comparison reveals that the WHO's transformation has been quite substantial. While the programs of the 1970s corresponded to the logic of the New International Economic Order (NIEO), the policies adopted in the 1990s were compatible with the neoliberal reasoning favored by the US government and the World Bank, among others. However, in the same way the WHO deviated from the NIEO logic in the 1970s (an argument I develop elsewhere), in the 1990s its policies and programs did not simply mirror exogenous expectations and, therefore, cannot be understood in terms of just being a direct result of imposition. Rather, in response to a severe crisis, mostly triggered by US pressures, the WHO leadership has strategically adapted the organization's policies and programs in a way that pacified the US government but preserved important WHO goals.

[Table 1 around here]

WHO in Crisis

During the 1980s, the WHO experienced growing political and economic difficulties. The main, albeit not only, cause of the myriad predicaments encountered by the WHO was the decision of the US government, given its fierce opposition to the New International Economic Order and any related programs and initiatives, to discipline developing countries and root out so-called "Third World radicalism." Since the United Nations was the official site for this North-South struggle and given the position of most UN specialized agencies in support of the developing world, the US government lost interest in supporting the UN. The ambassador to the UN under the Reagan administration, Jeane Kirkpatrick, declared "zero tolerance" against other countries' positions at the UN if they were incompatible with US wishes. The main concerns were UN declarations against Apartheid in South Africa and the Israeli occupation of Palestinian territories, but the resentment against Third World countries taking advantage

of their majority at the General Assembly soon turned into resentment against UN bureaucracies themselves. The US government therefore pressed for changes that would both weaken the ability of UN specialized agencies to act *and* weaken the influence of developing countries over those UN Agencies. As WHO policies in the 1970s were an attempt to contribute to the New International Economic Order, the WHO was exposed, like other UN agencies, to US attacks, leading both to a financial crisis and an authority crisis. US actions also exacerbated a legitimacy crisis caused by dissatisfaction with Dr. Hiroshi Nakajima, who served as WHO Director-General from 1988 till 1998.

The WHO's financial crisis was the result of three related developments, all linked to US assault on the UN. First, following pressure from United States and many European countries, the WHO – which used to have its budget grow at least 10% each year – agreed to freeze its budget. In addition, US Congress unilaterally reduced its relative contribution and, for a long period of time, did not pay the full amount of its assessed payments. As a result, the WHO had to function with a budget even smaller than the agreed assessments. This decline in mandatory payments was partly compensated for with an increase in the voluntary contributions granted to the WHO by member-states for programs of their choice. By the 1990s, voluntary funds were almost 60% of the total budget (Kelly 2008). While saving the WHO from an even worse financial fate, voluntary funds were "earmarked" for specific programs, and thus deepened the vulnerability of the WHO, undermined the autonomy of the WHO Secretariat, and weakened the influence of member-states in the World Health Assembly over global health programs.

The authority crisis was a result of other international organizations, particularly the World Bank, getting involved in pubic health programs and policies. As part of the structural adjustment programs in which the World Bank imposed economic policies on developing countries (Babb 2009), the Bank recommended a number of health-related policies. The suggested policies, which included budget cuts in the public health sector, privatization of health services, and user fees on health services, reflected a rigid application of neoliberal economic theories and were very much in conflict with the WHO's policies of the 1970s and 80s. In addition to policy recommendations, the World Bank also started providing loans for health restructuring, the total sum of which by 1990 was larger than the WHO's entire budget (Yamey 11/30/2002). This again signified the increased prominence of the World Bank at the expense of the WHO.

Another indication of the WHO's threatened authority was the decision of the US government and its allies to remove AIDS programs away from the WHO and establish in 1996 an independent organization, the Joint United Nations Programme on HIV/AIDS (UNAIDS), in which the WHO had equal standing as the other agencies involved, including the World Bank. The decision was motivated by substantive considerations – there was a legitimate concern that the WHO's view was over-medicalized for AIDS – but it was also due to donor countries' general impatience with the WHO.

Finally, the WHO also suffered from a legitimacy crisis. This was not the making of the US government, but rather an independent development with unfortunate timing.

In 1988, Dr. Hiroshi Nakajima was elected the new Director-General, with the support of developing countries and against the position of the United States. Nakajima was soon blamed for weak leadership, poor management, and, apparently with credible evidence, cronyism and corruption (Brown, Cueto and Fee 2006). While this was a serious leadership failure, it was no doubt rich countries' interest in weakening, or at least reforming, the allegedly biased, inefficient and bloated UN bureaucracies that turned this into a full-fledged legitimacy crisis. The mistrust in Nakajima pushed donor countries even more in the direction of earmarked funding, and it contributed to the transfer of authority over global health to competing organizations.

Since the early 1980s, then, the WHO was experiencing a growing crisis, with financial difficulties, threatened authority, and undermined legitimacy. Until 1988, under the leadership of Dr. Halfdan Mahler, who had been the Director-General since 1974, the WHO fought to preserve its existing agenda despite this manifestly changing environment. Between 1988 and 1998, partly due to the problems encountered by Dr. Hiroshi Nakajima, the WHO offered little by way of response. But in 1998, when Nakajima retired and Dr. Gro Harlem Brundtland became the Director-General, the WHO finally started searching for an appropriate response to the exogenous pressures that would allow it to regain the funds, authority and legitimacy it had lost.

WHO's Strategic Adaptation to Exogenous Pressures

In the late 1990s, in the face of mounting external pressures, the Executive Board of the World Health Organization elected Dr. Gro Harlem Brundtland as the new Director-General. Brundtland had little public health experience but, in addition to being the former Prime Minister of Norway, she had also served as the chair of the UN World Commission on Environment and Development, which championed the possibility of environmental protection in the context of economic growth, and, in public statements made during the period when she was considered for the position, she emphasized her intention, if elected, to position health in the *larger context* of development.[7]

Under Brundtland, the WHO was radically transformed in a way that *fit* the new institutional, financial and ideological environment, while preserving the WHO's material

[7] The history of the WHO reveals the critical role of Director-Generals in shaping the trajectory of an international organization. The most important turning points at the WHO were made possible due to the very aggressive position of newly-elected DGs (most noticeably, Mahler in the 1970s and Brundtland in the 1990s). But their influence should not lead us to over-emphasize the importance of individual personalities. The history of the WHO also indicates that, following early initiatives, Director-Generals have not been able to readjust to a transformation in exogenous conditions (as illustrated by Mahler's inaction during the mid-1980s, and which may also explain his retirement by the end of his third term). Consequently, newly-elected Director-Generals were expected to lead long-needed changes. And they were elected exactly for their capacity to make such changes *and* for the types of changes that the Organization believed would be necessary, as the nomination of Brundtland indicates.

interests and its core organizational agenda. At times, the WHO embraced neoliberal principles and claims that were acceptable to the political leadership in rich countries and to the international financial organizations, but translated them to policies that could serve the WHO's needs. At other times, the WHO defended existing programs and principles by framing them within an agreeable neoliberal logic. The WHO also used the neoliberal logic itself to oppose some of the external prescriptions. Specifically, the WHO developed active strategies of incorporation – including anchoring health on the development agenda, adopting cost-effective logic, expressing anti-state sentiments and supporting pro-market solutions, utilizing economic rather than normative reasoning for opposition, and engaging with the private sector while leaving room for exceptions – that adhered to the exogenous demands while always also manipulating those demands.

Anchoring health on the development agenda. Brundtland was forthright and unsentimental in her conviction that the only way to revive the WHO's deteriorating finances, legitimacy and authority was by actively incorporating the Organization into the new environment in which it was expected to function, and that, to do so successfully, the WHO had to broaden the range of its allies to include the *currently relevant* audience and to develop a revised message that the new audience would find appealing.

Who *was* the new audience? Traditionally, the WHO engaged with health ministers. With a somewhat brutal frankness, however, Brundtland assessed that health ministers were not a useful audience as they were already convinced of the importance of health, and, in any case, they had very little voice in governments.[8] Instead, she believed the WHO's only hope was talking with finance ministers, presidents and prime ministers, who had access to the resources that the WHO so desperately needed. As Brundtland wrote in an early editorial in *Science*, "Health ministers need little convincing, but WHO will remind presidents, prime ministers, finance ministers, and science ministers that they are health ministers themselves…" (Brundtland 6/26/1998).

But how could the WHO convince finance ministers to care about health? Brundtland was convinced that the only way to earn the support of finance people was not to talk about health but to talk about *finance*. To satisfy its new audience, therefore, the WHO abandoned its long-held claim that the pursuit of health was an end in itself and adopted the more agreeable premise that health was good for *economic growth*. In the same *Science* editorial, Brundtland wrote, "Our message will be that healthy people help build healthy economies" (Brundtland 6/26/1998). In speaking before the World Health Assembly in 1999, Brundtland similarly stated that, "WHO needs to remind prime ministers and finance ministers that… investments in the health of the poor can enhance growth and reduce poverty" (Brundtland 3/30/1999).

However, as Brundtland stated in an interview: "Anchoring health on the development agenda… involves not just reaching the minds of people who have decision-

[8] With the structural transformation of the state under neoliberalism, by the late 1990s health ministers had even less influence over national budgets than they had in the past (see Cox 1986).

making power in the broader fields of economics and politics, but also increasing the evidence base so that you have convincing arguments" (Yamey 12/7/2002). To make the claim that investment in health was good for development, in January 2002 Brundtland established the Commission on Macroeconomics and Health (CMH), which was asked to provide the evidence needed. The Commission was chaired by the economist Jeffrey Sachs, then of Harvard University. Sachs was at the time known for implementing economic "shock therapy" – including the sudden release of price and currency controls, withdrawal of state subsidies, privatization of public-owned assets and immediate trade liberalization within a country – in Bolivia, Poland, Russia and in other developing and transitional countries. But around that time, Sachs was also advising the United Nations, and a UN commission he had headed in 1999 called for the creation of a fund for AIDS (Cannon 6/25/2005). Other members of the Commission included former ministers of finance and officers from the World Bank, the International Monetary Fund, and the World Trade Organization. Brundtland, quite clearly, decided to coopt leading economists by giving *them* the task of presenting the WHO's position.

Brundland's instructions to the Commission members were clear: "Placing health at the heart of the development agenda. This is the purpose of the Commission" (Brundtland 11/8/2000). Indeed, the Commission found that improved health contributed to economic development. Even better, the Commission established that health was one of the *most effective* means to achieve development. The policy implications that followed were obvious: the way to achieve economic growth was a massive injection of financial resources into health services.

With the CMH Report, the WHO relied on the legitimacy of expert economists to grant the field of public health what was then the only justification for intervention and "investment" in the developing world: the possibility of economic growth. The WHO hence abandoned the prioritization of (equitable) distribution over (overall) growth. It also did not insist on a broader definition of "development" that would include factors like health as independent measures and capitulated instead to the reductionist logic that prevailed in the World Bank and donor countries, which reduced development to economic growth.[9] At the same time, however, the WHO used the CMH Report to insist that improvement in health was *necessary* for achieving the goal of economic growth. The World Bank has often emphasized the causal link between poverty and health to suggest that economic development leads to improved health. The report *reversed* this traditional vector, which went from poverty to disease, to emphasize instead the vector that went from disease to poverty, postulating that improved health leads to economic development.[10] The CMH Report, therefore, has turned the World Bank reasoning of

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[9] An alternative conceptualization of development is offered by the Human Development Report (HDR), which is published by the UN Development Program (UNDP). Its first publication stated, "Even in the absence of satisfactory economic growth… countries can achieve significant improvements in human development through well-structured public expenditures" (UNDP 1990, p. 3).
[10] Interview by the author with Dr. Steven Phillips, Medical Director, Global Issues and Projects, Exxon Mobil Corporation, Washington, DC, 11 January 2009.

development on its head. Instead of having to support budget cuts in the public sector, which was a central component of the World Bank's structural adjustment programs, the WHO could now use the goal of economic growth, on the contrary, to call for *greater* investment in public health.

Cost-effective calculations & disease-specific interventions. In order to legitimate investment in health, Brundtland also promised donor countries that the WHO's choice of programs would be based on cost-effectiveness, as the World Bank had preached for years.[11] Brundtland then chose as her roadmap for guiding WHO policy and for adjudicating between various health interventions the World Bank's World Development Report of 1993, which relied on cost-effective analysis, comparing "the net gain in health or reduction in disease burden from a health intervention in relation to the cost" (World Bank 1993). As a way to improve such cost-effective calculations, the authors of the World Bank report developed the concept of Disability-Adjusted Life Years (DALYs) to measure the cost of disabilities. DALYs evaluated the burden of a disease not merely by number of years lost due to premature death but also by number of years of *productive* life lost to disability (Specter 10/24/2005).

Using DALYs, the report concluded that the most cost-effective health services include promotion of breast-feeding, immunizations, salt iodization (prevents iodine deficiency) and vitamin A supplementation, anthelmintics (drugs that expel parasitic worms), smoking prevention, use of condoms, and cataract removal. The least cost-effective interventions include surgical and medical treatment of chronic diseases and cancers. While many of the recommended interventions were to benefit the poor, this was a matter of chance, not of methodological design (Segall 2003).

International organizations, including the WHO, have always been mindful of costs, and the WHO has consistently objected, for example, to the purchase of expensive medical interventions that poor countries could not afford. But neoliberalism introduced economic reasoning that marginalized all other considerations. The WHO's historical approach emphasized the primacy of equity, where priority in resource allocation was to be afforded to those most in need, even if this should be pursued as efficiently as possible. The World Bank report, in contrast, advocated a methodological approach that prioritized efficiency, with equity as an important but second order consideration (Segall 2003). Moreover, critics suggests that DALYs undermined the emphasis on equity since it consisted only of age, sex, disability status and time period, which did not allow individuals' socioeconomic circumstances to be taken into account, while an equitable approach to resource allocation would attach a greater weight to the illness of more disadvantaged people (Yamey 11/9/2002).

Brundtland not only embraced the World Bank Report, but also brought many of its authors to a newly-established unit at the WHO, called Evidence and Information for

[11] Cost-effectiveness was also a concern for the Commission on Macroeconomic and Health, as one part of its mission was to further the WHO's cost-effective approaches for some of the major killers (Ashraf 1/29/2000).

Policy. In 2000 this unit produced a World Health Report titled, *Health Systems: Improving Performance*, which evaluated health systems of countries based on their "effectiveness," "responsiveness" and "fairness," and which, like the World Bank report, adopted cost-effectiveness as a tool for priority setting (Yamey 11/9/2002, Ollila and Koivusalo 2002). A central algorithm in the Report, which offers a list of questions that should guide governments' process of decision-making, allows interventions that benefit the poor *only* if they are cost-effective (WHO 2000, Figure 3.2). According to the new WHO priorities, as formulated in the report, so-called "primitive" health care, which included "basic" or simple intervention only to the poor, was now replaced with a "new universalism," which promised "essential" and cost-effective interventions for everyone. Implicit in this universalism, however, was the abandonment of helping the poor *first*. Brundtland implicitly admitted the reversal between equity and cost-effectiveness by stating, in her message at the beginning of the Report, that, "while our work in this area [health system development] must be consistent with the values of health for all, our recommendations should be based on *evidence* rather than *ideology*" (WHO 2000: vii, italics added).

The WHO's adoption of cost-effective logic arguably compromised its commitment to equity. It also reinforced the WHO's move away from a comprehensive approach to primary health care towards a selective approach, which concentrated on specific health interventions. In contrast to a comprehensive approach to health care systems, the CMH report argued that, "poverty could be considerably reduced by addressing a *few* health conditions responsible for a high proportion of avoidable deaths and disabilities."[12] Based on cost-effective calculations and in line with the recommendations of the World Health Report (WHO 2000, p. 53), the WHO's priorities under Brundtland included: malaria, tuberculosis, and HIV/AIDS; cancer, cardiovascular disease, and diabetes; tobacco; maternal health; food safety; mental health; safe blood; and health systems (Yamey 11/9/2002). Notably, the list includes both issues that had been of concern to the WHO for years (e.g., malaria, tuberculosis and maternal health) as well as issues that have been traditionally ignored, often because they were considered "lifestyle" diseases with little impact on the very poor (e.g., tobacco). Hence, while the move from equity to cost-effectiveness led to the adoption of new priorities, it was possible, at least in some cases, to maintain the focus on old issues, by justifying them not based (only) on equity considerations but by judging the programs cost-effective. One particularly dramatic example, which also illustrates a case of reverse imposition, concerns the distribution of AIDS drugs. World Bank early reports had objected to the purchase of AIDS drugs as this was not deemed cost-effective (World Bank 1992), but the World Bank eventually reversed its position, partly because of the radical reduction in the prices of AIDS, but also due to pressures from the WHO and others (and see below). In this way, again, the WHO adhered to the neoliberal logic while protecting its core concerns.

[12] The representative of the Executive Board at the 55th World Health Assembly, 2002. Committee A: First Meeting, p. 16. Italics added [IMG 7438].

Moreover, cost-effective logic was instrumental in the process of *reverse imposition*, whereby the external environment came to accept the necessity of investment in global health. In a testimony before the US Senate, Jeffrey Sachs bitterly criticized the insufficiency of US contributions to fight AIDS in Africa, stating the following:

> "There is nothing lacking but the resources. In that case, Senators, there is nothing lacking but the few bucks that it would cost, and we have so far made a calculation that Africans are not worth $1 a day to keep alive… Are Africans really worth $1 a day to keep alive? Are Africans cost-effective at $1 a day? Is it cost-effective to have 40 million orphans?... Is it cost-effective to have millions going hungry because the farmers are dead? Is that what we mean by cost-effective?"

Sachs here seems to mock the notion that cost-effectiveness should determine foreign aid, but, in effect, he used cost-effectiveness to force US Senators to increase their support. Such strategies eventually led to more generous contributions for global health and to the establishment, among other initiatives, of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Anti-state sentiments & pro-market solutions. Reflecting neoliberal support of minimal state interventionism and faith in market efficiency, the 2000 World Health Report was explicitly critical of earlier WHO programs for not being sufficiently sensitive to the market and to the needs of the private sector (Navarro 2002), and showed a general anti-state bias. For example, the report seemed to endorse the World Bank's support of privatization of public health services,[13] and showed a bias in favor of private schemes, such as those adopted in Colombia and Chile, over public ones (Armada, Muntaner, and Navarro 2001). The report also called for strengthening the role of government in supervising private provision of health services as a way to facilitate the role of the private sector in health care (Armada et al. 2001). The WHO endorsed solutions that relied on market forces rather than state intervention in other instances as well. Regarding the possible ways to distribute insecticide-treated bed nets, for example, the WHO advised governments to build sustainable private for-profit markets or to create a not-for-profit commercial sector through social marketing, and did not favor the option of providing the bed nets free of charge (Noor et al. 2007).

Using economic logic against neoliberal initiatives. The instances described above show that, in response to the financial threats and the risk of losing its authority over global health programs, the WHO incorporated neoliberal themes and economic thinking into its practices and policies – the organization presented health as an integral

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[13] A1989 World Bank report, *Strengthening Health Services in Developing Countries through the Private Sector* (Griffin 1989) called for a mixture of private and public health services, and a 1993 World Bank report, *World Development Report: Investing in Health* (World Bank 1993), recommended to "promote diversity and competition" by introducing private or social insurance schemes, and foster competition in the delivery of health services (Abbasi 3/27/1999, Ugalde and Jackson 1995).

part of the larger development agenda, focused on cost-effective and disease-specific interventions, and incorporated anti-state sentiments and pro-market solutions. At the same time, while accepting economic reasoning and cost-effective calculations in some cases, the WHO managed to evade or even directly oppose exogenous prescriptions in other cases. Cases of overt disagreement included opposition to the World Bank's calls for budget cuts and user fees on health services, and to WTO agreements on liberalization of services and on intellectual property rights. Notably, in opposing those prescriptions, the WHO usually did not rely on logic based, for example, on normative principles such as human rights or Constitutional concerns of equity, which would suggest defiance, but rather on *economic* reasoning, which added weight and legitimacy to its arguments and minimized potential conflicts.

We have already seen that, with the help of the Commission on Macroeconomics and Health, the WHO managed to reverse the recommendation for budget cuts in health by elevating "investment" in health as a fundamental strategy for economic development in poor countries. The WHO more explicitly opposed another World Bank recommendation, which involved the practice of user fees. World Bank reports announced that the "faith that health care should be totally paid for and administered by governments needs to be vigorously challenged," and recommended the partial cost-recovery of public health services by charging patients (de Ferranti 1985, Akin, Birdsall, and de Ferranti 1987). Subsequently, user fees have become a condition for World Bank loans and donor support. By 1993, a WHO report identified the introduction of and increase in user fees for government services as one of the most significant changes over the previous five years (WHO 1993). Subsequent WHO publications and reports explicitly criticized this practice as harmful and discriminatory. A World Health Report on maternal and child health provided the following recommendations to governments: "For services to be taken up, financial barriers to access have to be eliminated and users given predictable financial protection against the costs of seeking care, and particularly against the *catastrophic payments that can push households into poverty*… To attain the financial protection that has to go with universal access, countries throughout the world have to move away from user charges…." (WHO 2005a, italics added). The report argued that, "by and large the introduction of user fees is not a viable answer to the underfunding of the health sector, and institutionalizes exclusion of the poor. It does not accelerate progress towards universal access and financial protection…." (WHO 2005a). In other reports, the WHO called for a phase-out of end user fees-for-services for disease-specific interventions, including tuberculosis (WHO 2003) and HIV/AIDS (WHO 2005b). The report on HIV/AIDS was unequivocal: "It is apparent that user charges at the point of service delivery 'institutionalize exclusion' and undermine efforts towards universal access to health services." Therefore, "Even with sliding fee scales, cost recovery at the point of service delivery is likely to depress uptake of antiretroviral treatment and decrease adherence by those already receiving it. Therefore, countries are being advised to adopt a policy of free access at the point of service delivery to HIV care and treatment, including antiretroviral therapy." Nonetheless, the report emphasized that, "This recommendation is… warranted as an element of the *exceptional* response needed to turn back the AIDS epidemic" (WHO 2005b, italics added).

In regard to user fees, then, the WHO positioned itself in opposition to World Bank recommendations, stressing the responsibility of governments for universal access to health services, particularly access by the poor. However, the most explicit declarations did not criticize user fees in general but merely referred to *particular* health issues (maternal health, tuberculosis and HIV/AIDS) and, somewhat defensively, emphasized *exceptional* circumstances. Additionally, instead of using normative reasoning, the WHO specifically used *economic* reasoning to justify its position. Regarding maternal health, the WHO warned of catastrophic payments that could push households into poverty. The report on AIDS shifted its focus from the individual household to the entire economy: "[F]or AIDS treatment and care services to have any impact, HIV-infected people must actually be able to access them. When fees are an insurmountable barrier to end users, *the economy may experience a large net loss due to ill health*, as people are pushed into poverty or prevented from moving out of it." In other words, since user fees have detrimental effect on economic growth, they should be avoided. Here again the WHO used economic reasoning to defend its position against the World Bank's own economic analysis.

The WHO also, albeit more cautiously, opposed the liberalization of health services under the General Agreement on Trade in Services (GATS), which was signed in 1994 under the auspices of the WTO. Negotiations regarding trade in services were initiated by the US government on behalf of American service companies, including the US health care industry, which sought the liberalization of services in foreign markets. But under GATS, commitments were voluntarily, so member-states could choose which sectors to include and which sectors not to include in the agreement, and developing countries in particular were reluctant to commit to the liberalization of their health services (Blouin, Drager and Smith 2005: 5). Still, GATS greatly increased the possibility for the participation of foreign private companies in health services in the future. In response, the WHO did not explicitly recommend against opening health systems to foreign markets, but WHO reports did alert developing countries to the potentially negative effects this might have on health equity. For example, a report on *GATS and Health Related Services* stated, "Before making any specific commitment under GATS, governments should ensure they have thoroughly assessed the implications of opening health systems to foreign services and the potential costs and benefits of making legally binding commitments" (Drager and Fidler 2004). The 2006 World Health Report, cautioning against the unfairness in the temporary movement of people who supply health services, stated that, "As with other GATS processes, the ability of poorer countries effectively to represent and defend their interests cannot be taken for granted" (WHO 2006: 43). While the WHO warnings against GATS may not amount to much, they nonetheless show, like the opposition to budget cuts and to user fees, that, while the WHO chose to embrace economic reasoning and cost-effective calculations to defend its material interests and maintain its authority in the field of global public health, it was able at times to strategically utilize similar economic reasons to evade and even modify some disagreeable components of neoliberal thinking as it applied to health reforms.

The WHO opposition to the WTO agreement on Trade-Related Aspects on Intellectual Property Rights (TRIPS) is another illustration of the WHO's willingness and

ability to challenge the environment in which it found itself. Yet it also serves as an exceptional case, in which WHO member-states from middle-income countries and WHO staff *rejected* Brundland's attempts for a balanced solution of strategic adaptation and chose a more explicitly-confrontational position.

The TRIPS Agreement, which was signed in 1994, restricted access to cheap drugs by prohibiting the manufacturing of generic versions of patented drugs and by potentially limiting the exceptions to such restrictions. In particular, the TRIPS interpretation favored by the US government and others dictated that countries were not allowed to use "compulsory licensing" (that is, to buy or manufacture the generic version of a patented drug without the permission of the patent owner) or to use "parallel importing" (that is, to buy a patented drug from a third party without permission from the patent owner).

The potential negative impact of TRIPS on access to AIDS drugs raised immediate concerns among poor WHO member-states, and Brundtland soon announced that, "Our aim must be to ensure equity of access to essential drugs, rational use, and quality. This is simply part of the fundamental right to health care. Achieving these objectives remains one of WHO's highest priorities" (WHO 1999a). However, she also initially conveyed an unequivocal defense of intellectual property rights: "To develop new drugs we need an innovative pharmaceutical industry, with appropriate incentives for innovation and protection of intellectual property rights. Experience demonstrates that protection of intellectual property rights goes hand-in-hand with successful research and development" (WHO 1999a). Accordingly, Brundtland sought ways to make AIDS drugs affordable, albeit *without* directly confronting the principles of intellectual property rights. So, initially, the WHO focused on pressing pharmaceutical companies to offer their AIDS drugs to poor countries with discounts, and intellectual property protection was not challenged (Motchane 2003, Gellman 12/28/2000).

However, this position failed to gain the support of developing countries and of the WHO's staff. Discussions regarding TRIPS and its effect on public health in Executive Board meetings and World Health Assemblies as well as in reports written by the WHO staff took a surprisingly defiant stance, explicitly challenging the appropriateness of applying intellectual property rights to the manufacturing and provision of drugs in the developing world. At World Health Assemblies, and against the vigorous opposition of US and some European representatives, Brazil mobilized other low- and middle-income countries and pressed for resolutions that stressed the importance of public health over commercial interests, called for protection of the right to produce cheap generic drugs in national emergencies, and urged developing countries to concentrate their AIDS policies not only on prevention but also treatment. WHO reports consistently supported the position of developing countries. Already in 1997, the Action Programme on Essential Drugs Division published a report, *Globalization and Access to Drugs: Implications of the WTO/TRIPS Agreement* (WHO 1997), which questioned the prevalent interpretation of TRIPS and suggested a more favorable reading that highlighted the legal flexibilities in the Agreement that could permit the manufacturing

and sale of generic versions of patented drugs.[14] A 2001 Report by the Secretariat, *WHO medicines strategy: Expanding access to essential drugs* (EB109/7), similarly infuriated the US representative to the Executive Board for allegedly showing "a profound bias against the private sector," and for its "inherent assumption that generic drugs were always preferable to those produced by the research-based pharmaceutical industry…."[15]

The influence of developing countries, as well as transnational activists, can be also seen in the logic of justification used. This time, WHO staff did not draw on neoliberal maxims or economic reasoning to justify the organization's position. Instead, they borrowed the human rights discourse that was prevalent among AIDS activists. The WHO's interventions were also justified by drawing on the Constitutional principle of equity between rich and poor nations. WHO staff repeatedly stated, "WHO must ensure that trade liberalization contributes towards a more *equitable distribution of economic benefits and a just society*" (Scholtz 1999, emphasis added).

The initial 1997 WHO report, *Globalization and Access to Drugs*, possibly influenced the South African *Medicines and Related Substances Control Amendment Act* ("Medicines Act"), which was the first implementation of TRIPS that enabled a government to locally produce or import generic versions of patented AIDS drugs by explicitly permitting compulsory licensing and parallel importing.[16] The South African Medicines Act triggered domestic legal struggles and transnational political debates, which ultimately led to another case of reverse imposition with WTO member-states signing the *Declaration on the TRIPS Agreement and Public Health* (the Doha Declaration), which dramatically stated, "We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health... We reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for [protecting public health and promoting access to medicines for all]" (WTO 2001).

In WHO reports and publications following the Doha Declaration, including a special issue at the Bulletin of the World Health Organization (Türmen and Clift 2006), WHO staff continued to criticize the impact of additional amendments to TRIPS, data exclusivity laws, and intellectual property provisions in bilateral trade agreements for increasing access to medicines. In 2002, the WHO Prequalification of Medicines Programme, which is responsible for examining drugs for purity, safety and efficacy, and for inspecting factories where drugs are manufactured, provocatively added Indian generic versions of patented AIDS drugs to its list of safe drugs. This step later allowed UN agencies, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria, to purchase generic drugs rather than the much more expensive brand-name drugs to

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[14] The US government immediately demanded the WHO to revise the publication. But the new version made only minor alterations to the previous one (WHO 1999b).

[15] EB. 15 January 2002. Summary Records: Fourth Meeting, p. 61. IMG 9319. WHO Library.

[16] Interview by the author with Germán Velásquez, head of WHO's Drug Action Programme, World Health Organization, Geneva, Switzerland, June 3, 2008.

distribute to poor countries.[17] When the Bush Administration challenged the quality and efficiency of generic versions of drugs, the WHO prequalification list was used to successfully dispute this challenge, ultimately forcing the US government to admit that generic drugs were safe and effective and to spend bilateral aid on purchasing generic drugs.[18] This mobilization against TRIPS confirms that neoliberalism was not simply imposed from above, and also suggests that, with counter-pressures from developing countries and activists, the WHO was able to, at times, avoid even creative adaptation and chose direct confrontation instead.

Engaging with the private sector. As part of its attempts to reform the UN, the U.S. government kept pressing for private sector involvement, which was expected to turn the inherently bloated, inefficient and even corruptible UN agencies into becoming more effective and efficient (Richter 2004). What more, the drying up of funds from the US government and other donor countries forced the WHO to look for alternative funds, including from private foundations such the Ted Turner's UN Foundation and the Bill and Melinda Gates Foundation, which conditioned their donations on particular managerial practices, including greater involvement of the private sector (WHO 1999b, Motchane 2003). Brundtland, who held a more positive perception of business than most WHO staff,[19] consequently declared that the WHO must "reach out to others" (Yamey 11/23/2002) and that, "WHO needs to be more innovative in creating influential partnerships," including with the private sector (Brundtland 3/30/1999). In line with the neoliberal reliance on market-driven logic, Brundtland considered business to be "part of the solution, not the problem,"[20] and she launched, as her first programs as Director-General, a number of in-house partnerships, including the Roll Back Malaria (RBM) and the Stop TB Partnerships, in which the private sector was invited to participate as an *equal* partner.[21] Brundtland also attempted to involve the private sector in other WHO

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[17] Interview by the author with Sir Richard Feachem, former Director of the Global Fund to fight AIDS, Tuberculosis and Malaria, San Francisco, March 27, 2007.

[18] Interview by the author with Lembit Rägo, Quality Assurance and Safety of Medicines, WHO. May 27, 2008.

[19] The trend in the UN of working more closely with the commercial sector started with the 1992 UN Conference on Environment and Development, where Brundtland was centrally involved.

[20] Interview by the author with Chris Hentschel, President and Chief Executive Officer, MMV, Geneva, Switzerland, May 19, 2008.

[21] The WHO also participated in public-private health partnerships that were administrated independently of the UN. Partnerships for the development of drugs or vaccines included Medicines for Malaria Venture (MMV), the International AIDS Vaccine Initiative (IAVI), and Drugs for Neglected Diseases initiative (DNDi). Many of these partnerships were funded by the Gates Foundation, with minimal WHO influence. Other public-private partnerships were devoted to the *distribution* of drugs and vaccines, and included, most centrally, the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight Malaria, Tuberculosis and AIDS (Global Fund). I analyze the implications of such partnerships elsewhere.

programs, by means such as financial support, in-kind donations, and secondment of personnel.

These much closer links with business raised serious concerns about the WHO's loss of autonomy vis-à-vis commercial interests, especially when companies participated in the decision-making apparatus. Indeed, one WHO staff publicly blamed the WHO leadership for self-censorship when criticism was made of the pharmaceutical industry (Horton 2002: 1605) and others accused the WHO of silencing debates that might lead to confrontation with infant formula manufacturers (Ferriman 5/20/2000). But here again, strategic adaptation allowed the WHO to confront at least some industries. As we saw, the WHO launched a concentrated attack on the pharmaceutical sector in attempt to ensure that intellectual property rights do not come at the expense of universal access to drugs. The WHO also initiated a successful drive against the tobacco industry, which resulted in the binding Framework Convention on *Tobacco* Control, as I discuss below, although an attack against the sugar industry was less successful.

To justify these confrontations, the WHO often relied on the rationale that was used to engage with the private sector in the first place, namely, the notion that corporations could be and *were* socially responsible, using this argument against those companies that were not. Under neoliberalism, corporations have not only claimed to be able to govern themselves more efficiently than if they were regulated by governments, but also to govern themselves responsibly. The WHO took advantage of such claims to lure businesses into cooperation, but the WHO also used those same claims to criticize and act against corporations that did not act as part of the "solution."[22]

Another strategy used by the WHO to justify a confrontational stance toward particular industries was to emphasize the exceptional circumstances that required intervention – usually presenting the industry as evil for knowingly harming the innocent. This explicit demonization was meant not only to justify the initiative, as was also done in the 1970s, but also to assure other industries that the WHO's position against one industry does not and should not reflect the WHO's position against other industries. The strategic adaptation in regard to relations with the private sector therefore consisted of forcing the companies, by way of cooperation, to be more responsible, while targeting only "exceptional" cases. The crusade against the tobacco industry demonstrates a successful case of such strategic adaptation.

The World Health Assembly passed a resolution supporting the development of a WHO framework convention on tobacco control already in 1995, but it was under

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[22] The WHO's strategies here can be seen in a larger context of corporate social responsibility in the era of neoliberalism. If governments cannot be trusted, attention is diverted to the companies themselves. This applies not only to the ability of companies to self-govern efficiently, but also to self-govern fairly. The WHO has internalized both perceptions. On the one hand, the Organization wanted to learn from Coca Cola how to have medicines in each and every remote village but, on the other hand, also wanted Coca Cola to restrain the marketing of their sugar-inflated drinks in poor countries.

Brundtland that negotiations began in earnest, and in 2003 WHO member-states finally agreed on an international tobacco control treaty, in which they committed to a number of steps aimed to reduce smoking in their perspective countries. The treaty includes a ban on tobacco advertising (except where a ban would violate national laws, as in the United States), it encourages nations to raise tobacco taxes, and it calls for specific steps to control tobacco use, such as requiring that health warnings on cigarettes packages take up 30 to 50 percent of the display area.

There were several unique conditions that allowed the WHO, while pioneering improved relations with business, to be equally adamant in its crusade against tobacco companies. First, studies established that smoking had become one of the major killers not only in developed countries but in developing countries as well, where 800 million of the world's 1.25 billion smokers lived (Taylor and Bettcher 2000). This development turned smoking into an issue that should be of concern to the majority of WHO member-states.[23]

Secondly, the World Bank had published its own criticism against the tobacco sector (Jha and Chaloupka 1999), which signaled that there was willingness even among economists to criticize the industry. Moreover, given the World Bank's interest in the issue, the anti-tobacco initiative allowed the WHO another channel through which to reclaim its leadership in global health matters.[24] At the same time, collaboration with the World Bank assured that tobacco control measures were packaged as cost-effective, and the WHO relied on World Bank analysis to assuage the concern that tobacco control would lead to unemployment and harm the economy in poor countries which are heavily dependent on tobacco, such as Malawi and Zimbabwe. Also, since smoking was not a narrowly medical issue, Brundtland hoped it would attract the attention of policy makers other than health ministers to the working of the WHO.[25]

Finally, it was quite easy to establish "tobacco exceptionalism," so that mobilization against the industry would not reflect on the WHO's general attitude toward business. Given the sinking reputation of the industry, including in the United States, due to extensive legal cases that demonstrated that tobacco companies had deliberately lied about their knowledge on health risks and addiction, it was relatively easy to distinguish the tobacco industry from all other commercial enterprises. The legal documents also

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[23] The recent prioritization of non-communicable diseases at the WHO stemmed not only from increased prevalence of "lifestyle" diseases in the developing world but also was due to the new way of calculating the burden of diseases as advocated by the World Bank, DALYs, which elevated the importance of chronic diseases, and due to Brundtland's "new universalism" approach, which focused on the number of victims rather than on victims' socio-economic vulnerabilities. In this way, the focus on smoking, as well as obesity, has been paradoxically related to the neoliberal turn at the WHO.

[24] Interview by the author with Katherine Deland, Free Tobacco Initiative, WHO, Geneva, Switzerland, June 2, 2008.

[25] Interview by the author with Katherine Deland, Free Tobacco Initiative, WHO, Geneva, Switzerland, June 2, 2008; Brundtland 1/7/2000.

revealed evidence of a “systematic and global effort by the tobacco industry to undermine tobacco control policy” in the UN system (Williams 10/30/1999) and to “contain, neutralize, [and] reorient” WHO's tobacco control initiatives (Vedantam 12/7/2001), which granted legitimacy to WHO attempts to *exclude* the tobacco industry from the on-going negotiations.

To differentiate the tobacco industry from “legitimate” business, Brundtland used particularly critical language. A cigarette, Brundtland claimed, “is the only product which when used as intended, will kill one half of its consumers” (Giles and Thornhill 9/22/2000), and “a cigarette is a euphemism for a cleverly crafted product that delivers just the right amount of nicotine to keep its user addicted for life before killing the person” (Williams 4/28/1999). Unlike other commodities, cigarettes were “*inherently* dangerous products” designed by tobacco companies to create and maintain nicotine addiction. Not only the inherent danger of the product, but also the marketing practices of tobacco companies, established the industry as a major villain. They targeted the youth, women, and “those less advantaged from the educational, social and economic points of view.”[26] One theme repeated by WHO officials was the unfair imbalance between the now-global industry and the costumers, particularly in the developing world. Brundtland argued, “It is not correct to say that they [smokers, especially in developing countries] know the risks and they make a deliberate choice” (Giles and Thornhill 9/22/2000). Brundtland has described smoking as a “communicable disease” – through advertising (Giles and Thornhill 9/22/2000) – and other WHO staff warned that many poor countries found it hard to fight against American, British and Japanese multinational conglomerates that had been making headway in Asia, Africa and Latin America (Taylor and Bettcher 2000, Economist 10/14/2000). Brundtland likened the role of the *tobacco* industry in creating health problems to that of the mosquito in causing malaria: both are blood-sucking, disease-spreading parasites (Economist 10/14/2000). Such distinctions, then, allowed WHO to be “unapologetic about cold-shouldering the tobacco-industry devils” (Economist 10/14/2000).

Somewhat counter-intuitively, then, a major attack on the tobacco industry did *not* require much courage.[27] It nonetheless reflects the ability of the WHO to utilize the new perception of business as part of the “solution” to global health issues in order to identify, and discipline, those business who were obviously not. In soliciting corporations’ participation, the WHO again embraced the dominant logic and, as a consequence, put itself in the vulnerable position of dependence, but, at the same time, the WHO was able to strategically use the same reasoning that justified its relations with business to also mobilize against exceptional cases.

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[26] EB. 1986. 77th Session, Summary Records: Ninth Meeting, p. 129. IMG 1528

[27] Of course, the transnational tobacco sector, with the unconditional support of the United States, Japan and other countries with big tobacco companies, vigorously opposed very many of the most central provisions, including taxes on tobacco products, limitations on free trade, public smoking bans that failed to provide smoking areas, and “shock” images on health warnings. As a result of such pressures, many of the provisions in the convention were much weaker than supporters originally hoped for.

In short, the instances described above indicate the WHO's ability to, in some cases, manipulate existing neoliberal formulations to push forward the Organization's own agenda and, in other cases, to take a stand against established neoliberal policies, and they show how strategic adaptation allows, at least in some cases, to neutralize the most disagreeable neoliberal elements.

CONCLUSION

During the 1980s and 1990s, the WHO experienced a wave of exogenous pressures for extensive institutional and substantive reforms. To increase its legitimacy, regain its authority and benefit from old and new sources of funds, the WHO turned into a neoliberal-compatible organization, which relied on charity, embraced economic theories of public health, drew on market-based solutions, and supported cooperation with the private sector.

In part, these transformations indicate the WHO's succumbing to neoliberal prescriptions imposed from above. *Active incorporation* required the WHO to surrender some of its principles and goals, and the WHO's previous agenda and its future capacity have been compromised. For example, while the embrace of cost-effectiveness, together with efficiency, accountability to donors, transparency, and similar managerial reforms, have likely benefited the delivery of aid to the developing world, replacing equity as the primary concern of the WHO with cost-effectiveness meant that there was no longer commitment for redistribution and for reaching the most vulnerable. Similarly, presenting health as a major aspect of economic development, rather than a goal in its own right, had the risk that donors would invest resources in health *only* if it had the added benefit of improving economic growth and, possibly, *only* if it was more effective than investing in other sectors. Strategic adaptation also meant that the WHO was usually in no position to pick up a fight against the US government, multinational corporations or the Gates Foundation. In the long term, the reliance on voluntary funds, understood by potential donors as investment or charity, raises the issue not only of sustainability, which is particularly relevant in the current economic situation, but, just as importantly, the question of representation. In their organizational compromises, especially in the context of public-private partnerships, developing countries have lost their most valuable source of influence in the United Nations: the one country/one vote rule.

But this paper shows that the WHO also manipulated the exogenous logic for its own purposes. The "neoliberal turn" was not simply top-down imposition but the result of *creative adaptation*. While acting under exogenous constraints, the WHO was able to translate the exogenous prescriptions and "fit" them to the Organization's interests and principles. As we saw, the WHO offered its own economic analysis of global health, which, while being agreeable to the exogenous forces, also supported greater spending on health programs; the WHO adopted cost-effective calculations while maintaining some of its old priorities; and the WHO used economic arguments to oppose some health policies advocated by the World Bank and others. The WHO also cultivated a closer relationship with the private sector, but maintained room for exceptions, which allowed the

Organization to confront corporations in extraordinary cases. In this manner, the WHO was successfully incorporated into the new neoliberal order, but also managed to neutralize that order so that it became more conducive to its global health agenda.

In strategically adapting to exogenous pressures, the WHO not only made its views compatible with the dominant logic, but also translated the dominant logic to make it more compatible with the WHO's views. As we saw, by recruiting "legitimate" economists who would argue that health was cost-effective *and* necessary for development, the WHO contributed to the shift in rich countries' willingness to contribute to global health projects. And by devising an agreeable distinction between the majority of "good" companies and a minority of "bad" companies, and otherwise expecting companies to act according to their "social responsibility" claims, the WHO contributed to attempts to make companies more accountable. In that way, the WHO's strategies of adaptation led to the reformulation of the hegemonic universe into which it was forced to integrate itself.

The spread of neoliberalism at the international level, therefore, cannot be described as a simple imposition from above, either by transnational capital, rich governments or experts. The experience of the World Health Organization as described here, but also of other international organizations,[28] forces us to consider the possibility of manipulation from below. While the WHO found it necessary to embrace neoliberal thinking, the policies adopted in line with neoliberal reasoning have been an outcome of strategic, rather than passive, adaptation. In the process of adaptation, the WHO transformed its claims so they would fit into the dominant logic, thereby successfully asserting that its claims were rightly deserved. Such adaptation required significant sacrifices. But in the process, the WHO manipulated the exogenous pressures and somewhat neutralized the dominant logic.

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[28] Other UN specialized agencies have made similar attempts to strategically adapt to the neoliberal world order. The ILO, for example, has fought its increasing marginality by involving itself in the development agenda, at the partial expense of its previous programs and declarations. The ILO Declaration on Fundamental Principles of Rights at Work, from 1998, committed member countries, and their employer and union bodies, only to few, and the least controversial, "core" standards; the ILO shifted its focus from vertical redistribution (between employers and workers) to horizontal redistribution (among workers, particularly gender equity); and came up with new visions – such as "decent work" – that intended to connect to UN debates on poverty and globalization (Standing 2008).

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TABLE 1: COMPARING WHO LOGIC IN THE 1970 AND 1990

	Late 60s – Early 80s	**Late 90s - Present**
Principles	Equity / justice	Efficiency / cost-effectiveness
Rationale for intervention	Health	Economic growth
Major initiatives	• Horizontal • Health for All • Primary Health Care • Basic health needs • Appropriate technolgoy	• Vertical / disease-specific • Development of drugs & vaccines • Distribution of drugs & vaccines
Source of funds	Collective self-reliance	Donations
Contributions from…?	Mandatory (rich countries)	Voluntary (rich countries + private foundations)
Principle of contributions	Obligation	Investment and/or charity
Relations w private sector	Anti-multinationals Appropriate technology	Pro-multinationals Technological "quick fixes"
Institutional logic	Member-driven UN agency	Public-private partnerships
Form of expertise	Public health	Economics & business