The New Atlantis
A Journal of Technology & Society

The Politics of the WHO

Steven Menashi

"The bid is rejected," Chinese ambassador Sha Zukang yelled at reporters last May. "Who cares about your Taiwan?" For the seventh year running, the People's Republic of China had succeeded in blocking Taiwan's appeal for membership in the World Health Organization (WHO) at the group's annual World Health Assembly meeting in Geneva. Taiwan had only applied for observer status—not as a sovereign state, but as a "health entity," a neologism designed to mollify Beijing, which opposes any hint of recognition for a country it regards as a wayward province.

The WHO is the health agency of the United Nations. Founded in 1948, it is governed by the 192-nation World Health Assembly, and among other things is charged with coordinating international response efforts to unexpected outbreaks of disease. This past year saw just such an unexpected outbreak, as Severe Acute Respiratory Syndrome (SARS) swept across East Asia. Taipei hoped that the spread of SARS would convince the assembly that the exclusion of Taiwan from WHO disease-control efforts left a "serious loophole," as one Taiwanese official put it, in global efforts to contain this and future epidemics.

Moreover, China's evident negligence in confronting the outbreak—and, indeed, its positive obstruction of WHO efforts to fight the disease—had put the lie to the notion that Beijing provides for Taiwan's health care needs, an idea reiterated by Chinese health minister Wu Yi at the conference. "Our Taiwan compatriots are members of the big family of the Chinese nation," she insisted.

The World Health Organization, it turns out, agrees. The group's position seems to be not only that Taiwan does not exist as a sovereign country, but also that the *de facto* health-care administration of the island comes from Beijing—a twofold denial of reality that is remarkable for a scientific organization. To be sure, a political organization like the WHO will always be constrained by some fictions (such as the United Nations's "one China" policy) endemic to political life. But the WHO's usefulness lies precisely in its ability to bring scientific evidence to bear in political disputes that often lose sight of facts on the ground. The group's recent history, however, reveals a bureaucracy increasingly unhinged from the real world.

The SARS Crisis and Taiwan

On February 28, 2003, a doctor at Hanoi French Hospital in Vietnam contacted the World Health Organization on the suspicion that one of his patients had contracted avian flu on a trip to Hong Kong. Under WHO coordination, the hospital

---

Steven Menashi *is associate editor of* Policy Review *and a public affairs fellow at the Hoover Institution, Stanford University.*

sent blood samples and throat swabs to research labs in Tokyo, the Centers for Disease Control and Prevention in Atlanta, and Hanoi's own National Institute for Hygiene and Epidemiology. Analysts began to suspect a link between the Vietnamese infection (which was spreading) and an apparent pneumonia outbreak in China, though the Chinese government had been less than forthcoming with medical information. WHO officers arrived at the Vietnamese Health Ministry on March 9, and they convinced health officials to admit an international team of public health experts into the country and to form a local task force, which was created within a week. "Days later," according to the *Washington Post*, "a dozen epidemiologists and pathologists had arrived from Britain, the United States, Sweden, Germany, France and Australia." The expertise, equipment, and rapid coordination provided by the WHO helped the Vietnamese contain SARS within about six weeks of the team's arrival.

Just as the international team arrived in Vietnam, neighboring Taiwan was reporting its own first SARS cases. Taipei authorities immediately informed the WHO, and eagerly offered to share information and to cooperate with all international organizations and governments fighting the disease. Yet WHO officials responded that the organization was unable to assist Taiwan with the outbreak because, in their view, Taiwan is a province of the People's Republic of China. The WHO directed Taiwanese officials to contact the central government in Beijing, which under the U.N.'s policy on China is said to represent Taiwan's health interests in the international body.

The Beijing government, meanwhile, was not nearly as open with the WHO as their supposed subjects in Taipei. For months, China had endeavored to conceal or play down information about the spread of SARS for fear of political and economic fallout. "You can imagine how people would have reacted if we had told them about the disease," a local health department official told the *Washington Post*. "They wouldn't eat out, nor would they go shopping or get together with family members and friends." The government even resorted to official censorship of newspapers and television to conceal the outbreak. By the time SARS appeared in Taiwan on March 14, Chinese officials had known of the strange new disease for months, but still would not permit the WHO to investigate the site of the outbreak in Guangdong province, let alone to assist the democratic island across the strait.

To its credit, Taipei continued to report its findings, but with little in the way of reciprocation from the global health body. "We kept sending out results and results," Dr. Lee Ming Liang, who directed Taiwan's SARS response program, told CNN. "We got some response but not in an active way." Taiwan found itself excluded from the WHO's information-sharing procedures. The island was unable to participate in meetings with WHO researchers or the organization's weekly videoconferences. The WHO's Global Outbreak Alert and Response Network, which transmits medical information to member states, excludes Taiwan. Instead, Taiwanese

researchers learned of new findings from the WHO website. "By the time the information is in the public domain, it's probably out of date," complained Yuan-Tsong Chen, director of the Institute of Biomedical Sciences at Taipei's Academia Sinica. Taiwanese authorities also lacked crucial information, such as the particular Chinese provinces in which the virus was spreading, which would have enabled them to trace the paths of infection from mainland China and more effectively control the disease. And while the WHO helped the island's neighbors establish effective quarantine and containment procedures, the same assistance was denied to Taiwan.

"Because we didn't have those kinds of data and procedures from the WHO, that is the reason why we had the hospital outbreak a few weeks ago," Taiwanese presidential advisor Joseph Wu told reporters in May, when his country saw the fastest spread of the disease on record. In all, Taiwan waited seven weeks—about the same amount of time it took a WHO team to contain the disease in Vietnam—between the country's first SARS case and the arrival of two WHO doctors in Taipei. The doctors had waited for approval from Beijing, which came only grudgingly, after almost two months.

"It is true that Taiwan was complacent and they were not prepared for the SARS outbreak. They thought they had the disease under control when the second round of infections started April 21," said Michael M. C. Lai, a professor of molecular biology and immunology at the University of Southern California Medical School. "However, the WHO investigative teams could have spotted the weaknesses in the public health infrastructure. Had the WHO sent in experts early, the recent outbreak could have been prevented."

Taiwan thus found itself triply wronged in the SARS crisis. The island democracy was first exposed to SARS by China's failure to implement rapid-response containment measures. Then, once the Taiwanese were suffering in the aftermath of that neglect, the global health body not only refused to assist them, but refused even to recognize their existence. To complete its political fiction, the WHO for a time did not even acknowledge the outbreak of SARS in Taiwan—until public criticism prompted the group to include "Taiwan province of China" in reports and statistical tables. "If we are truly serious about stopping this disease in its tracks, then we cannot ignore millions of people who are at risk, " U.S. Health and Human Services Secretary Tommy Thompson told the WHO assembly in May. There is no question that the WHO's refusal to work with Taiwan contributed to the spread of SARS in other nations in Asia last spring, and put at risk the entire international contagion control effort.

Neutrality and Sovereignty

In a certain way, the organization's "one China" absolutism (though sometimes fatal) might be less objectionable if the WHO did not go out of its way to engage in sovereignty disputes elsewhere around the world.

Border controversies, on the face of it, do not seem like an obvious preoccupation for a global health body. Indeed, other international health and medical organizations, most notably the International Red Cross, typically attempt to avoid becoming entangled in political disputes, and to provide treatment and aid without taking sides. "In order to continue to enjoy the confidence of all," says the official Red Cross policy, "the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature." Red Cross officials therefore cooperate impartially with de facto authorities in order to meet a population's medical needs. The traditional view, as Red Cross leader Hans Haug wrote in his *Humanity for All: The International Red Cross and Red Crescent Movement*, is that the movement "has not been created and is not called upon to have an influence on the establishment of the system of law and society and to participate in the struggle for power within States and in the world of States." The Red Cross's refusal to allow the Israeli ambulance service Magen David Adom to join the worldwide network belies these claims of neutrality to an extent, but there is no question that in times of crisis an international health organization is helped enormously by a willingness to work with local authorities, whoever they are.

But the WHO's view of public health is somewhat more expansive. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," reads the organization's constitution. High standards of health can be achieved, as the WHO's "World Health for All by 2000" statement put it, "through influencing lifestyles and controlling the physical and psychosocial environment," implicating nothing less than a "fundamental reorganization of human relationships in the world through the search for a New International Economic Order."

Indeed, the World Health Organization's claim to be unable to assist Taiwan out of respect for national sovereignty is all the more bizarre considering that the organization's public documents call for political reorganization in the interest of public health. The World Health Assembly, for example, has concluded that "Israeli occupation is a serious health problem" to be remedied only by a sovereign Palestinian state. Even as it rejected Taiwanese appeals merely to participate in global health efforts, the World Health Assembly (WHA) showed no hesitation in "reaffirming the inalienable, permanent and unqualified right of the Palestinian people to self-determination, including their right to establish their sovereign and independent Palestinian State, and looking forward to the early fulfillment of this right."

The WHO's annual condemnations of Israel at the World Health Assembly constitute the only country-specific resolutions adopted by that body. Yet, despite the organization's singular animosity towards Israel ("the occupying power," as WHO reports refer to the country), Palestinian health has improved

appreciably under the Israeli healthcare system. As historian Efraim Karsh has written, "mortality rates in the West Bank and Gaza fell by more than two-thirds between 1970 and 1990." In 1967, while under Jordanian and Egyptian rule, life expectancy in the Palestinian territories was 48 years. By 2000, the figure had climbed to 72 years—higher than the average life expectancy of 68 years in the larger region of the Middle East and North Africa. The introduction of Israeli medical care similarly reduced the infant mortality rate from 60 per 1,000 live births in 1968 to 15 in 2000—a substantially lower rate than those found in Jordan and Egypt, the previous administrators of the West Bank and Gaza (at 23 and 40 per 1,000, respectively). Other measures of the Palestinian "psychosocial environment," such as access to electricity, running water, and education, improved even more markedly over the same period.

Instead of health-related concerns in the territories, WHA resolutions and WHO "Health Situation Reports" condemn the Jewish state for requiring security checkpoints, building settlements, and responding militarily to terrorist attacks. All these may well be worthy of criticism and debate within a deliberative political body, but by presenting them as health concerns, the WHO attempts to pass off its political preferences as scientific expertise.

Politics and Science

The World Health Organization regularly holds itself up as a source of scientific rigor in public policy debates. "Although we accept that politics is part of our existence," the WHO staff associations representative told the organization's executive board last year, "we should not allow politics to rule us and dictate the activities of the Organization." Public health professionals at the WHO aim at getting health outcomes to conform to some standard that is presumed to be objective and scientific. The entire discipline of public health, according to the WHO's *World Health Report 1998*, is "the art of applying science in the context of politics so as to reduce inequalities in health while ensuring the best health for the greatest number." Of course, even that statement betrays clear political judgment; for it is by no means scientifically obvious that egalitarianism should have so central a place in international public health policy.

The effect of this overriding focus on equality is evident in some prominent WHO studies. The organization's *World Health Report 2000*, for instance, reported the absurd statistic that the United States ranks thirty-seventh in national performance among the world's 191 "health systems"—placing America well behind such celebrated centers of medicine as Colombia, Morocco, and Oman. Obviously, no sensible person takes such figures seriously. The WHO can indulge in its fantasy only because of its own ideological commitments. The criteria for the health-systems ranking, devised by something called the "WHO Global Program on Evidence for Health Policy," were primarily measures of

political egalitarianism. They included "distribution of health" and "distribution of financing"—criteria which measure inequalities, but have nothing at all to do with the absolute quality of healthcare. Another WHO standard is "fairness of financial contribution." "Colombia," explains the report, "achieved top rank because someone with a low income might pay the equivalent of $1 per year for healthcare, while a high-income individual pays $7.6." Predictably, the report insists that "ultimate responsibility for the performance of a country's health system lies with government" and dismisses market-based approaches as "the worst possible way to determine who gets which health services." More grandly, it declares that the "careful and responsible management of the well being of the population is the very essence of good government."

No one really believes that the WHO's findings were based on science, though their political preferences were hidden behind an elaborate facade of statistical analysis. The truth remains that science provides no action plan for government. The fact that chocolate or cigarettes are bad for you, for example, in no way settles the question of whether those products should be legal or not. Health, despite the rhetoric of the WHO, is not the *summum bonum* of good government.

As SARS wracked their country last spring, Taiwanese legislators petitioned the World Health Assembly: "The World Health Organization should not become a political stage," they wrote, "politics should remain out of healthcare." Taiwan's was certainly a legitimate grievance, but Taipei lawmakers were asking for the impossible. There is no way to take politics out of the question of who gets which health services, for it is a political question to begin with. Any organization that, like the WHO, claims to act in the public good must hold some substantive idea of what the public good constitutes, and this involves consideration of the demands of justice and ethics. In deciding how to distribute health resources, the WHO unavoidably acts on the basis of certain political principles. Some, such as equality, may be salutary in their proper proportion; others, such as the "one China" principle, may not make sense at all. Taiwan fell victim not to the politicization of public healthcare—a senseless expression—but to the biases of the WHO's particular political ideology. This may seem a trivial matter of semantics, but the insight that public health is always a political enterprise is often lost on healthcare professionals, especially those working for the WHO itself. Their political prejudices hide under the banner of science; their ideologies masquerade as expertise.

In practice as in theory, the notion of "public health" is often expanded to cover nearly the entire range of human experiences. It is not difficult to see how this attitude can lead to pervasive bureaucratic control of all facets of life, especially when authority is assumed over any social factor that might affect health or well-being. In 2002, for example, the World Health Assembly resolved: "Behaviors that encourage social polarization and practices of discrimination,

racism and violence and provide the social and cultural basis of several wars—often the major cause of mortality and morbidity—should be considered a public health issue and appropriate strategies and programs should be found to tackle them." In this vision, the most contentious and important political debates should be resolved not through public deliberation, but by public-health technocrats acting through a bureaucracy.

The World Health Organization's fault, then, is not to bring politics into what was always a political enterprise, but rather to present its political agenda as impartial medical expertise. Such a vision neutralizes political debate before it begins, replacing politics with government by medical experts. The WHO's presentation to the 2001 United Nations World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance reported that "health disparities are rooted in fundamental social structural inequalities, which are inextricably related to racism and other forms of discrimination in society." Because "mortality and health in general rarely diverge far from economics and social relations," the WHO insists that adequate public-health policy would include "comprehensive legislation, specifically prohibiting all forms of discrimination and providing civil and criminal penalties and remedies in all spheres of public life." All of society, it turns out, is a sick patient; all human endeavors are symptoms. A resolution of the WHO's Western Pacific regional office makes this idea explicit:

> Public health is primarily concerned with the collective action taken by society to promote and protect the health of entire populations. This may be compared with clinical medicine, which deals primarily with problems of individuals and, therefore, may be referred to as personal health services.

Policies such as affirmative action, which the WHO also advocates, are medical treatments for a diseased body politic. And there is little room, of course, to question the doctor's orders.

An Epidemic of Choices

Collapsing the distinction between political preferences and scientific fact also leads to bad science when the evidence fails to live up to the WHO's ideological aims. The organization classifies smoking, for example, not as an unhealthy personal choice, but as a disorder listed in its International Classification of Diseases. Needless to say, confronting the "tobacco epidemic" is a top priority. The WHO's Framework Convention on Tobacco Control obliges states to adopt an extensive system of regulation, taxation, and advertising bans with regard to tobacco products without any deference to the states' own legislative procedures. For the WHO, tobacco laws are not a matter to be left to accountable legislatures or public deliberation; as a central health concern they are to be determined by health-care professionals.

Yet the WHO's long-running war against the tobacco industry often outpaces the scientific research. In 1998, the WHO was scheduled to release an extensive ten-year multinational study on the links between second-hand smoke and cancer. The study found no statistically significant correlation: "There was no association between lung cancer risk and [second-hand smoke] exposure during childhood," the researchers concluded. A small recorded risk for adults living or working with smokers fell within the statistical margin of error, such that the numbers were consistent with an increased risk of zero.

But the full study was not published. The London *Telegraph*, prompted by a summary of the study in a report by the WHO's International Agency for Research on Cancer, accused the WHO of withholding the complete study from publication because its results conflicted with its anti-tobacco agenda. "The World Health Organization, which commissioned the twelve-centre, seven-country European study has failed to make the findings public," reported the newspaper, "and has instead produced only a summary of the results in an internal report." The *Telegraph* reported that the "scientists have found that there was no statistical evidence that passive smoking caused lung cancer." The next day, the WHO issued a press release angrily headlined "Passive Smoking Does Cause Lung Cancer, Do Not Let Them Fool You." The release claimed the study found a link between second-hand smoke and cancer, but noted that the study's small sample size made the increased risk statistically insignificant. In other words, the WHO could not disagree with the substance of the *Telegraph* report, just its emphasis. The WHO's political agenda prevented the group from dealing honestly with the evidence.

The World Health Organization is pulling no punches in this particular fight, for its supposed enemies are—to their minds—ruthless and dangerously powerful. "The evidence shows that tobacco companies have operated for many years with the deliberate purpose of subverting the efforts of the World Health Organization to address tobacco issues," reads an August 2000 report commissioned by the WHO. "The attempted subversion has been elaborate, well-financed, sophisticated and usually invisible." The organization had an expert committee review some 35 million pages of documents that had been made public during U.S. litigation against the tobacco industry. The committee found that tobacco companies had been engaged in lobbying governments and international organizations to stress the economic importance of the tobacco industry and had been funding research that conflicted with WHO conclusions.

This is all unsurprising, of course, for an industry whose business is growing and marketing tobacco products. What was the WHO trying to establish? As a report in *The Scientist* put it, the study "found evidence that may explain the poor impact of WHO's efforts to control tobacco use over the past 20 years, particularly in the developing world." But perhaps a better explanation for why the

WHO hasn't been able to contain the smoking epidemic is that a person can't "catch" smoking as one catches smallpox or malaria. Indeed, the prevalence of smoking isn't an epidemic at all, but the accumulated choices of individual smokers who, despite the risks, find some value in the activity. Surely, the WHO has a role to play in publicizing the health risks of various behaviors, so that accountable legislatures or individual citizens might make well-informed choices. But people's lifestyles are not diseases, and the attempt to medicalize them not only undermines open political decision-making, but places public-health authorities in opposition to the free choices of the public. And, as it turns out, you can't control human desires like cholera or SARS.

Neglecting the Mission

At its birth, the World Health Organization focused its efforts on combating infectious diseases. The global fight against smallpox, for example, was officially won in 1977, due in no small part to the WHO's coordination and research. But in recent years, the WHO has shifted its priorities. Former WHO director Gro Harlem Brundtland has called smoking the "biggest global health threat" and predicted that "by the year 2010 tobacco is going to be the biggest disease burden globally." In addition to what it calls "the deadly forces of tobacco and excessive alcohol consumption," the *World Health Report 2002* counts unsafe sex, obesity, and high cholesterol among the world's top ten health risks. To combat the obesity "epidemic," the organization plans to present its Global Strategy on Diet, Physical Activity and Health to the World Health Assembly in 2004. The WHO has also sponsored research on "economy class syndrome," the supposed tendency of cramped air travelers to develop blood clots in the legs, and runs a multimillion-dollar research program on the hazards of cell phone use.

To some extent, these priorities reflect the WHO's need to make itself relevant to those (largely healthy) first-world countries that pay the organization's bills. But ideology is an important motivation. A running theme for the WHO, recently reiterated at a September 2003 conference on youth in Eastern Europe and Central Asia, is that exposure to the so-called benefits of Western life are in fact hazardous to health, leading to such problems as mental illness and overeating. "The main reasons for the greater cancer burden of affluent societies," explains a recent WHO press release, include "Western nutrition and lifestyle." The group devotes a large part of its 2003 *World Cancer Report* to "the Western lifestyle and its health risks." (Evidently, "the West" was not included in the WHO's announced objective of encouraging "policy plans and health programs which are sensitive to ethnicity.")

Admittedly, nutrition, drug abuse, and maybe even "economy class syndrome" are real health concerns—though it is doubtful that unhealthy personal habits are some essential part of Western culture. But they are not priorities that

best use the resources of an international global health network. Infectious diseases, after all, are still killing people. As the *Washington Times* reported last April, "When Mrs. Brundtland took charge at WHO in 1998, about 17.3 million people died annually from largely preventable infectious and parasitic diseases, according to WHO's own estimates. Now at the close of her five-year tenure, the WHO estimates the death toll has climbed to about 18.4 million annually."

In some cases, the WHO's new priorities have directly hampered its more traditional mission of disease control. For example, even though the use of insecticides was instrumental in driving malaria from Europe and the United States, the WHO's "Roll Back Malaria" campaign eschews them in favor of bednets—which, though far less effective, do not offend environmentalist sensibilities. As a result, writes Roger Bate, a director of the nongovernmental organization Africa Fighting Malaria, "Only countries rich enough to support their own insecticidal spraying—such as India, South Africa, Ecuador, parts of Zambia—are managing to control malaria and other mosquito-borne diseases. They stand in stark contrast with those countries which are limited to using bednets." Nor is this exclusively a problem for poor countries, according to Bate: "Ever since Mexico reduced its use of insecticides—at the WHO's behest—cases of ages-old endemic mosquito-borne diseases are reappearing" in the United States.

In other cases, the WHO's lifestyle initiatives consume resources that could better be used elsewhere. The Roll Back Malaria initiative itself has been hamstrung for lack of funds. In July, WHO director-general Jong-Wook Lee announced that the organization's Global Polio Eradication Initiative required an additional $210 million to maintain its polio immunization and surveillance programs. These are the challenges the WHO is best equipped to confront, and should be the central focus of the organization. Malaria, unlike smoking, is an actual disease—and a scientific organization should be able to tell the difference.

Worldwide, there are many advocacy groups trying to reduce smoking and alcohol abuse. As the SARS crisis revealed, however, the WHO's singular usefulness lies in combating infectious diseases by providing up-to-date medical research and coordination among national health authorities. In Vietnam, it did this well; in Taiwan, it did not. And if there is a "sickness," it is in the political hallucinations of the WHO itself: Just as Beijing is not the administrative capital of Taiwan, military conflicts and personal behavior are not "epidemics" in need of medical "cures." In trying to medicalize all spheres of life, the WHO confuses scientific veracity with its own ideological imperatives. The result is bad science and bad politics. And that's bad medicine all around.