A new international health order. An inquiry into the international relations of world health and medical care
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Document Version
Publisher’s PDF, also known as Version of record

Publication date:
1978

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):
SUMMARY

A ‘New International Health Order’ (NIHO) is a new notion. In value the function of a NIHO, the present international health order, the socioeconomic order between the rich and poor countries will be taken into account. The factual and normative development of an international economic order (NIEO) will subsequently receive special attention. The study is based on
1) the necessity to integrate medical (health) care and national and international socioeconomic developments;
2) the unacceptability of the global health inequalities between the rich and poor.

CHAPTER 1 describes the history of the socioeconomic necessity of integration of the health sector. A survey is given of how in the present developed countries (DCs) during the Middle Ages phenomenological symbiosis existed of health(care) and the structure, activity and meaning of society. The Church-State doctrine with its ubiquitous norms of sickness and its blessing constituted the binding element. The Counter-Reformation increased the strength of the symbiosis gradually while the emergence of medical guilds and the evermore successful medical sciences resulted in a schism of health(care) and socioeconomic circumstances.

An explanation is given of how nationally in DCs the necessity of economic integration redeveloped. The acceptance by various political systems of the doctrine of welfare-through-industrial (incl. agricultural) growth (the ‘welfare state’, the ‘new industrial state’) implied the new symbiosis. On the one hand the principle of the collective co-responsibility of society for the social and economic wellbeing of its members led to a social right to health(care). On the other hand it became apparent that disease was often also the result of the socioeconomic growth. Whereas initially the state was only indirectly involved in the development of the health sector (delegation of authority to the profession, sanitary inspection, etc.), it now became the direct expression of the collective responsibility and primarily responsible for the protection against pathogenic socioeconomic factors. At the same time it became clear that economic equilibrium can contribute to productivity from nation and health care.

CHAPTER 2 deals with the principles upon the international creation of the present world order. The dimensions of these changes, the ‘Christian’ states, which subsequence together all the existing nations in more than a hundred new sovereign viability of this order. Under they were all brought together in

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An international economic order can be found as on the national population, etc. Especially because at some form of one-world (viz.: pollution, technological development) economic order can offer any productivity, but also for a new inte...
clear that economic equilibrium cannot optimally be obtained without the contribution to productivity from social sectors such as nutrition, education and health care.

CHAPTER 2 deals with the projection of these nationally developed principles upon the international order. To provide an insight into the creation of the present world order, the imminent end of this order and the beginning of a new world order, it is necessary to examine extensively the dimensions of these changes. Originally the ‘world’ consisted of a few ‘Christian’ states, which subsequently as the so-called ‘civilized’ brought together all the existing nations into one international order. The rise of more than a hundred new sovereign states in the Third World challenged the viability of this order. Under the new norm of ‘peace-loving’ nations they were all brought together in the United Nations.

By way of decolonization, racial equalization and growing economic integration (non-autarchy), the impact of the sovereignty of the new developing countries (LDCs) is described. Emphasis is put on the economic integration since it appears that both the new poor and the industrialized rich adhere to the national doctrine of well-being-through-industrial-growth. Thus internationally equivalent views emerged to integrate health(care) and socioeconomic growth.

It is concluded that a new international order is justified especially when taking into account the LDC point of view that Third World economic growth remains obstructed by the old-world-order socioeconomic position, behaviour and consumption of the rich countries individually and as a whole. This equally is supported by the fact that the national principle of the co-responsibility of the collectivity for the well-being of its weaker members is now universally endorsed by all states (‘the community of nations’). Consequently a NIEO will have to voice the responsibility of the ‘Rich North’ for the ‘Poor South’ (North-South Dialogue).

An international economic order cannot do without a social equivalent. If this social equivalent is divided into functional sectors, the same entities can be found as on the national level: nutrition, education, health, population, etc. Especially because of the evergrowing necessity to arrive at some form of one-world (viz. peace, natural resources, energy, pollution, technological development etc.) only a new international socioeconomic order can offer any perspective. Not only is there the necessity for a NIEO, but also for a new international population order, a new inter-
national food order, a new international environmental order, etc. Similarly a new international health order (NIHO) between the poor and rich countries will have to be established.

Next the necessity for integration due to the mutual dependency of socioeconomic sectors between poor and rich countries is discussed. OPEC price increases which are based on the capacity of the DC energy sectors notably influence LDC health sectors. The energy budget deficit e.g. Malawi is recouped out of the health care budget. Shown is how the fact the American air conditioner (25% of U.S. energy goes for air-conditioning) determines the health (care) in many LDCs. In Chapter 6 some of these relations are closely examined. The food sector, for instance, comprises among other things the DC health-LDC disease and DC disease-LDC health correlations. The excess sugar consumption in North America a clear pathogenic factor. It stimulates the sugar production in the Latin American LDCs providing sufficient income for several so that they have enough food and adequate housing conditions to remain healthy. If sugar consumption in DCs were to be drastically reduced for the benefit of DC health, many in LDCs would be deprived of their income and find themselves in 'subsistence' circumstances, with consequent (bad) health effects: health in LDCs at the cost of disease in DCs and health in DCs at the cost of disease in LDCs. Identical and more complex relations occur in other sectors such as population, pollution, education, etc. (fig. 57). These socioeconomic health relations are placed in the NIEO framework in that the significant correlations between the national income/caput and variables of socioeconomic growth on the one hand and the health level, the average life expectancy and the infant mortality on the other are examined (table 34 and figs. 52-55 incl.). It is concluded that a NIHO alone will not be able to control and to structure these correlations equitably among poor and rich. For a balanced world order also international health (care) will have to be united with the NIEO and the other new international social sectors.

On the basis of the five Reports to the Club of Rome, World Bank policy (McNamara) and the conclusions of the Special Sessions and World Conferences of the UN, the normative thesis is propounded that the inequalities between rich and poor countries are excessive (table 1). The development gap is a dangerous threat to the socioeconomic growth of the poor as well of the rich. It deprives the majority of the world population of a just existence and could jeopardize the universal value of peace. The NIEO endeavours have to be viewed in this light.

Before proposing the function concepts of equality and inequality scientific qualifications of these concepts are discussed (2.4 and 8.2). Consider excessive inequalities, the concept and DCs is standardized. The e.g. for the realization of a new world order.

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Qualitatively it is shown how medical care in LDCs has led to medical care in DCs which, in turn in LDCs as an expression of health conditions in DCs can be traced directly. Socioeconomic integration and determinants of a new world health order is determined by three different world-order-oriented. To achieve elementary; they are studied in
Before proposing the functional step towards a 'health gap', the concepts of equality and inequality are examined. In view of the weak scientific qualifications of these concepts, their form, function and content are discussed (2.4 and 8.2). Considering the present 'unacceptability' of excessive inequalities, the concept 'acceptable inequality' between LDCs and DCs is standardized. The equality of both facts and norms essential for the realization of a new world order (NWO), in case a NIHO, is classified.

An appraisal is made of the advantages of health(care) compared to other sectors to reduce the inequalities and by way of intersectoral chain reactions to act as the forerunner for an NWO. Before giving any specifications of a NIHO, the existence of a 'health gap' is examined.

CHAPTER 3. asserts that quantitatively and qualitatively a 'health gap' between the poor and rich countries can indeed be spoken of.

Due to the insufficiency of African and Asian statistics, the American DC-LDC Region is taken as pars-pro-toto for the world health gap. The quantitative inequality analysis is primarily based on the PAHO Report 'Health Conditions in the Americas'. It seems that in some cases the inequality grows less. In many cases, however, the inequality increases, either because of relatively faster improvements in DCs or due to worsening in LDCs. Successively the development and prognosis of population growth, mortality, morbidity, health facilities and health manpower are analyzed.

Qualitatively it is shown how the implementation of modern DC medical care in LDCs has led to an LDC-DC gap in the valuation of the concepts of health and disease. The unilateral flow of curative medicine, environmental hygiene and pharmaceutics from DCs to LDCs resulted in a dissociation of DC supply and LDC demand (need), detrimental to the latter. Conversely an inequality-reducing tendency occurs with respect to preventive and social medicine. The LDC concept of 'self-care' is gaining importance in DCs which, in turn, are beginning to acknowledge 'self-care' in LDCs as an expression of health 'self-reliance'. The health-center initiatives in DCs can be traced directly to the LDC-DC self-care flow.

Socioeconomic integration and LDC-DC inequality are the two primary determinants of a new world health order. The present international health order is determined by three different factors which are intrinsically less world-order-oriented. To achieve a NIHO, insight into these factors is elementary; they are studied in Chapters 4, 5 and 6.
In CHAPTER 4 the ever recurring medical functionalism is expounded, in this respect the term 'historical functionalism' is coined. It is described how both medical science and profession were catalysts of international health tolerance. The Sanitary Conventions since 1851, the Paris Office of the Health Commission of the League of Nations raised an international health system that was based on the orientations and needs of the then colonial DCs. The professional and scientific exertions led to an international system of mutual medical identification which was purely functional, excluding whatever political qualifications. Various norms of the Charter of the subsequently founded WHO relativized this functionalism by pointing out several political and socioeconomic dimensions of health (care). The increasing state influence combined with the rise of the new authoritarian new countries advanced intergovernmentalism in WHO, rendering it subject to the principles of international politics. Nevertheless, until the late seventies, WHO stuck to its historical functionalism which remained exponential of DC diagnosis, therapy and prevention.

CHAPTER 5. Thus the 'inadequacy syndrome' came into being. Health care in both DCs and LDCs did not only become ineffective but even inadequate. The inequality-enlarging paradox occurs that on the one hand the DC population has become continuously healthier but more knowledge, efforts and monies are spent on better health (US 1977: $ 160 billion, $ 700/caput), whereas on the other hand LDC health either stagnates or worsens but knowledge, efforts and monies decrease (fig. 3). The massive care for the overall healthy DC populations becomes unacceptable when compared to the slight inadequate care for the mostly people in LDCs. The 'historical functional' transplantation of DC medical orientation (curative, pharmacological) to LDC circumstances is considered to be one of the main reasons of LDC inadequacy.

The most important factor in DC-LDC international health relations is health aid. While the results of the medical orientation are also effectuated by way of health aid, 23 further instances of structural inadequacy are analyzed. These concern the flow of inadequate DC health systems to LDCs. For example, comparisons of health aid policy of donors and recipients, multilateral versus bilateral relations, medical and related training and the 'brain-drain problem' are investigated. It is observed that the health systems assistance which is to replace medical aid, will not be able to contribute positively to international LDC-DC health relations. This is endorsed by the classification of the political dimensions of these relations which determine the economic structure of the LDC health sectors (5.3). Besides these well-known political differences (incl. East European DCs) as to their LDC health(care), an adequate political emphasis on more equitable health aid for LDCs appears to be gaining more importance. This could well reduce the health care inequality between LDCs and DCs. Meanwhile adequate integration of health aid and health is demanded. This integration is the incentive for a new cooperation.

CHAPTER 6. examines the three sectors and their health implications for economic development. The medical sectors are dealt with in detail. Its function is propounded for the development-health(care) integration. The mutual international dependence of to the respective DC-LDC inequity model (fig. 57, 6.3) reflects that international health relations are interdependent on the international economic sectors, and conversely, health aid is determined by the world political dimensions of this relations which are analyzed in chapter 6.5.

The last two chapters study the following issues:
1) what is the present WHO policy (fig. 5) starting from the aforementioned inequity model (fig. 57, 6.3) reflects that international health relations (Ch. 7);
2) which concepts are to play a future role in realization of a NIHO (Ch. 8).

CHAPTER 7. The policy analysis is intended. Whereas WHO policy until 1978 completely to its historical functionalism (G.P.) clearly aims at closer connections for all (especially in LDCs) respects and experiences two dilemmas in this respect, the contrast of the political exigency of the Organization. WHO is on the one hand obliged to consider the sovereignty and self-regulation of the people and on the other hand is determined by the world political dimensions of the international relations which is to replace medical aid, will not be able to contribute positively to international LDC-DC health relations. This is endorsed by the classification of the political dimensions of these relations which determine the economic structure of the LDC health sectors (5.3). Besides these well-known political differences (incl. East European DCs) as to their LDC health(care), an adequate political emphasis on more equitable health aid for LDCs appears to be gaining more importance. This could well reduce the health care inequality between LDCs and DCs. Meanwhile adequate integration of health aid and health is demanded. This integration is the incentive for a new cooperation.

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European DCs as to their LDC policies and their negative consequences for LDC health(are), an adequate variable can be traced as well. The DC political emphasis on more equitable distribution among the poor and rich in LDCs appears to be gaining momentum precisely in the health sector. This could well reduce the health inequalities in LDCs and, therefore, between LDCs and DCs. Meanwhile it already seems to result in a more adequate integration of health and other socioeconomic sectors in LDCs. This integration is the incentive for the last group of factors.

CHAPTER 6. examines the three for an NWO most important present sectors and their health implications: food/nutrition, population and economic development. The mutual multisectoral effects of the four sectors are dealt with in detail. For instance a mortality-fertility reduction function is propounded for the population-economic-development-health(Mcare) integration. Especially important is the specification of mutual international dependencies between the four sectors as they relate to the respective DC-LDC inequalities per sector: the aforementioned model (fig. 57, 6.3) reflects that the international health inequalities are interdependent on the international inequalities in the food, population and economic sectors, and conversely so. The world health gap determines and is determined by the world food, population and economic gaps.

The last two chapters study the following two questions:
1) what is the present WHO policy with respect to a NIHO structure, starting from the aforementioned qualifications of LDC-DC health relations (Ch. 7);
2) which concepts are to play a major role in future WHO policy for the realization of a NIHO (Ch. 8).

CHAPTER 7. The policy analysis arrives at the following observations. Whereas WHO policy until 1978 (Fifth General Program) adheres almost completely to its historical functionalism, the 1978-1983 policy (Sixth G.P.) clearly aims at closer connection with NIEO efforts. WHO experiences two dilemmas in this respect. The factual dilemma involves the contrast of the political exigencies of the NIHO to the functional orientation of the Organization. With regard to the normative dilemma WHO is on the one hand obliged to provide for the basic needs of health for all (especially in LDCs) respecting the socio-cultural values and economic structures of the people and country concerned (in conformity with the sovereignty and self-reliance norm). On the other hand WHO feels that it is only possible to meet the basic needs if a number of inter-
nationally acknowledged specific configurations of these values and structures are adopted (7.1).

WHO policy until 1983 attempts to bypass these dilemmas with a number of functional concepts and their application. The multilateral approach, country health programming (CHP), technical cooperation, primary health care, rural health and the concept of 'social poverty' were critically reviewed. WHO attempts to absorb functionally the international political requirements for an effective link with the NIEO by a process of national multisectoral development, to which almost all these concepts relate. After demonstrating how this ignores the international inequality model, the various policies are tested as to their relationship with the NIEO relevance. The result is disappointing (7.2).

Special emphasis is given to human rights. In line with the general tendency towards human rights, the Organization attempts to arrive at human health rights, which because of their universal potential should be of utmost importance to a NIEO. On the one hand, to preclude the international health rights is considered to endanger the central values of peace and security. On the other hand, WHO has introduced the concept of 'health technology' as a first token of a human health right. The right to expedient health technology based on socio-cultural circumstances (conformity with self-reliance) invalidates the historical functionalism 'DC technology for LDC needs'. It supplies WHO with an effective means to design a differentiated order of all LDC health sectors. Since this order is not extended to DCs, the NIEO relation remains obscure. To arrive at a NIHO structuring, WHO would have to specify certain minima for LDCs that would reflect the 'human technology right'. Figures 59-62 provide some examples of possible minima, for instance, for clinical pathology and surgery.

Subsequently the data of the Sixth General Programme until 1983 are examined. Viewed from the NIHO angle, all 'objectives' are set forth in multilateral programmes with regard to onchocerciasis, tropical diseases, research and training, immunization and sanitation are scrutinized. A central theme is the technical cooperation between WHO and LDCs and since recently among LDCs (TCDC). The importance is stressed of the WHO decision to allocate at least 60% of its budget to actual assistance to LDCs and especially (MSA) LLDCs. The weakness of the 60% norm is apparent from its slight NIHO qualification. WHO excludes the DC North from its 60% policies by failing to acknowledge the aid cooperation relation as the most prominent factor in the present LDC-DC health relations. A NIEO endeavor to make joint efforts with all LDCs and with the DCs need adaptation in and by DCs, since the situation in the world health order.

A positive correction was made at WHO (WHA). A clear LDC-DC relationship Programme, stimulated by WHO smallpox program that made the DCs become focal. In fact WHO proposes to link the level of LDC health expenditure with the economic integration a link of the DCs. Furthermore two other capacities are stressed: occupational health and (under) capacity building in an analogous DC-LDC comparison. These propositions carry as yet incomplete with the DC members.

Thus, with respect to a NIHO, the following conclusions are made:
1. to stick to its historical functionalism,
2. to apply the socioeconomic in DC-LDC dependencies;
3. to recognize the reality of the DC-LDC relations within the framework of the DC-LDC dependencies;
4. to recognize the health goals to contribute intrinsically to the 'acceptable inequalities' among the DC and LDC members;
5. to pursue merely an empirical relationship introduced, without formulating the possible consequences. Furthermore, in the future the world's health situation will develop (figs. 63 and 64).

CHAPTER 8. Whereas especially the DCs are subject to these rather weak NIHO short-term policy (politically oriented), the initiatives mentioned in 7.4 and the initiatives mentioned in 7.4 of this study, these NIHO requirements should be reflected on the future development of the world's health situation. Thus, with respect to a NIHO, the following conclusions are made:

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health relations. A NIHO endeavour without the active support of all DCs together with all LDCs and without the diagnosis that a NIHO will equally need adaptation in and by DCs, shall not be able to procure one universal world health order.

A positive correction was made by the 30th World Health Assembly (WHA). A clear LDC-DC relationship was conceptualized for the Sanitation Programme, stimulated by the essential DC contribution to the WHO smallpox program that made it possible to locate the last variola foci. In fact WHO proposes to link the level of DC health expenditures to the level of LDC health expenditures. In terms of health gaps and socioeconomic integration a link of this kind would have far-reaching NIHO consequences. Furthermore two 1978-1983 objectives with respect to occupational health and (under)nutrition are tested on their NIHO capacities in an analogous DC-LDC link (7.4). For short term realization these propositions carry as yet insufficient weight in WHO and among its members.

Thus, with respect to a NIHO WHO is observed (8.1)
1. to stick to its historical functionalism with all the consequent improper DC-LDC dependencies;
2. to apply the socioeconomic integration concepts but only nationally in LDCs;
3. to recognize the reality of the necessity of health assistance but not to place it within the framework of LDC-DC relations;
4. not to recognize the health gap as the starting point for a NIHO and not to contribute intrinsically to the reduction of inequalities towards 'acceptable inequalities' among rich and poor;
5. to pursue merely an empirical policy as a reaction to the problems introduced, without formulating an active NIHO strategy of how in future the world's health situation among DCs and LDCs should develop (figs. 63 and 64).

CHAPTER 8. Whereas especially the middle and long term policies are subject to these rather weak NIHO aspects, shows Chapter 8 that the short-term policy (politically more sensitive) corresponds somewhat to the initiatives mentioned in 7.4. A systematic advancement of positive valuation can be discerned with respect to the elements necessary for a real NIHO. As described in the Chapter on the relevance and methodology of this study, these NIHO requirements are in fact 'scenario' elements (de Jouvenel).
The more elementary prerequisite concerns the situation of a more equal and equivalent world health relationship among DCs and LDCs. This relation is classified according to equality of health facts and norm. The interaction of these makes it impossible to arrive at a factual equality without a certain level of normative equality, and conversely so (norm/fact configuration). Thus what matters is the 'acceptable' degree of the health norm/fact configuration between the LDC-South and the North. From the logical as well as from the practical point of view it would be insufficient to procure 'acceptable' LDC minima to bridge 'unacceptable' inequality. Mindful of Gunnar Myrdal's observation that "The blunt truth is that without rather radical changes in the consumption patterns in the rich countries, any pious talk about a new economic world order is humbug", equally DC maxima should be set for a controllable NIHO balance of the LDC-DC health(care) relationship. Via quantitative and qualitative more or less conforming factual and normative health patterns will it be possible to attain the necessary identification and solidarity process between individuals, groups, people, countries and regions. Without this, analogous to the emergence of national peoples and countries, a one-(health)-world will appear to be inviable.

From the normative principle of the co-responsibility of the collective for the well-being of its members, it follows that this identification and solidarity with one-world-health order is to form the foundation for the structuring of the responsibilities for the optimization of the acceptability of inequality relations between DC maxima and LDC minima. This assumes international health(care) rights and obligations with respect to one's own and others health development, which apply not only to DCs with regard to LDC minima but also to LDCs with respect to DC maxima. A supranational authority will be necessary to structure these rights and duties with respect to the most fundamental limits of the world minima and maxima for health norms and facts.

Subsequently two matters are specified. Firstly a NIHO does not stand in the way of local, national or regional health cultures. The necessity of specific expressions of local health norms and facts in line with self-reliance in LDCs and in DCs is emphasized. A NIHO is concerned only with the limits of a federal world framework for constitutional and infrastructural norms and facts for acceptable inequalities and socioeconomic health integration. Within these in practice very wide limits, each community should be free to enlarge its own health identity independently.

Secondly a NIHO shall have to provide a dedication of more or less equal health order if it is merely an extension of factual configurations. A new synthesis of IHO.

Whereas the positive development of these forms are dealt with, especially mentioning. A factual and normative and the aim to strive for "The economic world order is humbug", the value of the DC for both LDCs and DCs. The need is advocated for DCs which may not be DCs. This holds true for countries. The relevance of the pharmaceutical industry in the DCs is recommended. Respect for the synthesis of collective health norms and facts of systems such as the Chi and Ayurvedic, the Guatemalan 'cooperatives' DDR industrial cooperative system, and so on.

Clear indications are found in the fields of technical cooperation, tropical diseases and sanitation, specific obligations towards the responsible for having European rights and duties for both DCs and LDCs and the total DC North and the total LDC South has also been made. Especially the integration is stimulated to accept the concept of 'collective self-reliance' for LDC-DC regions such as possible for DC North America-LDC Latin America prospect. At this point the supranational Organization is inclined to exercise 'directing' one. It is beginning with the international health organizational instructions by the Organization it is shown how WHO attempts to fit within the NIEO framework of the United Nations. It continues to...
Secondly a NIHO shall have to become a truly new order. The foundation of more or less equal health norms and facts will not lead to one order if it is merely an extension of one of the DC or LDC norm/fact configurations. A new synthesis of LDC-DC configurations is required.

Whereas the positive developments in WHO policy with respect to all these forms are dealt with, especially the following cases are worth mentioning. A factual and normative maximum for DCs is now discussed and the aim to strive for “The highest possible health level” seems no longer inviolable. The value of the present health technology is questioned for both LDCs and DCs. The new LDC concept of primary care is also advocated for DCs which may reinforce the self-care flows from LDCs to DCs. This holds true for Country Health Programming as well. The global relevance of the pharmaceutic innovations is considered to be low and an own LDC industry is recommended. The policy remains hesitant with respect to the synthesis of collective and individual health norms on the basis of systems such as the Chinese ‘barefoot medicine’, the Hindu ‘Ayurvedic’, the Guatemalan ‘curandero’, the American HMO and the DDR industrial cooperative system.

Clear indications are found in the emphasis on responsibilities. In the fields of technical cooperation, health technology, and the programs for tropical diseases and sanitation, WHO confronts its DC members with specific obligations towards the LDCs. The formulation of regional responsibilities is a positive influence. WHO’s ‘European Region’ is said to have European rights and duties. The incentive for a link between the total DC North and the total LDC South (‘North-South Health Dialogue’) has also been made. Especially the African factual and normative health integration is stimulated to arrive at one African Region through the concept of ‘collective self-reliance’. A world responsibility structure of LDC-DC regions such as possibly the inter-regions DC Europe-LDC Africa or DC North America-LDC Latin America seems at present not yet in prospect.

At this point the supranational function of WHO is considered. The Organization is inclined to exchange its coordinating function for a ‘directing’ one. It is beginning to emphasize its legitimate claim of being the international health organization of this world. Whereas many functional instructions by the Organization already enjoy supranational effect, it is shown how WHO attempts to achieve the consolidation thereof within the NIEO framework and the Proposals for the Restructuring of the United Nations. It continues to endorse even the necessity of a selective
World Top Body which would have to allocate all supranational health tasks to WHO. The Organization indicates that it will be necessary to national sovereignty (Annex 1) and that both DCs and LDCs will have yield certain legislative and executive powers. With reference to an important American initiative — "International Health Care in an Interdependent World" — this study examines the supranational importance the mutual interdependence between the health gap on the one hand and the DC-LDC inequalities in population, nutrition and energy on the other.

The question in how far WHO should adapt its Charter and its legal international authorities is given careful thought. The conclusion purports that amendments will be necessary but that in principle the present legal foundation offers more than sufficient opportunity to achieve a supranational leadership for a NIHO. Emphasis is placed on the importance of the separate and mutual powers between WHA, the Executive Board (E.B.) and the Director-General.

Especially the supranational legislation by WHA through the 'health regulations' contains ample capacity for NIHO initiatives. The universal binding force of WHA norm-setting is contemplated as well. The composition and the function of the E.B. are in principle already supranational; so are the possibilities of extending the emergency powers of the E.B. and the Director-General to handle 'structural emergencies', and of promoting LDC-DC integration through WHO's supranational 'information' powers. Also examined are the structuring of the DC-LDC responsibilities for technical cooperation by establishing new LDC and DC regions on the basis of regional norm/fact configurations which conform to the identification and solidarity of the regional collective self-reliance. The powers to sanction of WHA, E.B. and the Director-General offer many possibilities to harness member-states to their NIHO responsibilities.

Finally the leadership capacities of especially the E.B. and the Director-General are reviewed. By delegating certain powers of WHA to the E.B. its leadership could be strengthened considerably. The supranational powers of the Director-General are already large. Especially personality factors are shown to be of utmost importance for a NIHO application of these powers. The reappointment of H. Mahler as Director-General until 1983 is viewed as a positive contribution to WHO's NIHO function.