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**A new international health order. An inquiry into the international relations of world health and medical care**

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## SUMMARY

A 'New International Health Order' (NIHO) is a new notion. In order to value the function of a NIHO, the present international health order and the socioeconomic order between the rich and poor countries will have to be taken into account. The factual and normative development of a new 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 phenomenologically a symbiosis existed of health(care) and the structure, activity and meaning of society. The Church-State doctrine with its ubiquitous norms of sin and blessing constituted the binding element. The Counter-Reformation decreased 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 socioeconomic 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 very 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 and contribution to productivity from education and health care.

*CHAPTER 2* deals with the principles upon the international creation of the present world order and the beginning of a new world order and the dimensions of these changes. 'Christian' states, which subsequently brought together all the existing nations in more than a hundred new sovereign states, will have to evaluate the viability of this order. Under the conditions in which they were all brought together in

By way of decolonization, racial integration (non-autarchy), the industrialization of the developing countries (LDCs) is dependent on international economic integration since it appears that the industrialized rich adhere to the principle of industrial-growth. Thus international integration of health(care) and socioeconomic

It is concluded that a new international order must be created when taking into account the LLDCs. Economic growth remains obstructed by the economic position, behaviour and activities of the rich individually and as a whole. This is a national principle of the co-responsibility of the stronger members of the community of nations for the wellbeing of its weaker members is not a principle of the 'community of nations'. Consequently the responsibility of the 'Rich North' is a moral obligation (logue).

An *international economic order* must be created. If this social equivalent is divided among the rich, it can be found as on the national level, e.g. on the population, etc. Especially because of the pollution, technological development and the *international economic order* can offer any possibility for a NIEO, but also for a new i

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 socio-economic* 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 the rich members of the world community 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. The 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 in fact the American airconditioner (25% of U.S. energy goes for air-conditioning) determines the health(care) in many LDCs. In Chapter 3 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 is 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 'sub-sistence' 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 most 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 functional concepts of equality and inequality specific qualifications of these concepts are discussed (2.4 and 8.2). Consideration of excessive inequalities, the concept of equality and DCs is standardized. The equality for the realization of a new world order is defined.

An appraisal is made of the functional concepts of equality and inequality in other sectors to reduce the inequalities. Reactions to act as the forerunners of a NIHO, the existence of

*CHAPTER 3.* asserts that qualitative inequalities exist between the poor and rich countries.

Due to the insufficiency of a quantitative analysis of the DC-LDC Region is taken as pars pro toto. A quantitative inequality analysis of 'Health Conditions in the American Region' shows that health equality grows less. In many cases either because of relatively faster population growth or because of worsening in LDCs. Successively population growth, mortality, morbidity and health conditions are analyzed.

Qualitatively it is shown how the lack of medical care in LDCs has led to the development of concepts of health and disease. The lack of environmental hygiene and pharmaceuticals leads to the dissociation of DC supply and LDC demand. The latter. Conversely an inequality-preventive and social medicine. The importance in DCs which, in turn, is reflected in LDCs as an expression of health conditions in DCs can be traced directly.

Socioeconomic integration and the determinants of a new world health order is determined by three dimensions: a world-order-oriented. To achieve a new world order is 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 pharmaceuticals 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' (4.1.1). 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 most 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 syndrom' 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 ill 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 for LDC health(care), an adequate political emphasis on more equity in LDCs appears to be gaining momentum. This could well reduce the health gap between LDCs and DCs. Meanwhile adequate integration of health aid. This integration is the incentive

*CHAPTER 6.* examines the health sectors and their health implications for economic development. The mutual sectors are dealt with in detail. The function is propounded for the health(care) integration. Economic mutual international dependence to the respective DC-LDC inequity model (fig. 57, 6.3) reflects that the health and economic sectors, and consequently is determined by the world

- The last two chapters study the
- 1) what is the present WHO policy starting from the aforementioned relations (Ch. 7);
  - 2) which concepts are to play a role in the realization of a NIHO (Ch. 8)

*CHAPTER 7.* The policy analysis. Whereas WHO policy until 1978 completely to its historical function (G.P.) clearly aims at closer connections experiences two dilemmas in this respect contrast of the political exigencies and orientation of the Organization. WHO is on the one hand obliged for all (especially in LDCs) respect economic structures of the people and with the sovereignty and self-reliance feels that it is only possible to m

European DCs) as to their LDC policies and their negative consequences for LDC health(care), 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(care) 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 multisectoral approach, country health programming (CHP), technical cooperation, primary health care, rural health and the concept of 'social poverty' are critically reviewed. WHO attempts to absorb functionally the *international political* requirements for an effective link with the NIEO by a *political national multisectoral* development, to which almost all these concepts relate. After demonstrating how this ignores the international interest inequality model, the various policies are tested as to their NIHO 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 could be of utmost importance to a NIHO. On the one hand, to preclude this 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 (in conformity with self-reliance) invalidates the historical functionalist 'DC technology for LDC needs'. It supplies WHO with an effective means to design a differentiated order of all LDC health sectors. Since this right is not extended to DCs, the NIHO 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 mutually (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 or cooperation relation as the most prominent factor in the present LDC-DC

health relations. A NIHO endeavour together with all LDCs and without need adaptation in and by DCs, is world health order.

A positive correction was made (WHA). A clear LDC-DC relation in the LDC-DC Relation Programme, stimulated by WHO smallpox program that made foci. In fact WHO proposes to limit the level of LDC health expenditure to economic integration a link of the consequences. Furthermore two occupational health and (under) capacities in an analogous DC-LLDC these propositions carry as yet in members.

- Thus, with respect to a NIHO
1. to stick to its historical functionalist DC-LDC dependencies;
  2. to apply the socioeconomic in LDCs;
  3. to recognize the reality of the place it within the framework;
  4. not to recognize the health gap to contribute intrinsically to 'acceptable inequalities' among;
  5. to pursue merely an empirical introduced, without formulating future the world's health situation develop (figs. 63 and 64).

*CHAPTER 8.* Whereas especially subject to these rather weak NIHO short-term policy (politically motivated the initiatives mentioned in 7.4 valuation can be discerned with real NIHO. As described in the of this study, these NIHO requirements (Jouvenel).



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 socio-economic 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 or less equal and equivalent world health relationship among DCs and LDCs. This relation is classified according to equality of health facts and norms. The interaction of these makes it impossible to arrive at factual equality without a certain level of normative equality, and conversely so (the norm/fact configuration). Thus what matters is the 'acceptable inequality' of the health norm/fact configuration between the LDC-South and the DC-North. From the logical as well as from the practical point of view it would be insufficient to procure 'acceptable' LDC minima to bridge the '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. Only 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 unachievable.

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 optimalization of the acceptable 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 be based on a new configuration of more or less equal health norms and facts in world order if it is merely an extension of the existing configurations. A new synthesis of I

Whereas the positive developments in these forms are dealt with, especially in the context of the WHO, mentioning. A factual and normative health order and the aim to strive for "The health order is no longer inviolable. The value of the health order is to be set for both LDCs and DCs. The new health order is advocated for DCs which may run counter to the LDCs. This holds true for Countries where the relevance of the pharmaceutical industry in their own LDC industry is recommended. The WHO with respect to the synthesis of collective health norms on the basis of systems such as the Chinese 'Ayurvedic', the Guatemalan 'curandero' and the DDR industrial cooperative systems.

Clear indications are found in the WHO reports in the fields of technical cooperation, tropical diseases and sanitation, that specific obligations towards the LDCs with respect to responsibilities is a positive influence. The WHO has European rights and duties towards the total DC North and the total LDC South. This has also been made. Especially in the context of the WHO integration is stimulated to arrive at the concept of 'collective self-reliance' in the LDC-DC regions such as possible in the context of DC North America-LDC Latin America prospect.

At this point the supranational health organization is inclined to exercise a 'directing' one. It is beginning to exercise *the* international health organization's instructions by the Organization. It is shown how WHO attempts to exercise its authority within the NIEO framework and 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 pharmaceutical 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 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 of 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.