9 The World Health Organisation: a time for reconstitution

Richard E. Wagner

The World Health Organisation (WHO) was established in 1948 as one of several global organisations that were created in the aftermath of World War II. Among those other organisations were the International Monetary Fund, the International Bank for Reconstruction and Development (which became the World Bank), and the General Agreement on Tariffs and Trade (which became the World Trade Organisation). While this essay is concerned with the WHO and its activities as these are revealed in an examination of its budget for 2006–07, much of the underlying argument that informs this examination applies to international organisations generally.

This chapter unfolds in five stages. The first stage asks what would constitute reasonable performance for the WHO, and does so by postulating two concepts of performance that would surely command wide assent: smallpox and Mother Teresa.

The second stage examines the WHO's budget for 2006–07, exploring the extent to which those concepts can be identified within the WHO's line items. While this exploration does not show that the WHO has been an abject failure, it nonetheless gives the agency a low grade. To some, this might constitute a minimal pass while to others it would mean that the agency has failed.

The third stage examines the collectivist presuppositions on which the WHO was founded, and which to this day shape its performance.

According to those presuppositions, free markets are weak arrangements for societal organisation, and require domineering government intervention to secure tolerable performance. These collectivist presuppositions are now generally recognised to have been false, yet they still inform the WHO's conduct.

The fourth stage examines the WHO's guiding political and bureaucratic incentives, which lead it to support the interventionist agenda that prevails in the environmental and public health bureaucracies of the Western social democracies.

The fifth stage explains that since the WHO was initially constituted upon false presuppositions, securing improved performance requires a re-constitution of the agency. Fundamentally, this means that government ought to provide a supporting, and not a leading, role in social and economic activities which generate health of a people as one of their many outcomes.

Images of the WHO: smallpox and Mother Teresa

How are we to appraise the activities of the WHO? The WHO is a large organisation with a presence throughout the world. Its headquarters are in Geneva, and it also has six regional headquarters: Brazzaville for Africa, New Delhi for Southeast Asia, Manila for the Western Pacific, Cairo for the Eastern Mediterranean, Washington for the Americas, and Copenhagen for Europe.

Its budget for 2006–07 calls for an expenditure of $3.185 billion, distributed across 37 distinct line-items of activity, as shown in Table 1. Judging by its budget, about 31 per cent of the WHO's activities take place at its Geneva headquarters, another 28 per cent are distributed among its six regional headquarters, and the remaining 41 per cent take place within individual countries throughout the world.

Specific observations about some of these budgetary line items will be offered later, but any effort to examine those line items in great detail would quickly become mired in numerous complex issues that could obscure an overall vision of the organisation.

A coherent evaluation of the WHO's activities must start with some overarching vision of the organisation. This vision can be conveyed reasonably well by two simple concepts: smallpox and Mother Teresa (Wagner, 1997). Smallpox, a disease that was eradicated with the WHO's participation, represents communicable diseases which do not respect national boundaries and thus present potential issues of global concern. Mother Teresa represents charity towards impoverished people by those who are relatively well off. These two concepts represent valuable points of reference against which the WHO's activities can be appraised.

Before evaluating WHO's activities, however, it is worth putting into perspective more generally the role of the private sector, government and inter-governmental bodies in addressing health issues.

The first thing to be said about a market-based economy is that it will generate a wide variety of health-related products and services. The situation in this respect is no different for health than it is for food, shelter, amusement, or anything else. There is an underlying logic of economic relationships that governs such things as relative amounts of human activity directed at such services. That logic also informs the relative emphases which people give to inventing and developing new technologies in those varied areas of market activity. Entrepreneurs seek to develop, in a cost-effective manner, services that consumers will want to buy. Some entrepreneurs will develop exercise equipment; others will develop medications to combat diseases; and yet others will publish books about diet, exercise and other health-related matters.

To be sure, a governmental presence operates in the background of all market-generated activity. One of government's prime responsibilities is to maintain the framework of property rights and contracts that is essential for a well-functioning market economy. For instance, as a matter of formal principle, people will invest in medical research so long as they believe the return they anticipate receiving will make the investment worthwhile. The extent of this anticipated return, however, will depend on factors such as the terms on which patents can be secured and the extent to which they

are subsequently enforced. Hence, the pace of health-related research within a market economy depends on how successfully government discharges its background presence.

The difference between government in the background and in the foreground is extremely important. The world may be a stage, as Jacques asserts in *As You Like It*, but market participants populate the foreground while political officials remain in the background. That background entails essential work, for the play cannot go forward without the work of the stagehands. But it is background work nonetheless, out of the public's sight.

The foreground is occupied by those market participants (firms, entrepreneurs, customers, consumers) who establish hospitals and pharmaceutical companies, as well as the myriad other enterprises and transactions, which contribute to the generation of health-related enterprises and outcomes within a market economy. In the background, government facilitates commerce between these participants by protecting relationships established through the principles of property and contract.

Two categories of activity, conveyed by smallpox (to represent communicable diseases) and Mother Teresa (to represent charity towards the poor), might provide a justification for government agencies to move out of the background and into the foreground.

In dealing with communicable diseases, the presumption of market efficiency that generally obtains for non-communicable diseases becomes questionable. It is a truism to say that people will buy protection against diseases to the extent that they perceive such protection to be worthwhile. For non-communicable diseases, this creates a situation where people will rely on market-generated options to secure protection, so long as the cost of securing additional protection is less than the benefit they believe that additional protection will provide. In this benefit-cost sense, market-based outcomes with respect to health generate efficient levels of protection against non-communicable diseases.

However, the situation does not necessarily apply to communicable diseases. Someone who acquires a communicable disease

imposes a prospective cost on those with whom he comes into contact. Similarly, someone who reduces their own likelihood of acquiring a communicable disease thus also confers benefits on other people. Economists describe this phenomenon as an "externality," and it provides a plausible (though not conclusive) argument in support of some role for government in the foreground of health-related activity. Allthough individuals will purchase protection to the extent that they judge such protection to be worthwhile, their calculation of benefits does not account for the benefits or costs that their own choices confer on other people.

Influenza provides a good illustration of this point. There are several things people can do to protect themselves against influenza, none of which is perfectly effective but each of which offers some measure of protection. People can increase the frequency with which they wash their hands. They can reduce the amount of time they spend in crowded places. They can wear respirators in public. Most visible among these protective measures is inoculation. While inoculation is available for influenza, it may work well against some strains of the disease but not against others.

Each of these measures involves costs and entails some perception about the degree of protection secured. In a market economy, inoculation must be paid for, and thus carries a price. In some instances, inoculation will also involve negative side effects, and may not provide total immunity. When people take these various considerations and perceptions into account, they will purchase some volume of inoculation, which in turn will generate some level of protection against influenza within the society.

This account of individual choice and market outcomes does not account for the effect of one person's choice on other people. A person who increases his level of protection, whether through inoculation or changes in conduct, reduces the chance that he will contract the disease and subsequently transmit it to others. Formally speaking, that person would seek protection against communicable disease to the point where the cost of that added protection is equal to the perceived benefit from that protection. Ideally, however, that

Table 1 **WHO's budget by line item, 2006–2007, $000s**

Area of Work	*Total*
Communicable disease prevention & control	152,983
Communicable disease research	108,457
Epidemic alert and response	131,119
Malaria	137,509
Tuberculosis	134,526
HIV/AIDS	260,650
Immunization and vaccine development	381,211
Noncommunicable disease surveillance	56,103
Health promotion	48,146
Mental health & substance abuse	29,764
Tobacco	29,193
Nutrition	24,098
Environment & health	90,412
Food safety	23,717
Violence, injuries, and disabilities	17,505
Reproductive health	65,867
Making pregnacy safer	64,017
Gender, women, and health	17,703
Child and adolescent health	100,500
Essential medicines	61,968
Essential health technologies	31,182
Policy-making for health in development	39,533
Health systems policies & service delivery	116,349
Human resources for health	77,631
Health financing & social protection	42,975
Health information & research policy	57,586
Emergency preparedness & response	105,400
WHO's core presence in countries	197,776
Knowledge management & information technology	138,180
Planning, resource coordination, & oversight	27,590
Human resources management	51,873
Budget and financial management	46,155
Infrastructure and logistics	133,682
Governing bodies	37,388
External relations	35,126
Direction	39,433
Miscellaneous	71,797
Total	**3,185,104**

Country	*Regional*	*Headquarters*
63,481	50,976	38,526
3,275	6,397	98,785
52,121	44,423	34,575
55,767	47,167	34,575
68,147	38,719	27,660
163,010	68,004	29,636
193,318	123,682	64,211
25,019	14,982	16,102
17,731	9,670	20,745
13,696	8,659	7,409
12,778	9,204	7,211
8,990	8,193	6,915
38,287	25,947	26,178
8,652	8,348	6,717
6,672	4,610	6,223
12,599	7,036	46,232
33,982	19,169	10,866
5,656	4,144	7,903
42,769	34,022	23,709
25,236	11,048	25,684
11,312	8,016	11,854
19,300	10,552	9,681
58,813	33,432	24,104
42,701	22,384	12,546
19,864	12,245	10,866
27,021	17,723	12,842
77,634	19,863	7,903
176,145	16,692	4,939
21,140	47,890	69,150
4,961	9,787	12,842
479	16,819	34,575
330	23,598	22,227
2,193	55,424	76,065
58	11,646	25,684
2,183	13,383	19,560
488	11,945	27,000
1,178	12,119	58,500
1,316,986	**887,918**	**980,200**

protection should be extended to the point where the cost is equal to the combined benefit to the person choosing the protection *and* to all the others who in turn receive some enhanced protection.

While there is plenty of controversy over the extent to which government should be involved in the provision of health-related services, there is widespread agreement that communicable diseases provide a justification for some form of government participation in preventative measures.

Communicable diseases that originate in poorer regions of the world present more severe problems of global coordination than those that might originate in wealthier regions. Within a wealthier society, people are likely to achieve a level of care against communicable disease that exceeds what people in poorer societies would be able to attain.

In a setting of global mobility, this means that an externality exists. People in poorer societies will tend to take fewer precautions against contracting communicable diseases than people in wealthier areas might desire them to take. If residents of wealthier societies feel that they are threatened by contagious diseases when not enough precautions are taken by poorer societies, a case can be made for richer societies to support control of communicable diseases in the poorer societies.[1]

This justification based on contagion across national boundaries is independent of and distinct from any justification that might arise from poverty. It is clear that the most severe health problems in any society are found among its poorest members. This negative relationship between health and poverty holds throughout the world just as it holds within any single nation.

A society's wealthier members generally possess and display some charitable attitude towards fellow people who experience significant deprivation. Charity is a natural human sentiment, and it is plausible that charitable sentiments would find some expression on a global level.

To be sure, however, it does not follow that charitable sentiments should necessarily entail governmental participation. There is

plenty of charitable activity organised through voluntary arrangements of all kinds. Furthermore, it is doubtful to what extent charitable sentiments are truly expressed when the contributions are extracted from taxpayers by force, rather than by voluntary donation.

In general, the collectivist spirit that dominated much of the 20th Century has been replaced by recognition that free and liberal arrangements and institutions are the best way to enable human flourishing. Nevertheless, an organisation like the WHO might still play a role in the foreground of health-related activity, due to the existence of communicable diseases which ignore national boundaries, and possibly to carry out charitable sentiments directed towards the poor.

Communicable disease and charity, smallpox and Mother Teresa, moreover, are not independent of each another with respect to health. The places where communicable diseases are most prevalent are also the poorer places in the world. In any case, smallpox and Mother Teresa provide clear conceptual images to examine the WHO's budgetary activities.

The WHO's budget for 2006–07

Table 1 portrays the WHO's budget for 2006–07 in terms of 37 line items, along with the location of the expenditure as between Geneva, one of the six regional headquarters, or within individual countries. It would be a reasonable experiment to give the WHO's budget, along with the descriptive detail that accompanies the budget to a disinterested observer. The observer would be asked to reach a judgment about the extent to which the concepts represented by smallpox and Mother Teresa are reflected in the agency's budget.

Two conclusions would surely emerge out of such an examination. One is that the WHO's budget does contain some activities that reflect those concepts of combating communicable diseases and offering health assistance to impoverished people. The second, obverse, conclusion is that many of the WHO's activities have

nothing at all to do with those activities, and reflect instead an image of an interfering, self-absorbed bureaucracy that is involved in promoting anti-market ideologies and activities.

An initial analysis of the 37 lines of the WHO's budget could lead an impartial observer to distinguish between the first seven items, and the remaining 30. Judging by their titles, the first seven line-items convey clear images of smallpox and Mother Teresa. To be sure, those are not the only concepts that are conveyed; a bureaucratic image is also present in those seven items. For one thing, there is very little work to be done in Geneva that would reflect the images of either smallpox or Mother Teresa.

Comparatively speaking, however, the extent of bureaucracy is less for those first seven items than for the remaining 30. For instance, 25 per cent of the WHO's spending on these seven items is designated for the WHO's headquarters in Geneva. By contrast, 35 per cent of the spending takes place in Geneva for the other 30 items. On a comparative basis, the first seven items reflect a stronger orientation towards controlling communicable disease and providing assistance for the impoverished than do the remaining budget items. At the same time, those first seven activities constitute but 41 per cent of the WHO's budget. The remaining items occupy 59 per cent of the WHO's budget, and these more fully reflect an anti-market health bureaucracy at work. This is elaborated in subsequent sections.

The devolution of expenditure away from Geneva to the country level does not necessarily imply that the WHO's activities more fully reflect the concepts represented by smallpox and Mother Teresa. For instance, the third-largest item in the WHO's budget is "WHO's core presence in countries." This item is exceeded only by budget entries for "HIV/AIDS" and "immunisation and vaccine development." True to its name, moreover, 89 per cent of WHO's spending for its "core presence in countries" occurs at the country level.

At first glance, there might seem to be little bureaucracy evident here. The WHO's account of what this activity actually entails, however, suggests the image of a lobbyist. Its purpose is to cultivate

support for the WHO and its agenda of comprehensive health planning. For instance, one of the listed objectives for this line-item is to triple the number of countries "that have an updated WHO Country Cooperation Strategy." The other listed objectives within this line-item are likewise aimed at polishing the WHO's image in individual countries. The image reflected in this activity is one of bureaucratic self-promotion.

Some criticisms can be made about the budget entry for "policy-making for health in development," where three-quarters of expenditure occurs outside of Geneva. For that item, the WHO announces that it "seeks to influence a wide range of national and international policies, laws, agreements, and practices." In seeking to accomplish this, the WHO asserts that it not only pushes the Millennium Development Goals (a UN-sponsored adventure in development planning), but it also occupies the policy foreground with respect to "such issues as the relationship between health and human rights, poverty, aid instruments, macroeconomics, equity, ethics, globalization, trade and law."

If this is not sufficient testimony about bureaucratic self-promotion, the WHO's budget reveals objectives such as achieving a five-fold increase in the "proportion of low-income countries in which WHO has played an acknowledged role in enabling national authorities to develop Poverty Reduction Strategy Papers [and] national poverty reduction plans." Even its line-item for "essential medicines" seeks to promote medical nationalisation, and adopts as one if its objectives an increase in the "number of countries with public-sector procurement based on a national list of essential medicines."

The same bureaucratic imperative is present in the line-item called "health promotion." This item is dominated by the WHO's assertion that "governments must play a stronger role in developing health public policies; health ministries need to take the lead by advocating for the development and adoption of these [WHO-advocated] policies." Those policies have numerous objectives. At various places in the WHO's budget, we see that the WHO is concerned with

high blood pressure, cholesterol, weight, diabetes, heart disease, cancer, and smoking. While this may seem extensive, it is not the limit of the WHO's activities: it is also involved with depression, drug abuse, neurological disorders, violence, and traffic safety and numerous other issues.

Another line of inquiry would be to probe the effectiveness of the WHO's activities, by analysing the overall structure or pattern of its budgeted activities to examine the details of its operation. At a structural level, it could be concluded that approximately 40 per cent of the WHO's activities are described reasonably well by the concepts of smallpox and Mother Teresa. The details of how that 40 per cent is allocated and spent, however, might well reveal that those funds are being used relatively ineffectively. If so, a transfer of those funds to organisations that perform those activities more effectively would accomplish both more comprehensive control of communicable disease, and would provide a greater measure of health assistance for impoverished people.

Consider the line-item for "communicable disease research." By definition, this spending fits the concept of smallpox and to some extent the image of Mother Teresa, since problems of communicable disease are most severe in impoverished parts of the world. Yet a close examination might conclude that the $108.5 million spent in this category – 90 per cent of which is spent in Geneva – could do more good if it were redirected to other activities.

The WHO's spending on communicable disease research is a tiny portion of such spending worldwide. The issue here is the marginal contribution of the WHO's effort, especially when compared to other efforts the WHO might have undertaken with the same resources. It is likely that more would be accomplished if the WHO reduced its emphasis on research and redirected those funds to dealing with malaria, tuberculosis or HIV/AIDS.

It is even conceivable that the WHO's marginal contribution to the advancement of knowledge about communicable disease is negative. The agency's own description of this line-item suggests that it prefers a hierarchical approach to scientific inquiry. Its vision

of research on communicable disease is that the agency leads the way in articulating what research should be pursued, and individual researchers then follow the WHO's lead.

Yet scientific inquiry follows the same organisational principles as ordinary economic activity, which means that progress occurs more rapidly through open competition than through central direction or regulation. By attempting to centrally direct research, the WHO narrows the lines of inquiry that are pursued. In most cases, this retards progress (Kealey, 1997; Tullock, 1967).

Suppose the WHO were to shift resources away from research on communicable diseases into activities represented by its line-items for malaria, tuberculosis, or HIV/AIDS. There is no guarantee that extra money devoted to those specific diseases will accomplish much. The WHO's activities regarding malaria, for instance, are of dubious value. Since the WHO started its 'Roll Back Malaria' program in 1995, the global toll from malaria has actually increased. To be sure, this post hoc statement does not constitute proof of the WHO's ineffectiveness – but the agency has been reluctant to clearly support the use of DDT as a form of vector control, despite its clear success in controlling malaria in India, South Africa and many other countries (Roberts et al., 2000). Instead, it has almost exclusively promoted alternative measures such as insecticide-treated bed nets. These are several times more costly, as well as generally less effective than DDT. With such an implicit rejection of other methods to prevent malaria, the WHO has followed the expressed desires of environmental and health activists in the first world. Deaths from malaria now exceed one million annually, and some estimates are far higher (Snow et al., 2005).

Similarly, the WHO's attempts to scale up antiretroviral treatment for HIV/AIDS sufferers have been far from successful. Its '3 by 5' initiative – a plan to put three million people on life-extending antiretroviral (ARV) treatment by the end of 2005 – is arguably the single largest effort that any multilateral body has yet undertaken to tackle the disease.

However, by February 2005 only 700,000 people were receiving ARV treatment, well short of the 3 million proposed when the initiative was started in 2003, and a drop in the ocean compared with the minimum of six million people in Africa, Asia and Latin America who need the treatment.[2] Bowing to pressure from Western health activists, the WHO relied heavily on untested triple drug fixed-dose combinations in order to meet its self-imposed targets. In late 2004, it was forced to de-list these drugs, produced mainly by otherwise-reputable Indian drug companies, because of safety concerns.

There is no doubt that the concepts of smallpox and Mother Teresa can be observed in some of the WHO's work – but those images constitute a minority of the full range of its activities. Judging from its budget, the control of communicable disease and the provision of health assistance to the impoverished are secondary activities of the agency.

The primary activities of the WHO would seem to be of two interdependent sorts. One sort is simply bureaucratic self-promotion. However, this requires allies within the environmental and public health bureaucracies of the first-world nations, which are the WHO's largest source of budgetary support.

The majority of activities of the WHO seem to be focused on bureaucratic self-promotion. This appeals to the environmental and health bureaucracies that guarantee much of the agency's funding, and it explains why some of the WHO's primary activities involve promoting and supporting the agendas of those interventionist bureaucracies.

The heritage of a collectivist half-century

With the collapse of communism now receding quickly into the background of our memories, it is becoming increasingly difficult to recall the collectivist nature of the climate of opinion that reigned throughout the West during much of the 20th century. Though Western societies were grounded in individual liberty, with private

property and limited government providing the framework for a market economy, many intellectuals, including economists, were socialists even in the 19th century.

The Russian Revolution and formation of the Soviet regime early in the 20th century gave a huge boost to those socialist sympathies. While a few renegade economists like Ludwig von Mises and Friedrich Hayek argued that communist and collectivist planning systems could never generate the human flourishing that liberal, free-market capitalism had generated, the overwhelming climate of opinion sided with the socialists (Hayek, 1935; Roberts, 1971; Boettke, 1993).

To be sure, the Western-style socialist psyche recoiled at some of the regimentation that characterised Soviet-style socialism, and sought instead to establish a more humane form of market-friendly socialism. In this search, there was thought to be a grave trade-off: socialist planning might promote faster economic growth but would restrict liberty beyond what Western traditions would countenance. While traditions can always change, the Western concern was focused on expanding government's role in and control over economic and social life to boost economic progress, but stopped short of Soviet-style socialism.

Even as late as 1989 in the 13th edition of his renowned textbook *Economics*, Paul Samuelson described the splendid economic properties of a collectivist economic system which allowed the Soviet Union to grow at a significantly faster rate than the Western democracies, by asserting "the Soviet economy is proof that . . . a socialist command economy can function and even thrive." (Samuelson & Nordhaus, 1989). The challenge for those in the West who rejected Soviet-style collectivism was to find a middle way that would retain margins of modest liberty alongside a good deal of government participation in economic affairs.

Much of the Western concern about how much collectivism to embrace was based on predictions about the speed at which the Soviet Union's economy might surpass that of Western countries. Most intellectuals and economists were convinced that this would

happen unless effective (but gentle) collectivist counter-measures were undertaken. Economist Warren Nutter was a rarity: he studied the Soviet Union carefully and concluded that the majority of Western economists were wrong (Nutter, 1961): the Soviet economy was not a looming powerhouse but was economically puny (although militarily dangerous). While Nutter was pilloried at the time by most other 'experts' (who sided with Paul Samuelson's appraisal of the situation), the evidence that surfaced since the disintegration of communism shows that even Nutter over-estimated the economic performance of the Soviet Union: it was even weaker than he had suggested.

The WHO and the other international organisations were founded at a time in history when belief in collectivism and the distrust of free markets were at their peak in the West. As the Iron Curtain came crashing down, it was recognised that Soviet-style collectivism should be opposed.

However, the presumed success of its economy was used as a justification for a Westernised version of collectivism; ostensibly, Western-style liberalism of the old order was out-dated in our modern age. The Western tradition of private property and individual liberty that underpinned free markets was widely thought to be a weak and fragile institutional arrangement. Unless they embraced some of the features of collectivist control that characterised the communist empire, Western societies would be plagued continually by instabilities, monopolies and externalities.

The WHO and its siblings were created among this widely prevailing climate of opinion: they were promoted as global instruments of collectivist intervention which, when combined with similar intervention in the individual national economies, would create a kinder and gentler alternative to Soviet-style collectivism. This is often characterised as a mixed economy, to indicate some mixture of liberalism and collectivism as the social equivalents of oil and water (Littlechild, 1978; Ikeda, 1997).

It is generally recognised that the ideas which governed Western societies in the post-war period were false. Free markets are not

fragile and unstable institutional arrangements: they are robust arrangements that promote creativity and progress. Fragility and instability do appear in human societies, but when this happens the heavy hand of government is also close at hand.

This is true at a macro and micro level. On a large scale, the Great Depression is perhaps the prime instance of economic instability in the 20th century. For a long time this catastrophe was presumed to be the archetype of systemic market failure. Now, it is accepted that it was an outstanding and prolonged example of systemic government failure; the only remaining issues relate to the relative contributions of the various paths that government took in promoting depression.[3] Whatever the path, however, the Depression's origin lays with governments and not with free markets.

On a small scale, claims of market failure are voluminous. The argument is that externalities create market failures, which can only be corrected with some form of government regulation. Such claims often seem sensible on the surface, and equally often are shown to be wrong upon careful examination.

In a similar vein, it appeared reasonable for millennia to conclude that the sun rose in the west and set in the east. It wasn't until Copernicus examined the matter carefully that people came to realise that the surface impression was wrong. One of the archetypical claims of market failure – regarding bees and pollination (a situation that bears some resemblance to communicable disease) – was advanced by Nobel Laureate James Meade (Meade, 1952). Meade illustrated his argument with beekeepers and apple farmers, and claimed that markets would fail to secure efficient production. On the one hand, apple growers will plant too few trees because they do not account for the value that their trees provide to beekeepers. On the other hand, beekeepers will supply an insufficient number of hives because they do not consider the increased apple production that results from the pollination services the bees provide.

At first glance, this story seems sensible. Yet a closer examination of market relationships where honey and apples are produced shows this conclusion to be absolutely wrong: A wide variety of

contractual agreements exist among beekeepers and apple growers (Cheung, 1973).

For instance, apple blossoms provide little honey but bees do offer valuable pollination services, so apple growers pay beekeepers to provide their bees for such services. On the other hand, clover does not require pollination but yields much honey, so beekeepers pay to bring their bees into fields of clover. In either case, there is no market failure that leaves us with too few apples and too little honey. This illustration, replicated numerous times in different settings, is testimony to the economically robust character of market-generated commercial arrangements.

With respect to the subject of this essay, it is often claimed the sparse supply of new drugs to treat diseases common to poorer parts of the world is an illustration of market failure. Governmental intervention, including intervention on an international level, is thus advanced as a remedy to redress the situation.

However, a closer analysis reveals myriad ways, through regulation and taxation, that government failure has weakened the commercial viability of efforts to develop such drugs (Morris et al., 2005). For instance, Third-world governments often imposes taxes and tariffs on imported drugs that can boost the price by as much as 50 per cent. When combined with price controls, the incentive for the market-based supply of drugs may range between weak and dead. Furthermore, those countries often have poorly developed institutional arrangements regarding the protection of property rights and the fulfillment of contractual obligations.

The WHO, along with the other international organisations, was founded at a time when the central analytical presupposition was that market failure was ubiquitous and that governments were guardians against such failure. Over the past 40 years, this standard presupposition has been reversed from two directions. One direction has been a growing appreciation of market-based arrangements. The other direction entails recognition that government agencies and bureaucracies often lack the knowledge or incentive to promote well-functioning markets, and tend instead to promote

market failure. This suggests that government failure, not market failure, is often the source of observed societal problems and difficulties.

These considerations are relevant to a consideration of the WHO. The WHO was built upon a collectivist foundation which still guides the agency's work and activities. What it needs is not a renovation of its collectivist structure, but a new foundation that reflects the primacy of liberty and the supporting (rather than leading) role of government in the organisation of economic and social affairs.

A comparison of the experiences of South Korea and the Philippines over the past fifty years is a salient illustration of this point. Fifty years ago, each country had similar levels of per capita income, and each seemed to most analysts to face similar future prospects for economic growth and development. Today, per capita income in South Korea is around four times as large as that of the Philippines, due to a considerably faster rate of growth in the former. The Philippines' economy has been much more thoroughly plagued by interventionist government policies than that of South Korea.

Adam Smith claimed in the 18th century that "little else is requisite to carry a state to the highest degree of opulence from the lowest barbarism, but peace, easy taxes, and a tolerable administration of justice; all the rest being brought about by the natural course of things."[4] Smith's claim clashed severely with the collectivist orientation that was dominant throughout much of the 20th century, but in the post-socialist era, its wisdom has been reaffirmed as the most prosperous and robust economies are those where people have the greatest measure of liberty.[5]

A market economy grounded in private property and freedom of contract has two overwhelming advantages that are taken away increasingly as the blanket of collectivism spreads over an economy.[6] One advantage resides in the division and use of knowledge that characterises a market economy. In a famous essay entitled *I, Pencil*, economist Leonard Read noted that no single person could describe how to make a simple pencil, let alone actually make one. The task exceeds our mental capacities, for the

ability to buy a pencil is the result of achieving a coordination among the actions of millions of people throughout the world, and extends across a period of many years. We take for granted our ability to buy pencils because no one dictates our ability to buy pencils.

It is no paradox to find that when we are unable to buy a product, we will also find that some person or office is using the power of government, purportedly to assure a steady supply of the product in question. For instance, in the United States in the mid-1970s, the federal government took on the task of assuring Americans that they could obtain petrol for their cars. Sure enough, it became difficult (and often impossible) to buy petrol.

During the same period, there was an even greater proportional reduction in production of coffee than there was of oil – yet everyone was able to buy coffee. The only difference was that there was no person or office in charge of assuring Americans that they could buy coffee. The amount of knowledge that must be brought to bear in organising the supply of petrol, coffee, or pencils is far too complex for any person or office to master. The effort at such mastery overloads the capacity of the mental and organisational circuitry, creating bottlenecks that result in government-generated market failure.

This brings us to the second advantage of market-generated arrangements: the fact that they offer superior incentives to producers and consumers. In a market economy, a producer might initially allocate too much petrol to one region rather than another, or might produce too much kerosene relative to petrol. The producer has a strong incentive to revise the initial decision, for otherwise sales and profits would be lost. A public official, however, has no such incentive, because he or she will not suffer any lost profit by failing to reconsider and revise an initial decision. That official, moreover, may well be insulated from personal inconvenience because governments typically have the first claim on petrol for their vehicles.

Adam Smith was right: there is nothing mysterious about the positive relationship between freedom and prosperity. The place of

government in a flourishing society is mostly to occupy background positions. It is human nature, however, to seek the limelight of the foreground, and with this comes the age-old problem of the relationship between people and governments. Societies are more likely to flourish when governments and their officials occupy the background, but government offices are staffed by people who seek to occupy the foreground. Ideally, those governmental offices and officials work to maintain the framework of property and contract within which market participants interact to generate commodious living standards in free societies.

It is not their responsibility to ensure comfortable lifestyles for people in developed countries, for that comfortable living is generated through the creative, entrepreneurial efforts of all who engage in commercial activity. The contribution of government is important but modest, and it is clearly has a supporting but not a leading role in that process. Yet governmental officials are continually tempted to muscle their way into the foreground of economic and social activity. If they are too successful, taxes and regulation rise and prosperity is undermined.

What is true for wealth is also true for health: both are most effectively generated through free and open markets, with governments providing some important background services. But the WHO seeks to occupy the foreground of the stage of health-related human activity. While the WHO's Constitution lists 22 specific functions, the raison d'être of the agency is found in the agency's Preamble.

The Preamble asserts that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Nothing, it would seem, is outside the purview of the WHO. This assertion of omnipresence is followed by the assertion that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. . . ." After several more such assertions, the list ends with the assertion that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

Such assertions could be regarded simply as wishful thinking, much like wishing for a peaceable kingdom where lions would lie down peacefully with lambs. Such a statement of wishes would never be confused with reality, and moreover, would hardly be suitable material for a Preamble to a constitution.

Yet these assertions must be taken as serious objectives and not just as fond wishes about some 'end of history.' The Preamble reveals that the WHO's self-identity is that of an entity which possesses primary responsibility for health conditions throughout the world. Within such an orientation, the WHO has primary responsibility for health, though as the first item in its Preamble states, health is not just as the absence of disease, but is everything that might be thought of as curtailing human happiness.

Consider the WHO's concluding assertion that "governments have a responsibility for the health of their peoples." If we generalise this statement about health to a statement about wealth, it would read that governments have a responsibility for the wealth of their inhabitants. These formulations suggest that people cannot secure wealth and health without government, for such things are beyond personal reach. Unfortunately, the WHO is mired in the same ideas that dominated in the West at the end of World War II, which (while fading) are still a threat to liberty and prosperity.

The bureaucratic gap between vision and reality

The WHO, like the other international organisations that were established after World War II, is a global bureaucracy. The gap between the vision characterised by the concepts of smallpox and Mother Teresa and the reality of the WHO's actual conduct is an understandable result of the institutional arrangements within which it was constituted. By now, a considerable literature has developed to explain the performance properties of public bureaucracies at the national level. A brief consideration of the central themes of that literature can provide a foundation on which to consider the WHO and other international bureaux.[7]

Public sector organisations do not have the same incentives as commercial firms for efficient supply of goods and services. This weaker incentive reveals itself in a variety of ways. It often results in a more costly service, because there is no owner who can capture the gain that greater efficiency will create. If a private enterprise becomes more efficient, its owners gain, but they lose if the firm becomes less efficient. If a public-sector organisation becomes more efficient, the gain accrues to taxpayers as a general class, but they also bear the loss as a class if it becomes less efficient. Numerous studies show that services provided by government bureaux are more costly than similar services provided by commercial enterprises.

There are also substantial differences along many dimensions in the qualitative characteristics of the services offered by government and commercial firms. Commercial firms are highly responsive to the desires of their customers, for it is the customers who supply revenue to the firms. In a government bureau, the people who receive its services do not supply revenue to the bureau, except to the generally small extent that user charges accrue to the bureau (and even here user charges never operate as effectively as market prices) (Wagner, 1991). Government organisations respond not to the individuals who receive the services the government supplies, but to the legislators who provide the organisation's budgetary support. Effectively, these legislators are the "customers" whom the organisation must please.

What this means is that a government bureau will focus on activities that its key legislative sponsors and overseers deem important. In some cases those activities might coincide with customer desires more generally, but this is by no means always the case. A national health bureau, for instance, will be especially responsive to desires expressed by the legislators which can most directly influence its fortunes.

On other matters, bureaux will have wide leeway to do as they choose. For instance, some cost-conscious legislators may believe that a publicly-funded hospital should not exceed private hospitals

in the length of patient treatment. To pursue this thought, those legislators may examine average hospital stays for various categories of diagnosis. If this is the case, we may feel reasonably assured that the public hospital will generate the desired pattern of outcomes, or will have a good explanation for any discrepancy.

A closer examination might show that the public hospital achieved this outcome by selectively admitting patients, or perhaps by exercising discretion in its use of diagnostic codes, or perhaps by changing its standards for discharge. However, these kinds of issues are outside the range of oversight; what really influences the behaviour of a public-sector organisation is the interests of its political sponsors.

An international bureau is even less subject to oversight because it receives funding from a large number of donor nations. The WHO, for instance, receives funding from the largest and wealthiest first-world nations. Because the agency's budget is derived from many national governments (not just one), the WHO is less susceptible to political oversight than its national counterparts. Still, the agency must attract participation and contributions, and necessarily will be responsive to the strongly-held desires of its major donors and supporters. If those donors had a strong desire that the WHO acted according to the concepts of smallpox and Mother Teresa, its budget would look quite different.

The current budget reflects the variety of concerns and interests that inform the expansive health agendas of contemporary social democracies in the Western world. Part of that agenda includes an expansion of the meaning of "public health", away from communicable disease to practically anything that fits within the modern rubric of the therapeutic society. Thus, as communicable diseases have receded in significance, the WHO concentrates on activities relating to obesity, smoking, depression, and myriad other things in which now interest the public health bureaucracies of the rich world.

WHO transformed for a liberal world order

Our world has shrunk greatly over the past half-century, and will

continue to do so through technological innovation. Electronic communication is instantaneous, and aeroplanes can now carry 800 people half-way around the world at several hundred miles per hour. This shrinkage presents both opportunities and threats.

The opportunity before us is to witness human flourishing on an unprecedented scale. To achieve this opportunity requires a functioning social order on a global scale. Such order must be generated largely in bottom-up fashion, through the promotion of human flourishing through market-generated economic relationships.

As Smith noted in the 18th Century, human flourishing is largely the product of the self-ordering activities of a free people. It requires that governments operate mostly in the background, facilitating people's ability to generate commercial enterprises and civic associations. The primary threat to human flourishing is the hubris of collectivist control, which results when politics escapes its proper location in the background and muscles its way onto centre stage.

The WHO was founded at the apogee of collectivist belief in the West, but the strength of that belief has been steadily weakening for a generation. Meanwhile commerce is continually expanding and borders are continually shrinking, and simultaneously the world order is moving in a liberal direction (even if in jerky fashion). Nevertheless, collectivism still informs the activities of many national governments and international agencies. The UN's Millennium Development Goals project is a dying effort to salvage a collectivist order with government dominating the foreground.

There will be a role for a WHO-type organisation within a liberal world order, as communicable diseases will probably always be present even if the intensely geographical pattern of poverty someday disappears. In the interim, though, the presently constituted WHO presents a danger to that liberal order insofar as it retards the pace of development with ideological efforts to promote development planning at the expense of free markets and entrepreneurship.

One option for the future is the outright abolition of the WHO. Abolition would not eliminate efforts to control communicable

disease or to provide health assistance for the very poorest. The rich nations have the means to deal with communicable diseases, and do not need to funnel such efforts through the WHO. Many bodies exist that could co-ordinate actions at a supranational level, probably more effectively and in a less costly manner. A good number of privately organised charitable organisations already provide such services, and they would surely expand should the WHO shrink or die.

One example of how private organisations can successfully tackle global public health crises comes from Rotary International. The defeat of polio in the 20th century was largely the result of their funds and mass vaccination programmes. Twenty years ago, there were a thousand new cases of polio every day. Now polio strikes only about 1,000 children a year, and its complete eradication is imminent. By the time polio is entirely eradicated, Rotarians will have directly contributed at least $600 million – more than any other single organisation apart from the US government.

It is hard to see how the WHO could be reformed internally while maintaining the same character, at least as long as the agency is influenced by the interventionist policies advocated by the primary environmental and health bureaucracies of the Western world. One possibility along these lines would simply be to banish the WHO from the developed world. If the agency lost contact with those environmental and health bureaucracies, its attention would almost surely be devoted to matters of most immediate interest to those who inhabit poorer nations. This banishment would do no harm, even if there is no assurance about how much good it would do.

Whether the WHO is abolished or transformed, its focus should be on controlling the global transmission of communicable disease and not on promoting the expansive and interventionist agendas of the Western public health bureaucracies. As for whatever charitable activities the WHO might practice, other than what might emerge as a by-product of its work with communicable disease, such charity is far better for its intended recipients when it is conducted by private organisations. Mother Teresa, after all, was not an international bureaucrat.