

Critical analysis of WHO's role in promoting health

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From WHO's constitution to the Bangkok Charter

The Ottawa charter (WHO, 1986) defined Health Promotion as "the process of enabling people to increase control over, and to improve, their health" and recognised that the health sector could not be held responsible for it alone, nor governments could face the task alone. In fact, besides governments, health promotion demands a coordinated action by "other social and economic sectors, by non governmental and voluntary organizations, by local authorities, by industry and by the media". Going far beyond health care, Health Promotion requires policy makers in all sectors and at all levels "to be aware of the health consequences of their decision and to accept their responsibilities for health" and contribute to Healthy Public Policies.

The Ottawa Charter was built on the debate on intersectoral action for health in the preceding World Health Assembly, as well as on the progress made through the Declaration of Alma-Ata and the establishment of WHO's targets for Health for All.

Almost 20 years later, facing the challenges of a globalised world, the 6th Global Conference on Health Promotion (WHO, 2005) reaffirms in Bangkok the need to recur to Health Promotion to address the determinants of health and advocates for: health based on human rights and solidarity; investing in sustainable policies, actions and infrastructure; build capacity; regulate and legislate to ensure protection from harm and enable equal opportunity for health and well-being for all people and, finally to partner and build alliances between all sectors and subjects (public, private, civil society) for sustainable actions.

Evidently, today not only the "fundamental conditions and resources for health" identified in the Ottawa Charter (peace; shelter; education; food; income; a stable eco-system; sustainable resources; social justice and equity) have not been put in place, but the overall situation has notably worsened; and the probability is that it will continue to do so without a substantial change in the way health and health issues are addressed.

Recognising a wide "implementation gap" between the numerous resolutions signed at all level in support of health promotion, the Bangkok Charter "forcefully calls" to close the gap and "move to policies and partnerships for action". Avoiding to propose what has become the most fashionable approach to complex issues, i.e. the establishment of "Global Public-Private Partnerships" (Missoni, 2004), the Charter envisages instead commitment for "effective mechanisms for global governance for health" to address "the harmful effects of: trade, products, services, and marketing strategies"; health as a core responsibility for governments; empowerment of communities and civil society in exercising their power as critical consumers, and – finally - for ethical and socially responsible behaviour of the corporate sector, to be supported also by government incentives and regulations. The WHO Framework Convention on Tobacco Control (FCTC) is brought as an example to follow.

"The attainment by all peoples of the highest possible level of health" is the objective of the World Health Organisation which, to that purpose, according to the Constitution signed by all its member States, shall "act as the directing and coordinating authority on international health work" (WHO, 2006)

Did WHO live up to its role?

WHO's leadership and global health

To analyse WHO's role in leading the world toward its institutional goal, we may look divide its history into four periods the first (1948-1988) going from WHO's establishment as the UN's specialist agency for health (April 7th, 1948), to the end of the term of office of Hafdan Mahler as its third Director General, and the other three coinciding with the terms of office of his successors: Hiroshi Nakajima (1988-1998), Gro Harlem Brundtland (1998-2003) and the late Lee Jong-Wook (2003-2006).

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Development and leadership

The first period could be defined as one of development and leadership. In the first part of this period WHO launched important disease control and eradication programmes such as: syphilis mass treatment, malaria eradication, smallpox eradication (the latter successfully concluded with the World Health Assembly endorsing the certification of smallpox eradication in 1980). The International Sanitary Regulations (later renamed International Health Regulations) were adopted, representing until 2005 – when the Framework Convention on Tobacco Control (FCTC) entered into force – the only binding rules governing international health. It is in the last part of that period, however, under the leadership of Hafdan Mahler, that WHO is established as a “global health conscience” openly challenging the commercial practices of transnational pharmaceutical and food industries (Global Health Watch, 2005). Among others, the model list of essential drugs is introduced and the international code on breast milk substitutes is launched. It is under Hafdan Mahler that, in 1977, the World Health Assembly adopts the goal of “Health for all by the year 2000” and that the following year, with the Alma-Ata Declaration, Primary Health Care (PHC) is identified as the best strategy toward that objective, not only as an integral part of each country’s health system, but of its entire social and economic development, in a view based on equity and community participation, focussing on prevention and appropriate technology, with an integrated intersectoral approach to development. In line with those principles the Ottawa Charter is signed in 1986.

The dark years

The second period could be identified as a dark one for WHO and global health. With the advent and prevailing of neoliberal policies, a reductive, centralist and vertical approach to health care become dominant, i.e. “selective Primary Health Care” (Walsh & Warren, 1979) introduced earlier in the debate to face the structural implications of an holistic application of the PHC strategy. Attention was drawn away from health and focussed on the control of single diseases. Under the strong influence of international organisations and bilateral agencies, this soon resulted in the reorganisation of Health systems in “vertical programs”, the disarticulation of public health activities, along with a multiplication of costs and a waste of resources, not to speak of the complete detachment of these programs from development actions being implemented in other sectors (schools, production etc). This type of approach, disease-rather than health-oriented, was often more consonant with the political and administrative needs of main donor countries and organisations whose influence on choices made by beneficiary countries is well known. It adapted better to market strategies and to “social marketing” and, behind relatively cheap but highly visible campaigns, it often served to mask the lack of any real political will to improve people’s health conditions (Missoni, 2001).

In the 90s, at the urging of the World Bank, the international debate on health moved to health systems’ “Reform”, without considering that structural adjustment policies imposed on poor countries (social spending cuts, privatisation, abolition of protectionist barriers) had been among the main determinants in the worsening of people’s living conditions and in the collapse of those health systems, that countries were now asked to reorient (Stefanini, 1997).

Attention was focussed on Health systems efficiency (above all their costs), rather than the impact of public health policies on people’s health conditions. The issue was not whether the economic resources destined to the health system were sufficient to respond to people’s needs, but how to limit public health spending independently of the effects on people’s health. Once again it was proposed to identify a “minimum essential package” for the control of a limited number of diseases, on which the whole public health action should be based.

In the course of the 90s, the influence of the different players on the international health scene progressively changed. WHO leadership was being forced to deal with the numerous players claiming a role in the field of health: other UN organisations, the World Bank, regional development Banks and Funds, the private corporate sector of the great multinational pharmaceutical companies, along with the non-profit-making sector of a growing number of non-governmental organisations (Walt, 1998). In the meantime, instead of growing, Official Development Aid decreased by 20% during that decade.

The World Bank became the largest international donor in the health sector in middle and low-income countries, significantly altering the panorama of international health co-operation. With the size of its operations, the conditions imposed to countries in order to access to credit and the strategies it adopted, the World Bank changed the sectoral priorities and the relationship between donors and beneficiaries both at global and national level (Buse & Gwin, 1998).

WHO became over-centralised at headquarters and regions, top heavy, poorly managed, bureaucratic and its image reached a very low level also because of corruption suspects on its staff (Smith, 1995)

WHO director general Hiroshi Nakajima failed to come up with convincing responses to the challenges posed to world health and to WHO during this period, he alienated WHO staff and partners through his management style, high-profile disagreements and communication failures (Global Health Watch, 2005).

High profile and loss of drive

With the election of Dr. Brundtland as the Director General of WHO in 1998, it seemed that once again the organisation could put itself forward as the leading advocate of public health and the most competent organisation to provide expertise, set standards and assist Governments in strengthening their health systems.

On one hand, Brundtland was facing the necessity to restore the organisation's place on the international stage and, on the other one to reform WHO internally. Some authors argue that she was more successful in rising WHO profile internationally than at transforming the organisation internally (Yamey, 2002b).

From the moment of her appointment, Brundtland defined four strategic directions for WHO: reducing the burden of disease, reducing risks to health, creating sustainable health systems, and developing an enabling policy in the health sector (WHO, 1998). With a wider look, taking up her position, the new executive declared that the organisation's objectives were to combat poverty, underdevelopment and social inequalities (Lancet, 1998). In that sense it seemed that WHO would take a new lead in building Healthy Public Policies, as understood under the Ottawa Charter (1986).

A widely debated and often criticised outcome of WHO during Brundtland's directorate, was the World Health Report 2000. Opening a new phase in the debate, the report focussed on health systems. Defining the health system as "comprising all the organisations, institutions and resources that are devoted to producing health actions" and defining a health action "as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health" the accent was placed on the need for intersectoral cooperation in achieving good health and performance indicators included equity in financing and in the access to health services (WHO, 2000). However the set of health system indicators developed in the report was put under severe scrutiny (Richardson, Wildman, and Robertson, 2003; Braveman, Starfield and Geiger, 2001; Williams, 2001).

In the year 2000 Brundtland also established the "Commission on Macroeconomics and Health", led by Jeffrey Sachs, which added evidence to the direct relation between economy and health and how investment in the latter may induce economic development (WHO, 2001). However the Commission accurately avoided to explicitly question dominant macroeconomic policies, structures and mechanisms that contribute to the increase of worldwide health inequities (Sanders and Chopra, 2003). In addition, when it comes to identify solutions, the Commission's report lacks originality and proposes partial solutions, already identified by others externally to WHO; without any further evaluation it gives its own blessing to the Global Fund to fight AIDS, tuberculosis and malaria sponsored by UN Secretary General Kofi Annan and G8 governments (Missoni and Pacileo, 2004).

Brundtland herself openly supported the idea of the Global Fund and in general of the establishment of other Global Public Private Partnerships (GPPPs) to face a variety of specific diseases and health issues.

Brundtland had addressed the WHO involvement with public-private interactions from the moment of her appointment when she also defined the main characteristics these partnerships should have: clear statement of purpose, avoid of conflicts of interest, balance of industry and non-governmental organizations' involvement (Horton, 2002). Considering the difference between the objectives of WHO and those of corporate partners, and the increased dependence of WHO from private funds, Ford and Piedagnél (2003) anticipated that those interactions could potentially further reduce WHO independence.

One could imagine that WHO was looking for alternative, pragmatic ways to regain position and get needed resources. Brundtland's head of cabinet, David Nabarro, reportedly declared: "We certainly need private financing. For the past decade governments' financial contributions have dwindled. The main sources of funding are the private sector and the financial markets. And since the American economy is the world's richest, we must make the WHO attractive to the United States and the financial markets" (Motchane, 2002). But that policy of submitting WHO to the dictates of Washington and global liberalisation turned out to be ideological, not practical: WHO did not establish interactions it would coordinate, it rather offered unconditional support to partnerships that reduced WHO role to one of a purely technical adviser of those new international entities.

Two achievements must undoubtedly be recognised to Gro Harlem Brundtland: putting health on the agenda of the Millennium Summit and persuading all member states to endorse the 2003 WHO Framework Convention on Tobacco Control, that took effect as international law in 2005, establishing a milestone in the history of corporate accountability and public health (Global Health Watch, 2005).

More authors would agree that at the end of Brundtland's mandate, WHO's international credibility had been restored, the image and relevance of the Organization at the global level had been successfully improved (Minelli, 2003). Summarising, she contributed to make health of interest for those who actually detain the power to act, increased the visibility of the WHO, but further reduced the relevance of the WHO in steering the agenda without changing the earlier impression that "the WHO was no longer setting the international public health agenda" (Lerer and Matzopoulos, 2001), or that "WHO, once the main player [...] is now one of many. Other UN organizations are concerned with health, the private sector has a firm niche with health" (Walt, 1998).

Leading again to Health For All?

The influence of private foundations (e.g. Bill & Melinda Gates) and public-private partnerships (e.g. GFATM, GAVI) continued to grow and the question of WHO's place in that emerging configuration remained unresolved under the leadership of Dr Lee Jong-Wook (Global Watch, 2005), who succeeded to Brundtland in 2003, but whose term of office was prematurely interrupted by his dramatic passing away in 2006.

From the beginning Dr Lee confirmed his total commitment to achieving the Millennium Development Goals, noting that the MDGs agreed by the UN at the Millennium Summit are built on the WHO Constitution objective of "Health for All", and they are "strategic focal points within a broad health agenda that build on the Alma Ata legacy" (Minelli, 2003).

Introducing World Health Report 2003 "Shaping the future", the first published under his term as Director General, Dr Lee stated: "Today's global health situation raises urgent questions about justice" (Haines, 2003). The report reaffirmed the need for strengthening health systems, and urged to do so building on the values and practices of primary health care; it drew on notions of responsiveness to population needs and stewardship toward pro-equity health systems. Referring to the Report, Walt (2004) considered it "refreshing in its attempt to offer an integrated approach to improving health". The Report also reminded to Lee's flagship initiative to treat three million people with AIDS with antiviral therapy by the year 2005 (known as "3 by 5"), however also when focussing on particular diseases, emphasis was on how health systems will play a part in meeting overall health goals.

In terms of refocussing WHO in the perspective of health promotion, the most remarkable initiative of Dr Lee was probably The Commission on Social Determinants of Health, that he launched in March 2005 and that will complete its initial work in May 2008. The Commission, chaired by Michael Marmot, brought together leading scientists and practitioners to provide evidence on policies that improve health by addressing the social conditions which people live and work and to collaborate with countries to support policy change and monitor results (WHO, 2006 a)

WHO and health promotion: strengths and weaknesses

The comparative advantages of WHO may be easily identified in its representation through nearly universal membership, the legitimacy deriving from its mandate, its convening power, its position at the center of a global network of institutions and public health agencies, its authority in establishing standards and regulations, its unique position to gather health information, and its capacity to advocate policies (WHO, 2006 b).

According to the Global Health Watch (2005) analysing the successes of WHO over the years, only a few can be related to health promotion in the spirit and words of the Ottawa Charter, for example: advocacy for marginalised population groups such as the poor, people with AIDS and people with mental illness; the production of studies and reports providing an evidence base for policy, practice and advocacy; the promotion of agendas that are value-based, knowledge-based and support health rather than ideologically driven or politically motivated; innovative intersectoral programmes such as healthy Cities. In the same context, some praise for more recent work is also indicated, such as: returning health to the international development agenda; the gradual renaissance of primary health care and health promotion, including challenges to commercial interests that damage health. However, at the end of the list the Global Health Watch (2005) adds: "Much of this praise, however, has a ritual air, run through rapidly as an appetiser to the main dish – strong criticism".

The international community didn't maintain the pledges of the Ottawa Charter. The prevailing neoliberal focus on unrestricted economic growth² irrespective of its consequences on human life and on the environment, went in the opposite direction of Ottawa's commitment for healthy public policies, equity, control of the pressures towards harmful products, resource depletion, unhealthy living conditions and nutritional habits. The gap between and within societies increased as did inequities in health. The involvement of communities in decision-making processes remained purely rhetoric, and efficiency rather than impact on people's health has been orienting health services in all these years. The overall ecological issue of our ways of living doesn't seem, beyond rhetoric, to be a main concern of world most powerful decision makers.

2 Economic growth, measured by the increase of the GNP (Gross National Product) i.e. the total value of goods produced and services provided by a country during one year, equal to the gross domestic product plus the net income from foreign investments, is not neutral. Depending on the type of goods and services (for example: food or weapons; education or financial transactions), as well as the way they are produced (for example: an environmentally friendly or a polluting production cycle) they may have a very different impact on population's life conditions.

For too a long period, on these subjects the voice of WHO was hardly heard, for sure it didn't lead the debate in that direction. Its weakness translated into selective, vertical, disease- rather than health-oriented approaches, left by side the goal, the strategy and the spirit of Alma Ata. WHO was not only incapable of leading an intersectoral approach to health, but also lacked the political will (and the resources) to coordinate other health development actors' actions. It encouraged deregulation in the field of global health (including the mushrooming of Global Public Private Partnerships), instead of facilitating a more rational flow of resources from multiple international public and private sources toward the strengthening of poorer countries' capacity to face in a sustainable way the health challenge. Careless of the potential conflict of interest, it was keener for link and collaboration with the commercial sector, than to the often more appropriate (for their genuine interest for public health), natural partners in civil society. Cooperation across different sectors, lack of communication in empowering and providing a voice for people, and lack of leadership and direction in addressing the roots of health issues, rather than just the symptoms are considered the three focus areas in which WHO has historically poorly performed. Health Promotion is about empowering people; WHO was a key party within the formulation of this declaration, but that idea has largely been lost "instead WHO has continued to operate mainly within the logic and language of biomedicine" (Deane, 2003).

The lack of growth of its regular budget (since more than twenty years its member States have constrained the WHO regular budget to a zero-growth trend) inappropriately compensated by a proportional increase of extra budgetary, mostly ear-marked funds provided by bilateral agencies, other international organisations and private donors, imposed donor-driven priorities and short-term projects, in contrast with the high profile long term goals of WHO and the need for countries to develop their health systems (Yamey, 2002 a).

WHO and the Bangkok Charter: the way forward. Opportunities and Threats

In contrast with a footnote to the Bangkok Charter (WHO, 2005) stating that the Charter does not necessarily represent the decisions or the stated policy of WHO, in the inaugural words of late Director General Lee: "WHO wholeheartedly supports the principles outlined in the draft Charter" (Lee, 2005) and WHO's Eleventh General Programme of Work 2006-2015 (WHO, 2006 b) explicitly refers to the Bangkok Conference, as well as to the WHO Framework Convention on Tobacco Control, among other international agreements shaping the global agenda, outlined "for all stakeholders, not just for WHO".

It is remarkable that the same programmatic document, recommends action in line with with the Ottawa Charter, identifying the following seven priority areas:

- investing in health to reduce poverty;
- building on individual and global health security;
- promoting universal coverage, gender equality and health related human rights;
- tackling the determinants of health;
- strengthening health systems and equitable access;
- harnessing knowledge, science and technology and
- strengthen governance, leadership and accountability.

Looking more in detail to the description of those priorities a new trend emerges, much more in tune with a health promotion approach, rather than the traditionally prevailing bio-medical one.

Systems must become more equitable ("aligning contributions with ability to pay, and use of services with degree of need"). The role of Government is central and poverty reduction strategies must enable programmes across departments such education, environment and health. Most useful and accurate indicators to measure progress of those strategies, are not economic, but those related to health status.

Prevention and control of infectious disease is a priority, but equally important are risks pertaining to food and water insecurity. Focus is on health risks linked to broader factor such as education, gender equality, income, availability of food, water, fuel and land.

Priority attention to marginalised groups. All groups have the right to participate in the design, implementation and monitoring of health policies. Primary care services are to be strengthened. Ownership at country level and government's stewardship is a key to success for global initiatives.

Focus is on tackling key health determinants. Those related to social exclusion, such as income, gender roles, education and ethnicity. Those linked to exposure to risks such as living conditions, work

environment, unsafe sex and availability of water and food, with specific mention of the responsibility of global marketing of foods high in sugar, fat and salt in producing the growing epidemic of chronic noncommunicable diseases. And finally those of a broader economic, political and environmental nature, such as urbanization, intellectual property rights, trade and subsidies, globalization, air pollution and climate change. Finally, envisaging the need for increased governmental regulatory functions and enforcement capacities, as well as stressing the role of WHO in supporting governments to coordinate cooperation, ensure ownership, harmonization, alignment, results and accountability, as agreed in the Paris Declaration on Aid Effectiveness (2005), undoubtedly establishes a new trend.

The fact that health is much higher in the global agenda and the increasing consciousness about social and economical determinants of health, undoubtedly represent an excellent opportunity for WHO to reposition itself according to its constitutional role of "directing and coordinating authority" (WHO, 2006) engaging in political and economic discourse, beyond its traditional logic and language of biomedicine (Deane, 2003). The Framework Convention on Tobacco Control is an excellent antecedent to build on, as recommended by the Ottawa charter, for WHO to provide leadership and promote more coherent and effective development of international health law. In fact, as Taylor (2002) argues, WHO is the appropriate institutional instance for regulatory and legislative efforts related to issues that overlap with other realms of international concern (such as human rights, trade, environment, and others) but are central to the public health mandate of WHO and beyond the core mission of another public international organization.

Looking forward

After the sudden passing away of late Director General Lee Jong-wook the international health community looks with hope to the commitment of the new Director General, Dr Margaret Chan of working tirelessly "to make this world a healthier place" (Chan, 2006). Such an endeavour is strictly linked with our capacity to build social justice (Ruger, 2006; Ruger and Kim, 2006), ensure full and universal enjoyment of human rights, and protection of the environment. Such a vision measures development through the improvement of life conditions of those most in need and the reduction of inequalities, rather than indiscriminately through economic growth.

The real threat is that global commitment remains rhetoric and most powerful decision-makers do not really care or have not the courage to act for changing the present trend. Such a commitment needs strong reference to a "noble system of ethical values", political courage and a solid network of alliances with partners who share the same vision. In her speech Dr Chan made clear reference to the first, she will have to demonstrate to have the second and to be able to correctly identify the latter.

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