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CONSTITUTIONAL OUTLINES OF PUBLIC HEALTH’S “NEW WORLD ORDER”

David P. Fidler*

INTRODUCTION

In previous scholarship, I argued that containment of the 2003 outbreak of severe acute respiratory syndrome (“SARS”) revealed the emergence of a new way of governing global infectious disease threats.1 The responses, good and bad, to the unprecedented outbreak of avian influenza A (“H5N1”) in Asia in 2004 reinforce my argument that governance of global infectious disease threats has entered a new phase.2 In this article, I assert that this new governance context exhibits “constitutional outlines” that provide substance and structure to public health’s “new world order.” These outlines parallel governance features more commonly associated with constitutional structures than international ones.

The appearance of these constitutional outlines does not mean that “world health government” has arrived. The outlines bear the imprint of the anarchical conditions characterizing international relations. This article explores, however, how governance of public health has transcended previous models and approaches through the development of features that parallel how constitutional frameworks structure public health governance.3 After sketching these constitutional outlines, I reflect on their implications for public health governance,4 comment on potential deficiencies and vulnerabilities in this

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2. This Article does not comprehensively analyze the avian influenza outbreak but refers to policy responses to it at appropriate points in the argument. For an overview of the international legal implications of avian influenza, see David P. Fidler, Global Outbreak of Avian Influenza A (H5N1) and International Law, American Society of International Law Insights (Jan. 2004), at http://www.asil.org/insights/insigh125.htm.

3. See infra Part IV for a discussion of the similarities between transformations in public health governance in the United States and in international relations.

4. See infra Part IV.C for a discussion of the constitutional outlines of public health governance.
emerging structure, and offer some thoughts on prospects for the new regime.  

I. INTERNATIONAL AND CONSTITUTIONAL GOVERNANCE

A. Anarchy and Hierarchy

International and constitutional governance have traditionally had different purposes. International governance organizes and regulates political, economic, and social interactions among independent, sovereign states. Constitutional governance organizes and regulates political, economic, and social affairs within a single political entity, typically the sovereign state. International governance manages power in anarchy; constitutional governance establishes a hierarchy of power.

Rhetoric and concepts from constitutional governance have sometimes been applied to international relations, as illustrated by arguments that the Covenant of the League of Nations or the United Nations Charter represents a “constitution” for world affairs. The constitutional structures that provide the closest analogies to international politics are confederal or federal systems, which allocate sovereignty hierarchically among national and sub-national units. Historically, however, confederal or federal constitutional structures have not provided much utility for analyzing sovereign states interacting in a condition of anarchy. The federal constitutional system of the United States provided, for example, little insight into how Cold War intergovernmental relations functioned because the underlying political contexts (hierarchy v. anarchy) differed.

B. Allocating Power Horizontally and Vertically

Conceptually, international and constitutional governance allocate political power in different ways. Both involve horizontal and vertical allocations of power, but each has a distinct combination of such allocations. International governance’s primary allocation of power is horizontal among political units (states) that are formally equal. This horizontal allocation of power produces the international system, the dynamics of which center on the anarchical interactions of sovereign states. International governance’s secondary

5. See infra Part IV.D for a discussion of the weaknesses in public health’s new world order stemming from the anarchical environment of international relations.

6. See infra Part V suggesting that prospects for global health governance will be determined by the progress achieved under the public health preparedness and response function.


8. See Hedley Bull, THE ANARCHICAL SOCIETY: A STUDY OF ORDER IN WORLD POLITICS 9-10 (3d ed. 1977) (defining an international system as forming “when two or more states have sufficient contact between them, and have sufficient impact on one another’s decisions, to cause them to behave—at least in some measure—as parts of a whole”).
allocation of power is vertical, which traditionally involved a political hierarchy reflecting the distribution of material power and the special role great powers play in anarchical political systems.

Constitutional governance's primary allocation of power is vertical among different levels of governance within one political unit. Thus, the U.S. Constitution allocates the sovereign power of the United States between the federal government and the states of the Union. Such vertical allocation of power creates a legal hierarchy that establishes what level of government has primacy in exercising sovereignty. Constitutional governance's secondary allocation of power is horizontal and affects branches of government within particular levels of the hierarchy. The U.S. Constitution's separation of powers and checks and balances horizontally allocates power within the federal level of government.

The horizontal allocation of power achieved through international governance presumes (at least theoretically) that each state functions as an autonomous governance unit. The vertical allocation of power in constitutional governance creates interdependent governance entities relating in a functional hierarchy. In federal systems, constitutions assign certain governance functions to the national government (e.g., providing for the common defense), subnational governments (e.g., education), and individual citizens (e.g., defending a bill of rights against government encroachment).

Analogies to constitutional governance in international relations often appear in connection with international institutions.9 These analogies are made because such institutions add a "vertical" dimension to international governance through the creation of political entities that fulfill specific governance functions. For example, under the Charter of the United Nations, the Security Council is legally competent to authorize the use of force in situations not involving self-defense.10 Similarly, references to constitutional governance in international relations appear in advocacy for the "international bill of human rights," allegedly composed of the corpus of fundamental human rights in international law.11

International institutions and international human rights law disaggregate sovereignty on the international plane, echoing vertical allocations of governance power in constitutional structures. Historically, however, these echoes have ranged from faint to inaudible in international relations.12 By and large, states created international institutions to help calibrate the horizontal allocation of power structured by international governance. As the international

9. See, e.g., Helfer, supra note 7, at 194-97 (discussing benefits and detriments of comparing constitutional and international governance).
10. U.N. CHARTER, arts. 39, 42.
12. One exception is the creation of the European Community, which according to Helfer, has "evolved into a quasi-federal system with legislative, judicial, and executive branches that exercise significant lawmaking, adjudicative, and enforcement powers...." Helfer, supra note 7, at 199.
relations theory of institutionalism argues, international institutions reflect rather than rearrange the structural nature of international relations.\textsuperscript{13} In terms of human rights, concerns about the state of compliance with international human rights law suggest that the role of individual rights in constitutional governance has, for the most part, eluded the human rights movement in international relations.\textsuperscript{14}

Faint and inaudible echoes of constitutional governance in international affairs owe much to the privileges accorded sovereignty by international governance. Historically, states have only grudgingly limited their sovereignty vis-à-vis other states through international regimes. Similarly, principles that support sovereignty, such as the principle of nonintervention, have blunted the human rights effort to disaggregate sovereignty vertically as achieved in constitutional governance.

My thesis that public health governance in the post-SARS world exhibits "constitutional outlines" means that such governance has moved beyond faint and inaudible echoes of constitutionalism in the world politics of public health. To sustain this argument, I need to demonstrate that public health governance exhibits new characteristics that resonate more with constitutional than international governance. The constitutional outlines represent the emergence of governance functions that reflect a vertical reallocation of power in the realm of global public health.

\section*{II. FEDERALIZATION OF PUBLIC HEALTH IN U.S. CONSTITUTIONAL GOVERNANCE}

\subsection*{A. Public Health and the U.S. Constitution}

Because federal constitutional structures provide the appropriate frameworks with which to analyze governance in international relations, I sketch federal public health functions that arise under the U.S. Constitution and describe how the exercise of these functions now dominate public health governance in the United States. Subsequent parts of the article trace the emergence of similar functions outside sovereign states in global public health.\textsuperscript{15} These functions represent the "constitutional outlines" of public health's new world order.

Under the U.S. Constitution, the states of the Union rather than the federal government possess governance authority for public health.\textsuperscript{16} The federal


\textsuperscript{15} See infra Part IV for a discussion of how U.S. and international public health governance hint at "constitutional outlines" for global health governance.

government has no express enumerated powers on public health. Thus, in the U.S. Constitution's vertical allocation, public health sovereignty formally resides with the states. The federal government is, however, a significant actor in public health governance because the exercise of its enumerated powers affects public health in many ways.

Despite having no express constitutional powers for public health, the federal government developed important public health governance functions. The development of these functions highlights the growing importance of the federal government in public health. In essence, the increasing importance of these functions represents a de facto reallocation of power, which suggests the emergence of a radically different context for public health governance.

B. Public Health and National Security

The U.S. Constitution assigns responsibility for providing national security to the federal government.17 Defending the nation and promoting its interests abroad represent tasks no individual state could fulfill. Constitutional power for this purpose belonged at the federal level, where collective action vis-à-vis other countries could be effectively managed. Historically, public health has not featured prominently as an element of the federal government's exercise of its national security powers. Similarly, with public health authority residing in the states, the pursuit of public health in the constitutional system did not reflect national security objectives.

Public health arose as a national security issue in connection with infectious disease threats to U.S. military forces. The federal government sought to mitigate costs pathogenic microbes inflicted on U.S. military personnel during overseas campaigns and missions (e.g., the U.S. Army's anti-yellow fever efforts in the late nineteenth and early twentieth centuries). The federal government also concerned itself with the threat posed to U.S. national security by the development and use of biological weapons by potential adversaries.18

These limited contexts in which national security policy reflected public health concerns fell entirely within the allocation of powers in the U.S. Constitution. The past decade has witnessed, however, a revolution in the relationship between public health and national security.19 This revolution has

17. See, e.g., U.S. CONST. pmbl. (indicating that one of the purposes for establishing the Constitution was to "provide for the common defence"); U.S. CONST. art. I, § 8, cl. 11-16 (granting Congress the power to declare war, raise and support army and naval forces, and to make rules regulating military forces); U.S. CONST. art. II, § 2, cl. 1, 2 (vesting the President with the powers of Commander in Chief of the Army and Navy and of negotiating treaties and appointing ambassadors).


19. See generally David P. Fidler, Public Health and National Security in the Global Age:
increased the public health importance of the federal government’s national security powers. As public health more broadly has fallen under national security scrutiny, the constitutional function of the federal government in the public health governance has enlarged.

The federal government’s security function in public health has arisen in response to three threats, two of which have shifted constitutional responsibility for public health from state governments to the federal government. The first threat is bioterrorism, which has skyrocketed as a policy concern in the last decade. The threat of biological attack against the U.S. homeland has made the quality of public health systems at the state level a national security issue. As a result, the federal government has intervened in the public health sphere in unprecedented ways, making the federal government, rather than the states, the constitutional engine of public health governance.

The second threat involves naturally occurring infectious diseases and the dangers they pose to U.S. security. In another unprecedented policy shift, the United States in the 1990s, began to view emerging and reemerging infectious diseases, propelled by the forces of globalization, as a threat to U.S. public health, economic welfare, and national security. This shift continued in the early twenty-first century, accelerated by events such as the SARS and avian influenza crises. The challenge of responding to globalized infectious diseases mandates federal control because the scale and nature of this threat is beyond the capability of any individual state of the Union.

The threats from bioterrorism and naturally occurring infectious diseases have expanded the federal government’s constitutional functions synergistically. Defense against both threats requires a robust national public health system. The Constitution’s allocation of public health power to states creates a patchwork system vulnerable at many points to the disease threats faced by the United States. Thus, the responsibility for shoring up the country’s public health defenses falls to the federal government because of the scale and nature of the problem.

The third threat in the national security context concerns how infectious disease epidemics in foreign countries threaten U.S. national security and foreign policy interests. For example, in the 1990s and early 2000s, the U.S. government

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viewed the spread of the human immunodeficiency virus and the acquired immunodeficiency syndrome ("HIV/AIDS") epidemic in the developing world as a national security threat because of its potential to contribute to state failure and regional instability. Because foreign-source threats to national security and foreign policy are federal constitutional domains, this threat does not produce the shift in constitutional functions triggered by bioterrorism and invasion by naturally occurring infectious diseases. The moves made by the federal government to respond to infectious disease problems overseas deepen, however, the federal government's growing constitutional dominance of public health.

C. Public Health and Commerce

The U.S. Constitution assigns responsibility for regulating interstate commerce and commerce with foreign nations to the federal government. As with national security, such allocation of sovereignty makes sense because no individual state could shoulder these endeavors. The federal government's commerce powers have been a basis for federal action in connection with public health in two ways.

First, the Commerce Clause is a limitation on state-level public health governance. Federal courts have often reviewed state health measures that affect interstate commerce. The constitutional power of the individual states to exercise their public health sovereignty is not absolute, but is embedded in a constitutional system in which free flows of commerce is a structural principle. The Commerce Clause gives the federal government the constitutional function of balancing interstate commerce and the public health sovereignty of the states of the Union.

Second, the Commerce Clause empowered the federal government to legislate to address public health threats arising from interstate and international commerce. Foreign and interstate commerce can create negative health externalities through widespread trade in health-damaging products that the federal government can address legislatively under the Commerce Clause. As the speed, scale, and volume of interstate and foreign commerce has increased, the public health importance of the Commerce Clause has likewise increased because, again, the nature of the public health problem supersedes the

23. U.S. CONST. art. I, § 8, cl. 3 (assigning to Congress the power "to regulate Commerce with foreign Nations, and among the several States").
24. See, e.g., Kassel v. Consolidated Freightways Corp., 450 U.S. 662, 670 (1981) (holding that "the incantation of a purpose to promote the public health or safety does not insulate a state law from Commerce Clause attack. Regulations designed for that salutary purpose nevertheless may further the purpose so marginally, and interfere with commerce so substantially, as to be invalid under the Commerce Clause.").

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constitutional powers allocated to the individual states. The globalization of trade, investment, and markets highlights why the federal government's constitutional function of regulating commerce has become critical for protecting public health in the United States.

D. Public Health Preparedness and Response

The U.S. Constitution's allocation of public health sovereignty to the states of the Union assigns responsibility for public health preparedness and response to such states. State and local governments provide the bulk of personnel and resources devoted to public health in the United States. The federal government's role in public health preparedness and response has been to support state-level efforts, particularly with respect to handling problems that threaten to overwhelm state capacities (e.g., federal emergency management support during natural disasters). 26 This support role is consistent with the federal government's formal subordination in the constitutional system for public health.

The enlargement of the federal government's constitutional functions for public health under its national security and commerce powers caused the federal government's responsibilities for public health preparedness and response likewise to expand. Congressional legislation and appropriations have significantly increased in the last five years, 27 making the federal government the primary influence on preparedness and response efforts today. This shift in the federal preparedness and response function flows from the rise of public health as an issue for national security and the regulation of globalized commerce. Public health preparedness and response can no longer constitutionally be considered a function primarily of state governments.

The increased constitutional importance of the federal preparedness and response function manifests itself in federal efforts to strengthen both state and federal public health capabilities. The Constitution's allocation of public health sovereignty to the individual states has created a public health structure marked by federalism. Thus, robust federal activity on public health preparedness and response cannot ignore problems that exist at the state level. Federal leadership on preparedness and response is, however, transforming the traditional distribution of public health power into one in which the federal government plays the more decisive and powerful constitutional role.


27. Press Release, U.S. Department of Homeland Security, President's Budget Includes $274 Million to Further Improve Nation's Bio-Surveillance Capabilities (Jan. 29, 2004) (stating that "[s]ince September 11, 2001, the Bush Administration has spent or budgeted $12.9 billion to prepare and protect the nation from a bioterror attack, including $5.2 billion in the Fiscal Year 2004 budget. This is 15 times the $305 million spent in Fiscal Year 2001."), available at http://www.dhs.gov/dhspublic/display?theme=34&content=3091.
E. Public Health and Individual Rights

The Bill of Rights in the U.S. Constitution has always given the federal government the constitutional function of scrutinizing public health actions by government for compliance with constitutionally protected rights. Since the early twentieth century, federal courts have upheld and struck down state government public health actions that affected rights protected by the Constitution.\(^\text{28}\) The federal government's constitutional function with respect to individual rights demonstrates that the allocation of public health sovereignty to state governments is embedded in a constitutional system in which protection of civil and political rights is a bedrock principle.

Well before the SARS outbreak, commentators observed how protection of civil and political rights significantly increased in public health over the course of the twentieth century.\(^\text{29}\) The heightened importance of the protection of rights in connection with public health appeared in the United States in the HIV/AIDS epidemic in the 1980s, and in responses to bioterrorism and naturally occurring infectious diseases in the 1990s and early 2000s. Although controversies erupted concerning how to balance government action with the protection of rights in public health contexts (e.g., privacy rights in connection with HIV/AIDS surveillance and the use of quarantine and isolation in response to bioterrorism), these controversies demonstrated the extent to which the federal constitutional function of protecting fundamental human rights had become central to public health governance in the United States.

F. Federalization of Public Health Governance

The national security, commerce, preparedness and response, and individual rights functions described above reveal that public health governance in the United States today cannot be accurately described by the formal allocation of public health sovereignty found in the Constitution. These federal constitutional functions, and their growing importance, reflect the federalization of public health governance in the United States. This federalization indicates that the relationship between public health and sovereignty in U.S. constitutional governance has been transformed by political, economic, and technological developments, particularly in the past fifteen years. The Constitution's vertical allocation of public health power made state governments the primary governance actors and the federal government a secondary player. The federalization of public health governance has not altered the \textit{de jure} allocation of public health power, but it has changed the \textit{de facto} allocation of public health governance responsibilities so that the federal government has governance

\(^{28}\) See, \textit{e.g.}, Jacobson v. Mass., 197 U.S. 11, 24-25 (1905) (holding that state compulsory vaccination requirement for smallpox was constitutional); Jew Ho v. Williamson, 103 F. 10, 26 (1900) (holding that a discriminatory application of municipal quarantine regulation was unconstitutional).

\(^{29}\) See, \textit{e.g.}, George J. Annas, \textit{Blinded by Bioterrorism: Public Health and Liberty in the 21st Century}, 13 \textit{Health Matrix} 33, 55 (2003) ("Almost one hundred years after \textit{Jacobson} [v. Mass.], neither medicine nor constitutional law is what it was. We now take constitutional rights much more seriously . . . .").
primacy over the individual states.

The federalization of public health governance also reveals that the nature of public health as a governance problem has changed significantly. The framers viewed public health through the lens of the "police power," historically exercised effectively at the most local level.\(^{30}\) The expansion of federal constitutional functions suggests that political, economic, and technological developments have overwhelmed the Constitution's eighteenth century conceptualization of public health governance. In terms of public health, federalization appears increasingly necessary to achieve the constitutional objectives of forming a more perfect union, establishing justice, insuring domestic tranquility, providing for the common defense, promoting the general welfare, and securing the blessings of liberty for existing and future generations of Americans.\(^{31}\)

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31. Evidence of the federalization of public health can also be seen in the European Community ("EC"). First, EC treaties have always contained "commerce clause"-type provisions regulating the impact of health measures on trade. See Treaty Establishing the European Community (consolidated version), art. 9, 2002 O.J. (C 325) 1 (2002) [hereinafter EC Treaty] (establishing freedom of movement of goods); EC Treaty art. 30 (prohibiting quantitative restrictions on imports and all measures having equivalent effect). For analysis of how the EC law deals with trade-restricting health measures, see Marco M. Slotboom, Do Public Health Measures Receive Similar Treatment in European Community and World Trade Organization Law?, 37 J. WORLD TRADE 553, 555-64 (2003). Second, the role of EC institutions in public health has increased as the EC has developed, as evidenced by the EC Treaty's inclusion of specific EC public health responsibilities not found in the earlier treaties. See EC Treaty art. 152 (affirming the European community's commitment to public health). On the EC's activities under Article 152, see Activities of the European Union: Public Health, at http://europa.eu.int/pol/health/index_en.htm (last visited Aug. 11, 2004) [hereinafter Activities of the European Union]. Third, EC-level involvement in public health preparedness and response has also increased. See Programme of Community Action in the Field of Public Health (2003-2008) (2002) (including in EC's public health program "boosting the ability to respond rapidly and coherently to health threats such as the cross-border menace of HIV, new variant Creutzfeldt-Jakob disease and pollution-related diseases"), at http://europa.eu.int/scadplus/leg/en/cha/c11503b.htm (last visited Sept. 8, 2004). Fourth, the EC's preparedness and response function has been stimulated, in part, by concerns about weapons of mass destruction and bioterrorism, an indication that EC public health responsibilities have a security dimension. See Civil Protection: Report on Preparedness for Possible Emergencies, (2002) ("The network for the epidemiological surveillance and control of communicable diseases in the European Union was further developed. A programme for preparedness and response capacity in the event of attacks involving biological and chemical agents was set up. Cooperation with third countries and international organisations was developed in the framework of health protection. For example, the Global Health Security Action Group was set up. It enables an exchange of information on health intervention, monitoring of diseases, the contamination of water and food chains, and also on the supply and storage of medicines. With regard to bioterrorism, the Commission is also cooperating with the WHO. Action taken in the pharmaceutical field will provide the civil protection mechanism with the resources required (vaccines, medicines, etc.) in the fight against bioterrorism."). at http://europa.eu.int/scadplus/leg/en/lvb/l28124.htm (last visited Sept. 8, 2004). The EC's preparedness and response and security functions are reflected in the forthcoming creation of a new EU institution that resembles the U.S. Centers for Disease Control and Prevention. See Activities of the European Union, supra ("For some time now, the EU has recognised that it needs to improve its ability to protect its citizens against communicable diseases and bio-terrorism threats. . . . The EU is
Though the federalization of public health governance in the United States is dramatic, this development is not this article’s main focus. My thesis concerns public health governance beyond any single country. Although the federalization of public health governance forms part of public health’s new world order, an even more radical phenomenon is underway in international relations—the globalization of public health governance. The federalization of public health governance in the United States sets up the analysis of the revolutionary governance developments transforming the world politics of public health. The globalization of public health governance represents a new constitutionalization of public health governance in the anarchical context of international relations.

III. GLOBALIZATION OF PUBLIC HEALTH GOVERNANCE

In analyzing the SARS outbreak, I identified two contrasting governance frameworks for addressing public health problems—Westphalian and post-Westphalian public health governance.\(^{32}\) I use these concepts in this article, but in a modified form concerning post-Westphalian governance, to reflect analysis I developed subsequent to my SARS-specific scholarship.\(^{33}\)

Sketching these different governance frameworks highlights changes in public health governance beyond the sovereign state since the origins of international health diplomacy in the mid-nineteenth century. The latest developments in governance of public health in international relations reflect a vertical reallocation of power above and below the sovereign state. This reallocation of power contains features similar to the federalization of public health governance in the United States and encourages me to explore in Part IV below the “constitutional outlines” produced by the globalization of public health governance.

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32. See, e.g., FIDLER, supra note 1, at 21-41 (analyzing public health in the Westphalian system of international politics); id. at 42-68 (analyzing public health in the post-Westphalian system of global politics).

A. Westphalian Public Health Governance

As the name suggests, Westphalian public health governance reflects the "Westphalian" system of international politics. International relations scholars acknowledge the Peace of Westphalia of 1648 as a governance turning point because it established a political structure that dominated for three centuries.\(^3\)\(^4\) Independent, territorial states interacting in a condition of anarchy characterize the Westphalian system. Sovereign states are the structural units of the system and determine the nature of the anarchy in which they interact.

The Westphalian system allocates power horizontally among the system's units and creates no superior authority to which states answer. This allocation of power is grounded in international law and produces the concept that all sovereign states are equal under that law.\(^3\) This horizontal allocation generated governance principles to guide anarchical state interactions. The central principle is sovereignty: the state reigns supreme over the people and activities in its territory.

Sovereignty spawns two other governance principles. First, because sovereignty means supreme power, Westphalian governance opposes one state intervening in the domestic affairs of other states and thus contains the principle of nonintervention. Second, rules to govern sovereign interactions arose from the states themselves because no supreme, law-making entity existed. In Westphalian governance, a state was free to exercise its sovereignty as it saw fit unless that state consented to a rule of international law that disciplined its behavior.

The combination of the principles of sovereignty, nonintervention, and consent-based international law produced a governance system with the following attributes:

1. only states were involved in governance;
2. governance primarily addressed the mechanics of state interaction (e.g., diplomacy, war, and trade);
3. governance did not penetrate sovereignty to address how a government treated its people or ruled over its territory.

The vertical allocation of power seen in the Westphalian governance was political, rather than legal, because this allocation was based on the distribution of power in the system. The great powers largely determined how the Westphalian system functioned, and warfare and the balance of power were traditional tools of great-power management of Westphalian governance.

The Westphalian governance structure had been in place two centuries before the cross-border spread of infectious diseases became a subject of international diplomacy in the mid-nineteenth century. Beginning in 1851, the European great powers began developing diplomatic processes and international

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34. See JAN AART SCHOLTE, GLOBALIZATION: A CRITICAL INTRODUCTION 20 (2000) (arguing that the Peace of Westphalia "contains an early official statement of the core principles that came to dominate world affairs during the subsequent three centuries").

legal rules to facilitate cooperation on infectious diseases.\textsuperscript{36} For roughly the first hundred years of such diplomacy, international cooperation on public health conformed to the Westphalian structure and its governance principles. The processes and rules created by the great powers primarily sought to mitigate friction national measures designed to prevent infectious disease importation (e.g., quarantine) created for international trade.

The characteristics of Westphalian public health governance can be found expressed in the International Health Regulations ("IHR") promulgated by the World Health Organization ("WHO").\textsuperscript{37} The IHR are the only set of international legal rules binding on WHO member states concerning infectious diseases,\textsuperscript{38} and the IHR continue the Westphalian approach to cooperation on infectious diseases begun in the mid-nineteenth century. The IHR are classically Westphalian in structure and content.

The IHR's objective is "to ensure the maximum security against the international spread of disease with minimal interference with world traffic."\textsuperscript{39} The IHR's focus is solely on infectious diseases moving between states. The IHR seek maximum security against the international spread of disease by requiring governments to: (1) notify the WHO of outbreaks of diseases subject to the IHR; and (2) maintain certain public health capabilities at ports and airports. The IHR seek minimum interference with world traffic by regulating the WHO member states' trade and travel restrictions against countries experiencing outbreaks of diseases subject to the IHR.

In keeping with Westphalian governance, the IHR constitute rules of international law created by states. The rules respect the principle of nonintervention by addressing only aspects of infectious diseases that relate to intercourse among states. The IHR do not address aspects of public health governance that touch on how a government controls infectious diseases in its territory.

The IHR's limited framework is clear from the small number of diseases subject to its rules, currently only plague, cholera, and yellow fever.\textsuperscript{40} The small number of diseases subject to the IHR derives from the great-power origins of international health diplomacy. The great powers crafted rules to deal with disease threats exogenous to their territories, which reflected "not a wish for the general betterment of the health of the world, but the desire to protect certain favoured (especially European) nations from contamination by their less-

\textsuperscript{36} For analysis of this history, see generally NEVILLE M. GOODMAN, INTERNATIONAL HEALTH ORGANIZATIONS AND THEIR WORK (2nd ed. 1971); NORMAN HOWARD-JONES, THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851-1938 (1975); DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES (1999).


\textsuperscript{38} WHO, GLOBAL DEFENSE AGAINST THE INFECTIOUS DISEASE THREAT 63 (M.K. Kindhauser ed., 2002) [hereinafter WHO, GLOBAL DEFENSE].

\textsuperscript{39} IHR, supra note 37, at Foreword.

\textsuperscript{40} Id. at art. 1.
favoured (especially Eastern) fellows.”

The development of Westphalian governance should not create the impression that public health was a high priority in international politics. Public health ranked low as a foreign policy concern for states and became even less important for the great powers as they integrated better public health strategies and technologies into their domestic public health systems. Evidence of this low priority can be seen in the IHR's history. The IHR today only deal with the same diseases discussed at the first International Sanitary Conference in 1851, which suggests how marginal public health governance was to international politics. Widespread violation of the IHR by WHO member states also indicates the unimportance of these rules to state behavior. Acknowledgements by WHO personnel and public health experts in the 1960s, 1970s, 1980s, 1990s, and early 2000s that the IHR had not achieved their purpose underscore the low priority WHO member states accorded this governance regime.

B. Post-Westphalian Public Health Governance (I): Individual Rights, Human Solidarity, and Redistributive Justice

One reason why Westphalian governance generally, and the IHR specifically, suffered neglect was the development of an alternative conception of public health governance in the post-World War II period. The WHO Constitution's Preamble contains the concepts animating this new governance paradigm (see Box 1), and the key principles expressed in the Preamble are respect for the human right to health, the importance of human solidarity on health matters, and the need for redistributive justice to achieve the right to health and human solidarity.

The contrast between the Preamble's conception and the Westphalian template is striking. In many ways, the WHO Constitution's Preamble appears to have been drafted expressly to reject Westphalian governance. The Preamble replaces the centrality of the state with an emphasis on individual rights and the transnational solidarity of peoples. The Preamble substitutes a focus on the right to the highest attainable standard of health and the obligation to redistribute resources for the limited Westphalian concern with reducing public health burdens on trade. The Westphalian principle of nonintervention is replaced by principles that demand scrutiny of government behavior with respect to the health of citizens and peoples of other nations.

The WHO Constitution's Preamble promotes a vertical reallocation of power in public health governance. Where Westphalian public health governance focused exclusively on states and their interactions (thus hewing closely to the horizontal allocation of power among states), the post-Westphalian principles in the WHO Constitution’s Preamble sought to empower non-state actors—individuals and peoples—in public health governance beyond and within

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42. This section is based on Fidler, Caught Between Paradise and Power, supra note 33, at 68-72.
the sovereign state. Recognizing the participation and claims of such non-state actors challenged the horizontal allocation of power in the Westphalian system. Under the Preamble's pronouncements, no longer would sovereignty and nonintervention be sacrosanct principles. The Preamble also challenged the Westphalian system of consent-based international law through promulgating concepts animated by natural law ideas of fundamental rights and universal justice.

*Box 1. Principles in Preamble of the WHO Constitution*

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<th>Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.</th>
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<tbody>
<tr>
<td>The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.</td>
</tr>
<tr>
<td>The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.</td>
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<tr>
<td>The achievement of any State in the promotion and protection of health is of value to all.</td>
</tr>
<tr>
<td>Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.</td>
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<tr>
<td>Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.</td>
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<tr>
<td>The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.</td>
</tr>
<tr>
<td>Informed opinion and active co-operation on the part of the public are of utmost importance in the improvement of the health of the people.</td>
</tr>
<tr>
<td>Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.</td>
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</table>

International health organizations were created under Westphalian
governance to facilitate limited international cooperation on public health. The principles contained in the WHO Constitution's Preamble gave the WHO a more expansive purpose than international health organizations had under Westphalian governance. Although the substantive provisions of the Constitution do not match the Preamble's rhetoric, the Preamble's aspirations elevated the WHO's governance significance, at least conceptually. This elevation also represents an attempt to reallocate power vertically from sovereign states to an international organization.

The principles in the WHO Constitution's Preamble influenced the WHO's practical governance activities in the post-World War II period. This influence can be seen in three developments. First, as public health technologies such as vaccines and antibiotics improved, the WHO sought to apply such technologies directly within states through disease control and eradication programs. These efforts surpassed in importance the traditional Westphalian task of mitigating the burden health measures imposed on international trade.

Second, the WHO's focus shifted from tending the trade interests of the great powers toward improving health conditions in developing countries. This shift was consistent with the principles in the WHO Constitution's Preamble, especially those stressing human solidarity and redistributive justice. As this shift unfolded, international health's Westphalian link to trade dissipated, further highlighting the effort to reallocate power vertically in order to squeeze absolute notions of sovereignty through non-state actor claims and participation in, and international organization leadership of, public health governance.

Third, human rights norms grew in public health governance significance in the post-World War II period. One can sense this shift in the WHO policy by comparing the atrophy of the IHR with the WHO's high-profile push for Health for All, which began in the late 1970s. The Health for All effort rested on the foundation that attaining the highest attainable standard of health was a

44. The only concrete duties the WHO Constitution imposes on the WHO member states are to pay assessed financial contributions and report certain information to the WHO. WHO CONST., supra note 43, at arts. 7, 61-63.

45. Dyna Arhin-Tenkorang & Pedro Conceição, Beyond Communicable Disease Control: Health in the Age of Globalization, in PROVIDING GLOBAL PUBLIC GOODS: MANAGING GLOBALIZATION 484, 486-87 (Inge Kaul et. al. eds., 2003) (“In a period of great vitality in the scientific understanding of infectious diseases and of progress in medical technology—in vaccines for prevention and drugs for treatment—the WHO added eliminating communicable diseases at their sources to its mandate of containing their spread through more traditional functions of coordinating international health regulations and serving as an information clearinghouse.”).

46. See CHARLES O. PANNENBORG, A NEW INTERNATIONAL HEALTH ORDER: AN INQUIRY INTO THE INTERNATIONAL RELATIONS OF WORLD HEALTH AND MEDICAL CARE 343 (1979) (describing WHO as discarding “in all its principal policies both the first and second world[,] almost completely focusing on the LDC-world and enhancing the latter as a special subject of international law”).

47. See Declaration of Alma Ata of 1978, in WHO, REPORT OF THE INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE 2-6 (1978) (asserting that health is one of the world's most important social goals; essential to social and economic development), available at http://whqlibdoc.who.int/publivcations/9241800011.pdf.
fundamental human right, a concept never recognized in Westphalian governance.

The importance of human rights to post-Westphalian governance can also be seen in responses to the HIV/AIDS pandemic. When HIV/AIDS emerged, the WHO and other public health experts turned not to the traditional IHR for guidance, but to international law on human rights.\textsuperscript{48} Human rights law focuses attention on how a government treats its citizens and governs its territory, and thus embodies a vertical re-allocation of sovereignty that reduces government power and increases that of individuals, non-state actors (e.g., non-governmental organizations), and international organizations.

The post-Westphalian conception of public health governance advanced in the WHO Constitution's Preamble and the development of WHO activities in the post-World War II period contain a vision of a form of "constitutional" governance for world health. The horizontal allocation of power at the heart of Westphalian governance is rejected in favor of a more vertically-oriented approach under which state sovereignty remains an important structural feature but is subject to rights-based claims from individuals and leadership from international organizations in pursuing health for all.

This post-Westphalian vision of global governance for public health has not, however, fared well. Comprehensive analysis of the failure of the post-Westphalianism expressed in the WHO Constitution's Preamble and WHO policy in the post-World War II period is beyond this article's scope, but limited observations about this failure are in order. First, the vertical reallocation of sovereign power from governments to non-state actors and international organizations occurred in theory only. Protections for civil and political rights in the U.S. Constitution have meaning because institutions—the federal courts—were created in which rights-holders could enforce the Bill of Rights. The right to health at the center of this post-Westphalian governance vision has never benefited from effective institutional support.\textsuperscript{49}

Second, the vertical reallocation of sovereign power from governments to international organizations also occurred in theory only. The WHO's formal authority to act is severely limited under the WHO Constitution, leaving the WHO subject to the political interests of member states and its own capacity to develop authority and leadership. In short, the traditional horizontal allocation

\textsuperscript{48} Jonathan Mann, Human Rights and AIDS: The Future of the Pandemic, in Health and Human Rights: A Reader 216, 217 (Jonathan M. Mann et. al. eds., 1999) (arguing that WHO's emphasis in the late 1980's on preventing discrimination against those infected with HIV/AIDS constituted "the first time in history [that] preventing discrimination toward those affected by an epidemic became an integral part of a global strategy to prevent and control an epidemic of infectious disease").

\textsuperscript{49} For example, the only monitoring mechanism for the right to health in the International Covenant on Economic, Social, and Cultural Rights, adopted in 1966, was state reporting on progress made in the progressive achievement of such rights. See International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, art. 16.1, 993 U.N.T.S. 3 (requiring states parties to submit "reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein").
of sovereign power was not seriously challenged by the post-Westphalian vision contained in the WHO Constitution's Preamble and post-World War II WHO policy. The WHO's authority and leadership also suffered in the 1980s for many reasons, ranging for the continued growth of the HIV/AIDS pandemic in the developing world to allegations of mismanagement and corruption at WHO headquarters.

Third, the post-Westphalian governance envisaged in the WHO Constitution's Preamble lacked sensibilities about governance in the context of anarchy. The Preamble's proclamations of fundamental rights, transnational human solidarity, and universal distributive justice reject the roles that power and interests play in international politics. The disengagement of international health from international trade provides an example of post-Westphalian governance moving from one extreme (i.e., Westphalian governance's dominance by the great powers) to another (i.e., universal rights, solidarity, and justice produced without acknowledgement of the selfish interests of states and the role of the great powers).

C. Post-Westphalian Public Health Governance (II): Global Health Governance and Global Public Goods for Health

A second conception of post-Westphalian governance developed in the last fifteen years. In analyzing SARS, I focused on this post-Westphalian framework because the global containment of SARS illustrated the power of this new governance approach.50 I do not repeat my previous analyses of this new post-Westphalian governance framework because I explore a different thesis in this article. For my purposes here, however, an overview of the latest post-Westphalian conception governance is in order.

The global crisis in emerging and reemerging infectious diseases in the 1990s stimulated experts to rethink strategies for the global infectious disease control. The new thinking departed from the Westphalian template and the earlier post-Westphalian governance alternative. The new framework centered on a new process—"global health governance"—and new substantive goals—"global public goods for health" ("GPGH").

1. Global Health Governance

Westphalian public health operated on the basis of "international governance" or governance activities undertaken by state actors directly with each other or through intergovernmental organizations. States represented the only legitimate governance participants. This state-centric approach dominates the IHR: Surveillance information upon which the WHO can act under the IHR, for example, can only come from governments.51

50. See FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 106-55 (examining how the post-Westphalian health governance successfully contained the SARS outbreak).

51. See WHO, GLOBAL CRISSES—GLOBAL SOLUTIONS: MANAGING PUBLIC HEALTH
The governance vision found in the WHO Constitution's Preamble, and at the heart of WHO activity in the post-World War II period, operated on the basis of "global governance," or governance activities involving not only states and intergovernmental organizations but also non-state actors. The right to health elevates individuals, at least theoretically, as governance actors in public health within and beyond the sovereign state. The Preamble's concerns with vulnerable populations, transnational solidarity, and distributive justice also break with state-centric Westphalianism.

The ferment in thinking about infectious diseases in the 1990s and early 2000s stressed the need for global rather than international governance. Post-Cold War analyses of global health often noted the growing involvement of non-state actors, particularly nongovernmental organizations ("NGOs") and multinational corporations ("MNCs"), in health governance. This involvement takes two forms. First, non-state actors participate indirectly in governance by attempting to influence national governments, international organizations, and other non-state actors (e.g., NGOs directly seeking to change the behavior of MNCs).

Second, non-state actors participate directly as formal actors in governance mechanisms. NGOs have long had formal relationships with the WHO by entering into "official relations" with the Organization. Global governance creates, however, more direct and participatory non-state actor involvement. The best examples of this direct non-state participation are the public-private partnerships that have multiplied rapidly in the last decade and, according to the WHO, have reshaped global public health's landscape. The Global Fund to Fight AIDS, Tuberculosis, and Malaria ("Global Fund") includes, for example, non-state actor representatives on its Board of Directors, giving non-state actors direct participation in policy making on an equal footing with governments. This type of participation differs from the more limited model of "official

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EMERGENCIES OF INTERNATIONAL CONCERN THROUGH THE REVISED INTERNATIONAL HEALTH REGULATIONS 3 (2002) ("The IHR wholly depend on the affected country to make an official notification to WHO once cases are diagnosed.").

52. See, e.g., WHO CONST., supra note 43, art. 71 ("The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental."); WHO, PRINCIPLES GOVERNING RELATIONS BETWEEN THE WHO AND NONGOVERNMENTAL ORGANIZATIONS, IN WHO, BASIC DOCUMENTS 74-79 (40th ed., 1994) (detailing specific criteria to be met and procedures to be followed for the WHO to establish official relations with an NGO).

53. See, e.g., PUBLIC-PRIVATE PARTNERSHIPS FOR PUBLIC HEALTH 1 (Michael R. Reich ed., 2002) (discussing "ethical and organizational" issues in the rising trend of partnerships between public and private organizations created to effectively address growing global health concerns).

54. WHO, GLOBAL DEFENSE, supra note 38, at 22.

relations" with the WHO.

The WHO pursued the potential of global governance to improve infectious disease control in revising the moribund IHR. Beginning in 1995, the WHO proposed expanding the surveillance information it could collect to include epidemiological data from non-governmental sources. Under this proposal, non-state actors would be direct participants in the global governance on infectious diseases. Technological developments, such as the internet and e-mail, made it possible for the WHO to cast its surveillance net much wider than government ministries.

The power of global governance in the context of infectious disease control was apparent before SARS in the establishment of the WHO's Global Outbreak Alert and Response Network ("Global Network"). As I analyzed in detail elsewhere, the global management of SARS reinforced the need for, and benefits of, global governance in connection with infectious disease surveillance. The same lesson has been learned in the avian influenza outbreak, where non-state actors provided information to international organizations.

The importance of global governance in the SARS outbreak extends beyond infectious disease surveillance because the containment of this outbreak relied upon the participation of non-state actors in scientific research on the causative agent of SARS, the formulation of clinical treatment protocols, and efforts to develop diagnostic and vaccine technologies. Non-state actors were comprehensively engaged in the global governance of SARS. The response to avian influenza likewise has involved non-state actors in the efforts to improve surveillance, provide support for affected governments and international organizations, increase laboratory capacity, and counsel on hospital infection control.

The participation of non-state actors in the responses to the SARS and avian influenza outbreaks differs from the vision of global governance emanating from the WHO Constitution's Preamble and WHO policy in the post-World War II period. The Health for All model of global governance conceives of


57. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 114-25, 132-36.


59. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 146-48 (discussing global production of surveillance data, clinical treatment guidelines, basic scientific information about the causative agent of SARS, and diagnostic and vaccines technologies).

60. WHO, H5N1, supra note 58 (reporting on WHO's urgent request to its governmental and non-governmental partners in the Global Network for help in many different areas connected with bringing avian influenza under control).
individuals and populations as legitimate claimants against state actors, largely influenced by the concept of the right to health. Although this conception of global governance creates space for non-state actors, particularly NGOs, to influence policy, the state remains in the governance-driving seat. This placement makes sense if the engine of global governance is the individual's right to make claims against his or her government concerning health.

The participation of non-state actors in the global governance of SARS and avian influenza has been more immediate and direct. As China discovered during SARS, the WHO's access to non-governmental information destroyed the Chinese government's ability to maintain control of SARS information and the direction of its policy response.61 The governments of Thailand and Indonesia similarly suffered embarrassment when their failures to report their avian influenza outbreaks were revealed rapidly and transparently.62

Together, the WHO and non-state actors now have the upper hand on sovereign states, which no longer retain the initiative in infectious disease surveillance and response.63 Further, in connection with surveillance information, scientific research, clinical treatment protocols, and development of diagnostics and vaccines, non-state actors participated side-by-side with state actors in these governance activities, not as supplicants to governments for recognition of rights-based claims on scarce resources.

The SARS outbreak revealed another feature of the new global governance framework not present in the earlier post-Westphalian model. Under Health for All, the WHO acted as an intermediary between the rights of individuals and the duties of governments. Where effective health technologies were available (e.g., smallpox vaccine), the WHO contributed to the progressive realization of the right to health without challenging state sovereignty. Beyond those restricted contexts, the WHO's ability to influence and change state behavior was limited

61. See FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 116 (“China's refusal to provide SARS outbreak information to WHO in a timely, transparent, complete, and verifiable manner ran headlong into the global health governance mechanism of formal integration of non-governmental information into global infectious disease surveillance. Information provided by non-state actors provided the catalyst for WHO and other countries to intensify pressure on the Chinese government, forcing it to retreat repeatedly until the charade could not longer be sustained in any form.”). For more analysis on China's experience with SARS, see id. at 106-31; and, in this symposium issue, Ruotao Wang, China's Response to SARS, 77 TEMPLE L. REV. 147 (2004) and Jacques deLisle, Atypical Pneumonia and Ambivalent Law and Politics: SARS and the Response to SARS in China, 77 TEMPLE L. REV. 191 (2004).

62. See Shawn W. Crispin, Margot Cohen, & Timothy Mapes, Spreading Disease: Bird-Flu Outbreak Revives Concerns Stirred by SARS, WALL ST. J., Jan. 28, 2004, at A1 (reporting on accusations that Thailand and Indonesia covered up their avian influenza outbreaks); Shawn W. Crispin & James Hookway, Indonesia Balks at Culling, As Asian Governments Try to Coordinate Response, WALL ST. J., Jan. 29, 2004, at A16 (reporting on allegations that the Thai and Indonesia governments had tried to cover-up their avian influenza outbreaks).

63. This new reality for states was reflected in how the avian influenza outbreak unfolded. See Alan Sipress, Thailand Concedes Missteps on Bird Flu; Prime Minister Urges Transparency, Cooperation Following Denials of Outbreak, WASH. POST, Jan. 29, 2004, at A24 (noting that Thailand's admission of mistakes “reflected an emerging consensus among Asian countries that they must act openly and in close cooperation to avoid the outbreak of a devastating human epidemic”).
because states protected their sovereignty from disaggregation.

The SARS outbreak witnessed the WHO playing a governance role unthinkable under either Westphalianism or Health for All. The comprehensive involvement of non-state actors in the various aspects of the SARS effort heightened the WHO's governance power because only it was in a position to coordinate such a global endeavor. No single sovereign state, not even the United States, could have managed the global governance of SARS as WHO did.

The same dynamic unfolded in the avian influenza crisis because the WHO, in partnership with the Food and Agriculture Organization of the United Nations ("FAO") and the World Organization for Animal Health ("OIE"), spearheaded the global response to the 2004 bird flu outbreak. These organizations set the response agenda and forcefully acted to ensure that governments and non-governmental actors follow the strategies outlined. For example, when Indonesia balked at instituting wide-spread culling of poultry flocks to contain its avian influenza outbreak, WHO officials quickly criticized the Indonesian government publicly. Indonesia reversed its policy the next day.

During SARS, the WHO's governance significance went beyond the functional necessity for WHO to coordinate the various actors involved in containment. The WHO also took governance actions unprecedented not only for the WHO, but also for international organizations generally. Without any express legal or policy authority, the WHO issued travel alerts and recommendations that caused affected countries serious political and economic damage. The global governance model that emerged during SARS accorded the WHO independent power vis-à-vis its member states, an astonishing development that indicates the extent to which Westphalian governance has been abandoned.

69. WHO issued no travel alerts or advisories with respect to countries affected by avian influenza because the H5N1 virus did not establish efficient human-to-human transmission that would make travel to these countries dangerous. See WHO, Advice to International Travellers, COMMUNICABLE DISEASE SURVEILLANCE & RESPONSE, at http://www.who.int/csr/disease/avian_influenza/travel_2004_02_11/en/ (Feb. 11, 2004).
70. Although not exercising independent power as WHO did in SARS, the international organizations spearheading the global containment of avian influenza proposed that FAO, OIE, and WHO have joint decision making authority with affected governments as part of a regional coordination group for managing the crisis. See Recommendations of the Joint FAO/OIE Emergency
After SARS and avian influenza, the governance power possessed by non-state actors and the WHO reallocates sovereignty over public health, especially with respect to epidemiological surveillance. Excluding China, the level of reporting and cooperation exhibited by states affected by SARS was unprecedented in the context of a serious epidemic. The solidarity among non-state actors, governments, and the WHO in governing this outbreak was, from a historical perspective, astonishing. Moreover, this cooperative global governance took place without any international legal framework in place mandating compliance—another indicator of Westphalianism's demise.

The same lesson emerges from the avian influenza outbreak. As the Thai and Indonesian governments discovered, efforts to hide serious infectious disease outbreaks are futile in today's technological environment and counterproductive from political, public health, and economic perspectives. In terms of human cases of avian influenza infection, countries have reported them to the WHO despite having no international legal obligation to so report. More difficulties have been experienced in the reporting of avian influenza outbreaks in poultry flocks; but the WHO, FAO, and OIE jointly emphasized the need for solidarity on transparent reporting of animal diseases of potential public health concern.

Global health governance constitutes a vertical disaggregation of sovereignty in international relations more powerful than the one envisaged in Health for All. The behavior of states with respect to SARS and avian influenza suggests that governments are learning, sometimes in painfully unnecessary ways, that Westphalian governance is dead. The disaggregation of public health sovereignty witnessed in the SARS and avian influenza outbreaks has not, however, been driven by concepts of human rights, transnational solidarity, and universal justice. Raw self-interest led to state acquiescence of the disaggregation of public health sovereignty because globalized disease threats, and the need for effectively coordinated global governance of such threats, transforms the context in which states exercise such sovereignty.

2. Global Public Goods for Health

The second feature that distinguishes the post-Cold War "new thinking" on
global health from Westphalian and Health for All models concerns the production of global public goods for health ("GPGH").73 "Public goods" are goods or services the consumption of which is non-excludable and non-rivalrous.74 "Global public goods" exhibit non-excludability and non-rivalry in consumption across national boundaries and traditional regional groupings.75 GPGH are health-related public goods or services the benefits of which are globally accessible.76 Containment and prevention of globally dangerous infectious diseases and the production of health-related information, such as global surveillance data on infectious diseases, are both considered GPGH.77

Under Westphalianism, the regime for infectious disease control sought to reduce trade and travel problems caused by cross-border microbial traffic. The objective was tailored to the national interests of the great powers, which feared pathogen importation from poor, developing countries and wanted to mitigate the impact of quarantine practices on their export trade. The GPGH concept departs from the narrow, state-centric objectives of Westphalianism in two ways. First, GPGH envisage policy results that reach beyond the state and its national interests vis-à-vis other states. The ambition is to produce public goods that are globally accessible by governments and non-state actors. Thus, GPGH encompass more than state interactions and are sought for reasons beyond defending against exogenous threats and promoting national exports. Finally, GPGH promise to benefit not only the great powers, but also people in developing countries.

Second, GPGH deviate from the traditional Westphalian approach in how the goods are produced. In Westphalian public health, states produced regimes that applied strictly to governmental behavior. GPGH differ because they seek participation from not only governments and international organizations but also non-state actors. Public-private partnerships best illustrate the process innovation in the GPGH concept, and this innovation connects to the development of global governance mechanisms.

GPGH also differ from the post-Westphalianism of Health for All. Although the WHO Constitution's Preamble has principles that echo the

73. See generally GLOBAL PUBLIC GOODS FOR HEALTH: HEALTH ECONOMIC AND PUBLIC HEALTH PERSPECTIVES (Richard D. Smith et al. eds., 2003) (discussing the concept of global public goods for health).


75. See Kaul et al., supra note 74, at 10 (discussing and defining the global public); Woodward & Smith, supra note 74, at 8 (describing the under-supply of public goods in a free market).

76. See Woodward & Smith, supra note 74, at 10-15 (discussing global public health as a public good).

77. Id. at 10-12, 14.
substance of GPGH. The "public goods" framework arises from economics rather than rights-based discourse, and thus is not in harmony with the core tenet of Health for All. In economic theory, a public good is an economic good that will not be produced without public intervention because the incentives or resources for private actors are insufficient. The need for public goods arises, thus, from "market failures." Advocacy for interventions to produce public goods neither require nor reject a rights-based foundation. GPGH can be supported on both utilitarian and deontological grounds, providing opportunity for different conceptual perspectives to converge on a common policy.

As I explored elsewhere, the global management of SARS revealed the power of producing GPGH. The production of epidemiological surveillance, scientific research on the causative agent of SARS, protocols on clinical treatment of SARS patients, and data for diagnostics and vaccines all represent GPGH. Similar efforts to produce GPGH have emerged in the global fight against avian influenza, including surveillance information, clinical management on humans infected with the H5N1 virus, scientific research on the highly pathogenic strain of H5N1 circulating in Asia, vaccine development efforts, advice on proper poultry flock destruction, and food safety issues.

GPGH production also reflects a disaggregation of sovereignty as understood in Westphalian governance. Westphalianism focused on narrow state interests, largely trade expansion through removal of trade-restricting health measures. GPGH do not destroy the concept of the "national interest."

78. See, e.g., WHO CONST., supra note 43, at pmbl. ("Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.").

79. See Kaul et al., supra note 74, at 2-9, for basic definitions of pure public good, impure public good, externalities that affect the good, and the role of public intervention.


81. Id. at 145-48.


85. See, e.g., id. (setting as a strategic goal "the immediate development of a new vaccine for humans against H5N1").


but broaden that concept such that the state's interests in global health are defined expansively rather than narrowly. The enlargement of the national interest's scope reflects the realization of the globalized nature of public health threats and the reality that such threats can only be managed through concepts of the national interest and governance that transcend Westphalian assumptions and attitudes. National interests become interdependent horizontally among states and integrated vertically through participation of non-state actors and the leadership of international organizations in governance endeavors.

D. The "New Way of Working"

During the SARS outbreak, David L. Heymann, WHO's Executive Director for Communicable Diseases, argued that the world was witnessing a "new way of working" on infectious disease threats in the twenty-first century.\(^8\) WHO's Michael Ryan similarly argued that, during SARS, global public health crossed a governance Rubicon, meaning that "[t]here's no going back now."8\(^9\) The governance responses orchestrated by WHO concerning avian influenza in 2004 underscore that a new template has superceded the Westphalian and the Health for All models. The "new way of working" is important in its own right, but next I analyze how these developments, along with others, combine to suggest that an even deeper and perhaps more profound governance change is underway.

IV. CONSTITUTIONAL OUTLINES IN GLOBAL HEALTH GOVERNANCE

Having traced transformations in public health governance in the United States and international relations, I highlight in this part similarities between these phenomena in order to demonstrate that their parallels hint at the emergence of "constitutional outlines" for global health governance. These outlines are evidence that a new context for public health governance is taking shape globally, however nascent and precarious the shaping process remains.

A. Parallels between the Federalization and Globalization of Public Health Governance

The federalization and globalization of public health governance share characteristics in causes and effects. In both, unprecedented changes in the nature, volume, and speed of threats to population health, especially from infectious diseases, have caused the \textit{de facto} vertical reallocation of governance power. This reallocation of power reflects the inadequacy of traditional governance frameworks.

In the United States, the vertical allocation of public health sovereignty to


the states of the Union no longer provides a sufficient foundation for tackling globalized health threats, such as bioterrorism or naturally occurring infectious disease outbreaks spread through globalization. In international relations, the horizontal allocation of public health sovereignty to states likewise is ill-suited to handle globalized health threats in the twenty-first century. The legal allocations of public health sovereignty in the traditional constitutional and international governance frameworks have not been formally overturned, but threats have sufficiently developed to trigger shifts in how such threats are governed within the United States and in the international system.

The federalization and globalization shifts underscore the unprecedented rise of public health as an issue of national and global governance. Traditional constitutional and international governance shared the characteristic that public health was not a prominent political, economic, or social issue. Laurie Garrett observed that “[p]ublic health in the wealthy world . . . struggled to maintain respect, funding, and self-definition in the late twentieth century.” She noted that “[i]n the United States, ‘public health’ had become—incorrectly—synonymous with medicine for poor people. Few Americans at the millennium thought of ‘public health’ as a system that functioned in their interests. Rather, it was viewed as a government handout for impoverished people.”

Public health in international relations shared the same fate. Even when Westphalian governance prevailed, public health was never an issue of “high politics” in international relations. After WHO’s establishment, “international health” became associated with improving health in poor countries. This situation reflects the transition from Westphalian to post-Westphalian governance policies at WHO and elsewhere. For developed countries, post-Westphalian health activities after World War II, such as those undertaken by WHO, became humanitarian matters not directly connected to their core national interests. For “most of the post-1945 period, . . . the internationalization of public health has held marginal interest for developed countries that view it merely as a means for developing states to transition toward improved public health.” Post-Westphalian efforts were, to paraphrase Garrett, viewed in

92. Id. at 8.
93. For example, public health has not attracted much attention from scholars working in the discipline of international relations. See Ilona Kickbusch, Global Health Governance: Some Theoretical Considerations on the New Political Space, in HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE 192 (Kelly Lee ed., 2003) (noting “the gulf that divides scholars of policy/International Relations and public health”); Kelley Lee & Anthony Zwi, A Global Political Economy Approach to AIDS: Ideology, Interests, and Implications, in HEALTH IMPACTS OF GLOBALIZATION, supra, at 13 (noting that “little attention has been devoted to health in the I[nternational] R[elations] field”).
developed nations as governmental and intergovernmental handouts to poor people.

The federalization and globalization of public health governance reveal how dramatically public health has risen as a political, economic, and social concern in the early twenty-first century. The rise of public health has led to the transformations captured by analysis of the federalization and globalization of public health governance. Both processes demonstrate that the traditional loci of governance authority are no longer adequate, creating the need for vertically reallocating power in a manner that provides a better foundation for controlling globalized health threats.

Despite these parallels, federalization and globalization of public health governance differ in one respect. Reallocation of power in the U.S. constitutional system draws on the Constitution's vertical allocation of specific functions (e.g., national security, interstate and foreign commerce) to the federal government. Thus, the Constitution provides a clear legal framework into which governance of globalized public health threats can be rearranged. No such preexisting vertical allocation exists in international law to accommodate the transformations triggered by the globalization of public health governance. Thus, vertical reallocation of power in the globalization of public health functions through "networked anarchy," in which the multiplicity of state and non-state actors clash and cooperate to produce global health governance.95

This distinction between federalization and globalization is a reminder that the political contexts of constitutional and global governance are radically different. The nonexistence of a preexisting framework for the vertical reallocation of public health governance power in international relations merely reflects that governance in this context unfolds in political anarchy. Because constitutional governance is about political hierarchy, the constitutional framework has a template for handling new challenges. Unitary governance hierarchies are unlikely to be achieved in international relations.

Within the decentralized environment of anarchical governance, the emergence of "constitutional" functions in global health governance can be, however, detected. These functions mirror the evolution of public health governance functions by the U.S. federal government in the federalization process. The resonance between the development of these functions in the federalization and globalization of public health governance suggests a nascent constitutionalization of public health as a governance concern in global politics.

95. WHO's Global Outbreak Alert and Response Network is a good example of global health governance by "networked anarchy." See WHO, Global Outbreak Alert and Response Network, Communicable Disease Surveillance & Response ("The Global Outbreak Alert and Response Network is a technical collaboration of existing institutions and networks who pool human and technical resources for the rapid identification, confirmation and response to outbreaks of international importance. The Network provides an operational framework to link this expertise and skill to keep the international community constantly alert to the threat of outbreaks and ready to respond."), at http://www.who.int/csr/outbreaknetwork/en/ (last visited Aug. 20, 2004).
B. "Constitutional" Functions for Global Health Governance

Part II traced four federal governance functions that have grown more important in addressing public health concerns: (1) provision of national security; (2) the regulation of interstate and foreign commerce; (3) support for public health preparedness and response; and (4) protection of individual rights. The globalization of public health governance reveals the emergence of equivalent functions for global governance, which this section analyzes.

1. Public Health and Global Security

Section II.A examined how characterizing public health threats as national security problems contributed to the federalization of public health governance in the United States. At the global level, the parallel development involves the characterization of public health crises as threats to global security. This characterization has produced unprecedented public health governance responsibilities for international organizations, in a manner similar to the new constitutional functions the federal government shoulders through the linkage between national security and public health.

WHO policy recognizes the emergence of a global security function in its work by building strategies to achieve “global health security.”\footnote{96} This concept encompasses security against direct threats to public health, including those created by bioterrorism and naturally occurring infectious diseases. One reform the WHO has proposed for the revision of the IHR—shifting from disease-specific notification to notification of “public health emergencies of international concern”—captures features of the “global health security” concept. As WHO has explained, its proposal would require WHO member states “to notify all events potentially constituting a public health emergency of international concern . . . occurring in their territory, irrespective of cause, including those associated with the accidental, natural, or suspected intentional release of pathogens, chemical or radionuclear materials.”\footnote{97}

96. See, e.g., WHO, Global Health Security: Epidemic Alert and Response, World Health Assembly Resolution WHA54.14 (May 21, 2001) (commenting on development of plans for responses to international public health emergencies); Global Health Security, 76 WEEKLY EPIDEMIOLOGICAL REC. 166 (June 1, 2001) (on various resolutions adopted to address new and re-emerging infectious diseases); WHO, GLOBAL DEFENSE, supra note 38, at 14-19 (on global health security).

This proposal includes traditional WHO concern with naturally occurring infectious diseases but is more expansive because it also covers: (1) more than a limited number of infectious diseases; and (2) public health threats involving (a) the intentional use of pathogens, and (b) the accidental or intentional release of chemicals and radio-nuclear materials.\textsuperscript{98} The influence of national and global security concerns with weapons of mass destruction is evident in WHO’s thinking about revising the IHR.

National security concerns about bioterrorism and naturally occurring infectious diseases reinforce the emergence of a security function in global health governance because the foreign policies of concerned governments, such as the United States, include recognition of the need for international cooperation and global support for national security efforts. The United States has stressed, for example, the importance of the WHO’s surveillance capabilities as part of a strategy to address the bioterrorism threat.\textsuperscript{99} The United States joined with other members of the G-7 and Mexico in the Global Health Security Initiative, which focuses on both intentional and naturally occurring infectious disease threats.\textsuperscript{100}

Global health security also involves addressing security threats posed by infectious diseases contributing to state failure and instability in developing countries. In an unprecedented move, the United Nations Security Council in 2000 addressed the HIV/AIDS pandemic as a threat to international peace and security.\textsuperscript{101} Major global health efforts, including the Global Fund\textsuperscript{102} and WHO’s “3 by 5” Initiative,\textsuperscript{103} seek to bring more resources to bear on major infectious disease crises to help mitigate their impact on regional instability, state capacities, and individual health.

These and other developments in global health policy indicate that global health security represents a critical function for global governance in the twenty-


\textsuperscript{100.} Overview: Global Health Security Initiative (GHSI) (Nov. 26, 2003) (on file with author).


\textsuperscript{103.} See WHO, The “3 by 5” Initiative (describing organization’s goal to provide access to antiretroviral treatment to three million people living with HIV/AIDS in developing countries by 2005), at http://www.who.int/3by5/en/ (last visited July 7, 2004).
first century. Severe security threats in the public health context require both the federalization and the globalization of public health governance because the nature of these problems transcends the ability of the states of the Union and individual sovereign states to manage. In international relations, the governance function of providing global health security must be fulfilled by networks of actors, state and non-state, because of the absence of centralized system of government. Nevertheless, this function’s emergence in global health governance parallels the emergence of the equivalent function in constitutional governance in the United States, providing evidence of the interdependence of the federalization and globalization phenomena.

2. Public Health and the “Global Commerce Clause”

As Section II.B described, the Commerce Clause in the U.S. Constitution has long given the federal government the function of calibrating state protection of health with the flow of interstate and foreign commerce. The existence of the Commerce Clause means that the constitutional power of the states of Union to regulate for health purposes is embedded in a constitutional system in which free flows of commerce is a structural principle. The Commerce Clause also empowers the federal government to legislate to address health threats arising through interstate and foreign commerce, a power increasingly important as the speed, scale, and volume of both kinds of trade have increased.

As Westphalian governance indicates, public health and international trade have a long history during which states (mainly the great powers) tried to balance the state’s sovereign right to protect the health of its people with maintaining or increasing levels of international trade. This balancing function, accomplished originally through international sanitation treaties and continued in the IHR, faded from international health in the post-World War II period as policy focused on other issues.

The trade-health linkage continued after World War II in international trade law, including in the General Agreement on Tariffs and Trade ("GATT");\footnote{104. See General Agreement on Tariffs and Trade, Oct. 30, 1947, 61 Stat. A-3, 55 U.N.T.S. 188, art. XX(b) [hereinafter GATT], reprinted in Wto, The Results of the Uruguay Round of Multilateral Trade Negotiations 423 (1999) [hereinafter Wto Legal Texts] (providing a general exception to GATT obligations for measures necessary to protect human, animal, or plant life or health).} but the linkage was problematical because: (1) the ideological conflict between communism and capitalism limited the global reach of this body of law; (2) problems with the manner in which the linkage operated in international trade law (e.g., abuse of “health” as a reason to restrict trade in the GATT);\footnote{105. See Fidler, International Law and Infectious Diseases, supra note 36, at 126-33 for a discussion of problems experienced with GATT Article XX(b).} and (3) GATT’s application to trade in goods only.

The establishment of the World Trade Organization ("WTO") in 1995 has stimulated, however, the emergence of a “global commerce clause” in global health governance. Rules and agreements within WTO law have created a
dynamic similar to the one the Commerce Clause produces in U.S. constitutional governance. First, international trade law under the WTO means that the power of WTO member states to exercise their sovereignty for public health purposes is not absolute but is embedded in a governance system in which liberalized trade is a structural principle. Just as the federal courts will scrutinize health measures of states for compliance with the Commerce Clause, the WTO's Dispute Settlement Body has compulsory jurisdiction to decide disputes between WTO member states concerning trade-restricting health measures.\textsuperscript{106}

Second, WTO agreements and rules represent "legislation" that balances the objective of trade liberalization and the public health sovereignty of WTO member states across not only trade in goods\textsuperscript{107} but also trade in services\textsuperscript{108} and trade-related aspects of intellectual property rights.\textsuperscript{109} Like the federal government, sovereign states adopted rules regulating the impact of trade-restricting health measures on global commerce.

In addition, controversies concerning WTO's rules have led to global governance instruments clarifying the balance between trade and health, most notably the Doha Declaration on the TRIPS Agreement and Public Health\textsuperscript{110} and the Agreement on the Implementation of Paragraph 6 of the Doha


\textsuperscript{107} GATT, supra note 104, at 424 (stating that the original GATT was aimed at tariffs and trade on goods).


Declaration on the TRIPS Agreement and Public Health. Similarly, global governance efforts, coordinated by WHO, produced an unprecedented treaty, the Framework Convention on Tobacco Control, to address negative health externalities produced by the globalization of trade in tobacco and tobacco products.

The emergence of a "global commerce clause" in global health governance is a nightmare for many WTO critics because they perceive that this development compromises the ability of a sovereign state to protect the health of its citizens. Analyzing these fears is beyond this article's scope, but arguing that global health governance contains a function involving the balancing of trade and health is neither pro-health nor pro-trade.

Constitutional (e.g., United States) and quasi-constitutional (e.g., European Community) governance systems regulate the impact of health measures on the flow of trade within their jurisdictions. In these systems, the necessity of the balancing process is not controversial because the participating units share the conviction that health protection is interdependent with other political and economic objectives. The intensification of trade and investment stimulated by globalization accentuates the importance of having governance systems equipped to calibrate the demands of trade and public health.

The globalization of public health governance thus creates the "global commerce clause" function for global health governance.

The controversial operation of the "global commerce clause" has raised the political and governance profile of public health in international and national politics. The controversies and battles fought over the meaning of WTO agreements have brought public health unprecedented international political and legal attention. In addition, some experts believe that global health governance has been productive in striking acceptable balances between public health sovereignty and liberalized trade in important areas of the WTO, including the


113. See José E. Alvarez, The WTO as Linkage Machine, 96 AM. J. INT'L L. 146, 149 (2002) (noting that WHO moved to "regulate tobacco at least in part because another, the WTO, has been, altogether too successful in reducing barriers to the tobacco trade and has ignored the resulting negative externalities.").

114. See, e.g., Public Citizen, Warning: The WTO can be hazardous to public health, excerpts from Lori Wallach & Patrick Woodall, WHOSE TRADE ORGANIZATION? THE COMPREHENSIVE GUIDE TO THE WTO (analyzing WTO cases that bring about new constraints on public health goals and policies on grounds of interference with trade), at http://www.citizen.org/print_article.cfm?ID=10444 (last visited July 7, 2004).

115. See Slotboom, supra note 31, at 555-64 (outlining how the EC regulates health law, and summarizing relevant cases).

116. The WTO and WHO jointly recognized the governance importance of balancing trade and health in jointly publishing WTO Agreements & Public Health: A Joint Study by the WHO and The WTO Secretariat in 2002.
3. Public Health and Global Preparedness and Response

The federalization of public health governance in the United States included the expansion of the federal government's function of supporting public health preparedness and response. This expansion relates to public health's emergence as a national security issue and the intensified responsibility of the federal government's commerce function created by economic globalization. The globalization of public health governance likewise expands the preparedness and response function for global health governance.

International health organizations have historically supported national governments' preparation for, and response to, public health problems. Supporting public health preparedness and response in sovereign states is, thus, a classical function of international health governance. In the 1990s and early 2000s, the need for international support for national-level public health capabilities increased as public health systems around the world came under heightened stress, particularly those in the developing world. Sovereign states found themselves in a position analogous to individual states in the United States requiring help in confronting the globalization of public health.

Many examples can be cited of global health governance mechanisms mobilizing support for national-level public health preparedness and response. WHO has continued and intensified traditional disease eradication strategies, such as the ongoing polio eradication effort. Public-private partnerships have formed to develop new drugs and vaccines for diseases neglected by private industry and to increase access in developing countries to essential medicines, such as antiretroviral therapies. Perhaps the best-known public-private partnership, the Global Fund, represents an unprecedented effort to redistribute wealth from rich to poor in the name of infectious disease control. Individual


118. See, e.g., M. Gregg Bloche & Elizabeth R. Jungman, Health Policy and the WTO, 31 J. L. MED. & ETHICS 529, 530 (2003) (arguing "that portrayal of the WTO and its associated agreements as implacable threats to the health of people constitutes pessimism bordering on panic. Not only does this portrayal overlook potential synergies between trade and health: it all but ignores recent developments within the WTO that have affirmed member states' power to promote health.").

119. See supra Parts II.

120. See, e.g., WHO CONST., supra note 43, art. 2(c) (stating that one of WHO's functions is "to assist Governments, upon request, in strengthening health services").


122. See WHO, GLOBAL DEFENSE, supra note 38, at 22-31 (discussing the "recent wave of public-private partnerships" designed to "discover new drugs and vaccines for diseases neglected by research and industry, and to vastly improve access by the poor to existing products").

123. Global Fund, How the Fund Works, (stating that "[t]he Global Fund’s purpose is to attract,
philanthropists, such as the Bill and Melinda Gates Foundation, and powerful countries, such as the United States, are pumping unprecedented sums of money into public health preparedness and response in the developing world.

The WHO's construction of the Global Network also constitutes a new global health governance endeavor for preparedness and response. Through this Network, the WHO is establishing a system that will more rapidly identify threats to public health and more effectively bring national and global personnel and resources to bear in order to prevent such threats from becoming epidemic or endemic. Evidence collected by the WHO prior to SARS demonstrated that the strategy was working, and the successful containment of SARS and the mobilization in response to avian influenza further illustrate the benefits of WHO's leadership on public health preparedness and response.

Importantly, the WHO's global health security strategy implemented through the Global Network supports public health preparedness and response in all states, not just developing countries. As SARS and avian influenza show, developed and developing countries confront the need to respond early and rapidly to emerging health threats. A global surveillance and response system is vital to such early and rapid response. Historically, the WHO's support for preparedness and response has focused on developing countries. Its global health security strategy, however, offers preparedness and response support on a truly global basis. The preparedness and response function of global health governance constitutes, thus, a GPGH.

WHO's proposed revision of the IHR also highlights the preparedness and response function of global health governance. In addition to strengthening WHO's position in global infectious disease surveillance and response activities, the proposed IHR revision attempts to increase preparedness and response at the national level. According to WHO, the proposed revision "provides States with direction regarding the minimum core surveillance and response capacities required at the national level in order to successfully implement the global health security, epidemic alert and response strategy."


126. See WHO, GLOBAL DEFENSE, supra note 38, at 65 (arguing that the Global Network has made an "immediate—and measurable—difference" to infectious disease surveillance and response).

127. IHR Revision Draft, supra note 97, Foreword, at 3. Further, Articles 4.1 and 10.1 of the IHR Revision Draft require WHO member states to develop and maintain the capacity to detect, report, and respond effectively to public health risks and events potentially constituting public health
As with the national security and commerce functions, supporting public health preparedness and response through global governance represents a more decentralized and complex task than experienced in the federalization of public health governance in the United States. Nevertheless, supporting public health preparedness and response around the world has become more important and is a governance function that can only be fulfilled by mechanisms of global health governance.

4. Public Health and Global Scrutiny for Human Rights

The federalization of public health governance in the United States involved heightened sensitivity to the protection of individual rights in contexts of public health action by governments. This sensitivity appeared in many areas, including HIV/AIDS-related discrimination, treatment of persons infected with drug-resistant pathogens, and planning for public health responses to bioterrorist attacks.

An analogous human rights sensibility developed in global public health during the last twenty years of the twentieth century, largely driven by the human rights strategy adopted to combat HIV/AIDS. Human rights as an aspect of post-Westphalian governance began with the WHO Constitution, and the emphasis in the post-World War II period was on the right to health, as illustrated by the Health for All campaign. The right to health has received renewed attention in recent years, as evidenced by the United Nations' issuance of General Comment No. 14 on the right to health and appointment of a

emergencies of international concern. Id., arts. 4.1 and 10.1, at 7, 9.

128. See supra Part II.E.


NGOs have also concentrated more attention on the right to health in the last decade, especially in connection with campaigns to increase access to antiretrovirals in the developing world. Concerns about, and criticisms of, the TRIPS Agreement expressed by U.N. human rights bodies also demonstrate the heightened human rights scrutiny alive in global health today.

The HIV/AIDS pandemic also raised the profile of civil and political rights in public health policy, and developments in the last decade, particularly policy responses to bioterrorism, have solidified the importance of thinking about the impact of public health actions on such rights. One of the main sources of discourse on the public health-human rights linkage has been the potential need to resurrect quarantine and isolation as public health tools to deal with dangerous epidemics, whether caused by bioterrorism or naturally occurring infectious diseases. The resort to quarantine and isolation in SARS containment proved that civil and political rights are important issues to consider in global health governance. The public health responses necessary in dealing with avian influenza, such as destruction of poultry flocks, have also raised the importance of compensating owners for the destruction of their property in the public interest, an outcome supported by the human right to property.

Thus, we can discern another important function for global health governance in the early twenty-first century—scrutinizing policies and actions of state, intergovernmental, and non-state actors that affect public health against...
principles of international human rights law.

C. Implications of the Constitutional Outlines of Global Health Governance

The four functions emerging in the globalization of public health governance suggest that global health governance is developing structural features and substantive objectives that parallel what happened in the federalization of public health governance in the United States. Drawing parallels between trends in U.S. constitutional governance and global governance represents an attempt to discern some structural and substantive coherency in the profound and radical changes that have emerged in the governance of public health in international relations.

Analyses of "global governance" and "global health governance" often dwell, for good reason, on the new multiplicity of actors in post-Westphalian politics. These analyses often lack a sense of what the multiplicity of new actors and their networks represents beyond the breakdown of the old Westphalian order. At times, post-Westphalian trends might appear to herald the end of power politics and the beginning of a progressive "new medievalism" with emancipatory potential for humanity. At other moments, post-Westphalianism looks chaotic, cacophonous, and inchoate, a situation in which the strong find new ways to dominate the weak.

The emergence of security, commerce, preparedness and support, and human rights functions in global health governance points to neither emancipation nor neo-Westphalianism. Rather, these functions reflect pragmatism in health governance that seeks to balance interests and values in a globalizing world. Behind these functions is the development of three global understandings that provide the foundation for the post-Westphalian public health governance now emerging.

The first global understanding concerns the acknowledgement of new geo-technological realities. The global responses to SARS and avian influenza reflect a growing appreciation that the globalization of transportation, trade, and information technologies has permanently altered the politics of public health. China's humiliation during the SARS outbreak, and Thailand's and Indonesia's embarrassment in the avian influenza crisis, are the death rattles of old-school Westphalianism in the new geo-technological environment of public health.

The ease with which the WHO's use of nongovernmental sources of information in global surveillance became standard operating procedure without a formal change in the applicable international legal framework provides another example of the resignation of states to technological transformations that are futile to fight. The unprecedented levels of country reporting to the WHO that have been seen in the SARS and avian influenza outbreaks, for which there is no basis in international law, also underscore that states have concluded that a "new way of working" has been forced upon them.

The second global understanding involves recognition that the new geo-

141. See BULL, supra note 8, at 245, 254-57 (discussing the concept of new medievalism).
technological realities produce unprecedented geo-biological interconnectedness. A country's interest in protecting its population from infectious disease epidemics requires, in the new geo-technological context of public health, an expanded conceptualization of that interest. In some respects, this idea is not new because public health experts have long argued that public health governance requires international cooperation. Recent infectious disease crises have, however, hammered home how interconnected human populations are in the early twenty-first century. As diseases that jump from animal species to humans, SARS and avian influenza also demonstrate how interconnected human and animal populations are. Geo-biological interconnectedness of such intensity creates a pragmatic solidarity of interests and values concerning public health.

Geo-biological interconnectedness requires governance if pragmatic solidarity is to have traction in the face of accelerating geo-technological change. The third global understanding is awareness of the need for governance integration in the new geopolitics of public health. Just as public health governance between the federal government and the states of the Union has become more vertically integrated through a process of federalization, the distinction between national and international governance has fragmented through the process of globalization. (In this sense, federalization and globalization of public health governance are interdependent phenomena.) Integration develops in global health governance through the four "constitutional" functions, which provide a platform for the evolution within "networked anarchy" of a post-Westphalian body politic or commonwealth for public health.

D. Deficiencies in, and Vulnerabilities of, Public Health's "New World Order"

My assertion that a post-Westphalian public health commonwealth is emerging, grounded the four "constitutional" functions, does not pretend that this commonwealth is sustainable. The vertical reallocation of power within constitutional governance in the United States is more robust than the integration of governance in the anarchical environment of international relations. Anarchy creates deficiencies in, and vulnerabilities for, public health's new world order that do not appear in U.S. constitutional governance. Comprehensive discussion of these deficiencies and vulnerabilities is beyond this article's scope, but let me mention a few concerns.

In terms of deficiencies, one could compare the successful containment of SARS and the unchecked rampage of HIV/AIDS in the developing world and argue that the new world order still reflects the strategic priorities of the old world order, that is, the interests of the great powers. The "constitutional" functions of security, commerce, preparedness and response, and human rights weigh heavily in favor of developed countries' interests in their national security, their economic opportunities, their public health capabilities, and their conception of human rights. The human suffering and societal devastation wrought by infectious diseases in the developing world may suggest the human
rights function is hollow, or geared toward civil and political rights rather than taking the right to health seriously. One might add that the mixture of functions in global health governance disadvantages the attempts to include equity and justice as governance functions in the post-Westphalian public health commonwealth.

The role of the great powers also looms as a vulnerability of contemporary post-Westphalianism. Such powers have, by definition, disproportionate power that does not drain away under the global understandings described above. In fact, as I argued in connection with the aftermath of SARS, the current post-Westphalian context in some ways enhances the power of strong states, especially with respect to the financial and other resources required to retrofit national and global public health preparedness and response capabilities. 142

Making the post-Westphalian public health commonwealth work on a sustainable basis will take material resources only to be found within the sovereign control of the great powers. Unlike the U.S. federal government, the global public health commonwealth has no "power of the purse" among its "constitutional" functions to pay for what global health governance requires. The lack of sufficient resources is, and has long been, an Achilles heel for global health efforts, as illustrated by the WHO's chronic shortage of funds, low levels of foreign aid from developed states for health improvements in developing countries, and financial problems afflicting the Global Fund, 143 the Roll Back Malaria campaign, 144 and the "3 by 5" Initiative. 145 The federalization of public health governance has not proved cheap, and neither will the sustainability of global health governance.

V. FROM OUTLINES TO PILLARS? PROSPECTS FOR THE POST-WESTPHALIAN PUBLIC HEALTH COMMONWEALTH

My assertion that "constitutional outlines" are emerging to structure global health governance means that prospects for public health's new world order are tied, for better or worse, to the fate of these outlines. Will the four functions of the new governance system solidify into pillars for the post-Westphalian public health commonwealth, or will these outlines become faint or inaudible echoes of a world that might have been?

In thinking about the future of governance regimes concerning global public health, it is important to recall that previous innovations have not proved sustainable, as illustrated by the fate of the Westphalian IHR and the post-

142. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 174-79.

143. Id. at 68 (describing the financial difficulties experienced by the Global Fund).


Westphalian Health for All vision. The promising developments in global health governance seen in the SARS and avian influenza outbreaks must be balanced by the continuing disaster of the HIV/AIDS pandemic, for which no extant governance concept appears to have a credible strategy.

Another cautionary note emerges from the realization that the "constitutional outlines" for global health governance have appeared against the background of worsening conditions for public health around the world. In other words, but for the perilous condition of public health globally, these functions would not have emerged to provide structure for global health governance. Although the same holds true for the process of federalization in U.S. constitutional governance, such a parallel is hardly comforting in contemplating the prospects for an embryonic transformation in how public health is governed globally.

After watching the global response to the avian influenza crisis unfold, I will venture to argue that prospects for the emerging system of global health governance will improve if serious multi-country threats continue to occur. The avian influenza outbreak has reinforced governance lessons learned during SARS. More outbreaks will groove global health governance more deeply into the pattern of political behavior in states, intergovernmental organizations, and non-state actors.

As mere outlines, each of the four governance functions contains ambiguity, the clarification of which will influence the prospects for the sustainability of global health governance. How broadly, for example, will "security" be defined in the pursuit of global health security? Countries in Sub-Saharan Africa have different security interests vis-à-vis infectious diseases than the bioterrorism-focused United States. How will the post-Cancún pursuit of bilateral and regional trade agreements by developed countries affect the dynamics of balancing trade and health through the global commerce clause?

What balance should be struck in supporting public health preparedness and response between infectious and non-communicable diseases, the latter of which pose different governance challenges nationally and globally? With global morbidity and mortality from non-communicable diseases on the rise, how will

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146. For analysis of previous governance innovations in infectious disease control that suffered from various problems, see FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE, supra note 1, at 157-62.

147. The pursuit of regional and bilateral free trade agreements by the United States has raised concerns that the United States may use these agreements to water down the public health safeguards found in the TRIPS Agreement and reinforced by the Doha Declaration on the TRIPS Agreement and Public Health. See, e.g., Oxfam America, TRIPS-Plus Provisions, at http://www.oxfamamerica.org/advocacy/art5391.html (last visited July 7, 2004) (stating that the United States "has pressured trading partners to agree to provisions in regional and bilateral trade agreements that mandate even higher levels of IP protection than those they agreed to under TRIPS. Developing countries are thus required under these trade agreements to include very high levels of protection in their national laws, with grave consequences for public health and other national policy objectives.").

148. See generally Robert Beaglehole & Derek Yach, Globalisation and the Prevention and Control of Non-Communicable Disease: The Neglected Chronic Diseases of Adults, 362 LANCET 903 (2003) (discussing the rising tide of non-communicable diseases including 56 million deaths globally in
the four functions, which are closely connected to infectious disease governance, be utilized or revised to deal with non-communicable disease problems, from tobacco-related diseases to diseases linked to obesity?

The human rights function is perhaps the weakest of the four functions structuring global health governance, which creates uncertainty about its role in the evolution of the post-Westphalian public health commonwealth. Will this function become a morally compelling but politically ignored mantra; as perhaps has been the fate of the global human rights strategy on HIV/AIDS? What theoretical and practical implications will efforts to revisit civil and political rights vis-à-vis quarantine and isolation or to reinvigorate the human right to health in global health governance have?

The existence of many questions about the future of global health governance highlights the challenges that await the post-Westphalian public health commonwealth. Other articles in this symposium issue explore the challenges to post-Westphalian public health, so I will not prolong my analysis in this regard but conclude my remarks with a general observation:

The prospects for global health governance will be determined by the progress achieved under the public health preparedness and response function. The objectives of security, commerce, and human rights depend on robust, sustainable national and global systems of disease surveillance and response. Without such systems, security, trade, and individual rights will be compromised globally. The same is true for prospects for the federalization of public health governance in the United States, which again highlights the integration of public health governance caused by geo-biological interconnectedness created by geotechnological realities.

Public health preparedness and response capabilities require more than adoption of the revised IHR, which, as presently worded, would require WHO member states to develop and maintain the capacity to detect, report, and respond effectively to public health risks and events potentially constituting public health emergencies of international concern present in its territory. The proposed revision of the IHR spells out the core capacity requirements for surveillance and response but does not contain a strategy for assisting


151. IHR Draft Revision, supra note 97, at 7, 9.

152. Id., Annex 1, at 25-27.
countries, technically or financially, in achieving this minimal level of preparedness and response competence.\textsuperscript{153}

Such a strategy must be fueled by political motivations sufficiently strong in the anarchical context of international relations to sustain public health preparedness and response capabilities nationally and globally for decades. The security, commerce, and human rights functions represent three compelling motivations that can potentially sustain governance in the post-Westphalian public health commonwealth. The governance integration mandated by geo-biological interconnectedness, which is triggered by geo-technological realities, perhaps creates a global geopolitical dynamic that will ensure public health’s “new world order” avoids becoming hegemonic, utopian, or irrelevant.
