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International Law and Global Public Health

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I. INTRODUCTION

In the decades since the Second World War, international activities concerning public health carried out by intergovernmental organizations and nongovernmental organizations made little use of international law. During a period in which the field of international law expanded dramatically, the potential for international law to contribute to global public health remained unexplored. In the second half of the 1990s, public health antipathy toward international law has started to change. One of the leading international legal scholars on public health issues, Dr. Allyn Taylor, has observed that there has been in the past few years an "unprecedented burgeoning interest, meetings and activities related to national and international public health law." For example, the World Health Organization (WHO) and the Indian Law Institute sponsored an International Conference on Global Health Law in New Delhi in December.
1997, at which the delegates adopted the New Delhi Declaration on Global Health Law. In November 1998, the University of Durban-Westville and the South African Medical Research Council held an International Colloquium on Public Health Law. In addition, WHO is currently engaging in potentially far-reaching international legal reform efforts in the areas of infectious disease and tobacco control.

This Article seeks to explain this historical shift in attitude about international law in the global public health community. It also argues that this recent willingness to examine the role of international law in global public health is really only a beginning in fully understanding the function of international law in the world of public health. In Part II, I analyze the structural and public health reasons why more people today see a need for international law to play a role in global public health strategies. The structural reasons arise from the nature of international relations: humanity is divided into sovereign states that can only achieve common objectives through cooperation facilitated by the system of international law. The public health reasons flow from the nature of public health problems in the era of globalization. What we are witnessing today is the globalization of public health, a phenomenon that increasingly forces states to cooperate to address public health threats. In short, the structure of the international system combined with the globalization of public health produces the need for international law in global public health strategies.

These structural and public health reasons are not unique to the late twentieth century, as illustrated by states' extensive use in the late part of the nineteenth century and first half of the twentieth century of international law in dealing with public health problems. This historical experience with international law in the public health realm served as the empirical basis for the innovative international legal powers crafted into the WHO Constitution in the late 1940s. Despite the history and the authority to develop international health law, WHO neglected international law during its first fifty years. Part III of the Article explores the historical application of international law to public health problems, WHO's international legal powers, and the neglect of international law by the WHO.

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4. See infra Part III.
The structural and public health reasons behind the need for international law, combined with WHO’s historical neglect of international law, produce arguments that WHO should dramatically change its attitude toward international law. While important, these arguments for more WHO interest in international law need to be supplemented by a deeper understanding of the place of health in international law. Part IV attempts to provide this deeper understanding in order to show that health is an objective of multiple international legal regimes ranging across the entire spectrum of international relations. How this deeper understanding affects interpretation of the human right to health is featured in Part IV’s analysis.

Raising the flag of international law so conspicuously in the public health context invites, however, some disturbing questions about the impact of the processes of globalization on the state and international law. Advocates of more WHO activity in international law cannot be blind to the discourses now raging about the future relevance of the state and the possible increasing impotence of international law in globalized human affairs. Part V deals with these difficult questions.

Arising from the analysis in Part V is the need for new ways to think about law and public health in the era of globalization. In Part VI, I present the concept of global health jurisprudence as potentially useful in providing a framework for thinking about and using national and international law to deal with public health threats in a globalized world. The concept of global health jurisprudence captures the interdependence between national and international law, reflects the increasingly important role of non-state actors in international relations, and grounds future legal thinking about public health law in a global context in keeping with the global nature of the threats facing humanity’s health.

I conclude by warning that neither law nor global health jurisprudence provides a panacea for the public health problems facing the planet. “World Health through World Law” is just as fanciful a notion as the ridiculed slogan of “World Peace through World Law.” Law is ultimately an instrument in human affairs, not an end in itself. How the instrument of law is used in the global public health context can be improved; but legal energy alone is not sufficient to establish footholds on the mountains of problems now confronting the health of humankind.

II. PUBLIC HEALTH AND THE ANARCHICAL SOCIETY: THE NEED FOR INTERNATIONAL LAW IN DEALING WITH PUBLIC HEALTH THREATS

Recent WHO policies and initiatives suggest that WHO’s decades-old antipathy toward international law is changing. WHO is currently revising the International Health Regulations (IHR), which are the main set of
international legal rules for infectious disease control.\textsuperscript{5} The WHO Executive Director of Communicable Diseases has indicated that the revised International Health Regulations are a prelude to the development of a convention on infectious diseases.\textsuperscript{6} WHO is also undertaking the development of a framework convention on international tobacco control.\textsuperscript{7} In addition, WHO’s new \textit{Health for All in the Twenty-First Century} policy emphasizes the importance of international law.\textsuperscript{8} The new policy states that “WHO will develop international instruments that promote and protect health, will monitor their implementation, and will also encourage its Member States to apply international laws related to health.”\textsuperscript{9} The \textit{Health for All} policy also demonstrates an appreciation of the importance of different international legal regimes to WHO’s global work, including human rights, international trade, and environmental protection.\textsuperscript{10} WHO staff have also identified a wide range of international legal regimes that

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\textsuperscript{8} \textit{Health for All in the Twenty-First Century}, WHO Doc. A51/5 (1998) [hereinafter \textit{Health for All}].

\textsuperscript{9} \textit{Id.} para. 52.

\textsuperscript{10} \textit{Id.} paras. 2, 23, 25.
\end{flushleft}
affect WHO’s mission of global public health. Scholarly efforts stressing the importance of international law to WHO’s mission have preceded and accompanied the new attention WHO is paying to international law. The change from the stagnant Nakajima regime to the reform-minded Brundtland team has opened new spaces for debate about international law and a host of other important issues concerning WHO’s future. The need for international law in global public health is deeper, however, than the attitudes of any particular WHO administration. WHO needs to take

11. See Aude L’hirondel & Derek Yach, Develop and Strengthen Public Health Law, 51 WORLD HEALTH STAT. Q. 79, 83 (1998) (identifying tobacco control; infectious disease control; standards for biological, pharmaceutical, and similar products; international trade in blood and human organs; xenotransplantation; misuse of antimicrobial drugs; health products and services on the Internet; and issues arising out of the linkage between global health and international trade as areas within WHO’s domain that require international legal attention; and identifying international trade law; international human rights law; international environmental law; international law on biological, chemical, and nuclear weapons; international maritime law; law of the sea; international law on bioethics; international intelectual property law; and international telecommunications law as areas of international law relevant to WHO’s global health agenda).


international law more seriously because the structure of international politics places international law in a central position in states’ attempts to deal with global problems. In addition, the nature of public health problems in the era of globalization requires international cooperation and coordinated action through international law. Underneath WHO’s new sensitivities to international law are fundamental structural and public health reasons why international law must play a role in combating threats to human health.

A. The Role of International Law in International Relations

International law is a confusing aspect of international relations for many people. Every year law students struggle with the paradox that international law permeates every aspect of international relations, and yet many think it unimportant in the actual conduct of inter-state affairs. Some students gravitate toward the attitude expressed by Jean-Jacques Rousseau in *The State of War*: “As for what is commonly called international law, because its laws lack any sanction, they are unquestionably mere illusions, even feebler than the law of nature.”13 Other students are drawn to the inspirational quality of international law through legal tenets that favor peace over war, human rights over *raison d’etat*, and hope over a naked struggle for power. As is often the case with extreme positions, the truth lies somewhere in between.

The key to mastering this seeming paradox in the nature of international law is to grasp that this body of law arises within the context of a very specific type of political interaction. Since the development of the territorial state in the late European Renaissance, and especially since the Peace of Westphalia in 1648, humanity has been divided politically into sovereign states. At first, such divisions were a European phenomenon, but the territorial state eventually became the primary model for organizing human politics around the world as European power and influence spread globally.14 The last phase of this development occurred during the period of decolonization in the second half of the twentieth century.

The division of humanity into sovereign states produced a particular political structure for human interaction across the borders of these states: the international system. As defined by Hedley Bull, an international system “is formed 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 part of a whole.”

The international system contains independent territorial units that are interdependent because they interact and affect each other’s fate. Because there is no supreme power to control the behavior of states in an international system, the potential for cooperation and conflict always exists. As systemic interaction was unavoidable, states needed to develop mechanisms for regularizing their contacts, both in peace and in war. A chief mechanism devised for this purpose was international law: the rules regulating the interactions of states.

International law differs fundamentally from law within a state because it arises from a completely different political structure. The argument that international law is a mere illusion because it cannot be enforced flows from the wrong assumption that domestic law, which can be enforced centrally by the government, reflects the nature of law in every context.

International law exists, however, largely because there is no supreme political authority in the international system. To argue that international law is not enforceable like domestic law just describes the factual context of international relations, rather than saying anything interesting about international law itself. International law arises and operates within a very particular political structure, and it is within this structure that we have to try to understand what function international law serves.

Most generally stated, the function of international law is to help create what Hedley Bull called the “anarchical society.” States interacting in a situation of anarchy have used international law as a primary means to create an international society. According to Bull, an international society “exists when a group of states, conscious of certain common interests and common values, form a society in the sense that they conceive themselves to be bound by a common set of rules in their relations with one another, and share in the working of common institutions.” This conception of international society presupposes the existence of not only an international system but also international law. The rules of international law form the sinews of international society.

18. Id. at 13.
19. See id.
These observations tell us nothing, however, about the substance of international law. Because states are the main source of the rules of international law, the substance of international law reflects their common interests and values. These interests and values change over time, and such change is driven by transformations within states (for example from dictatorships to democracies) and alterations in the nature of the international system (for example the shift from an ideologically divided, bipolar international system to an ideologically homogenous, multipolar international system). The content of international law derives, therefore, from the nature of the states in the international system and the dynamics of their systemic interactions.

As a matter of political structure, international law is fundamental to (1) states wishing to protect certain interests or achieve certain goals, (2) the functioning of the international system, and (3) the existence of an international society. The substance of the rules of international law tells us much about the nature of the anarchical society at any given moment in history. In connection with the relationship between public health and international law, the next analytical step involves understanding how public health has found its way into international law and thus into the dynamics of the anarchical society.

B. The Globalization of Public Health

Much of the recent literature refocusing public health attention on international law points to the phenomenon of the "globalization of public health" as a key factor in needing to rethink the role of international law in global public health. As a general matter, the prominence of the globalization of public health in these debates indicates that something has happened to public health that now forces reconsideration of international law's role. Somewhat lost in the contemporary discussions is the fact that the globalization of public health is not a new phenomenon, having first


21. See, e.g., Fidler, Globalization, International Law, and Emerging Infectious Diseases, supra note 12, at 79 (analyzing need for international law to deal with globalization's effects on emerging infectious diseases); Yach & Bettcher, The Globalization of Public Health, I, supra note 20, at 736 (arguing for "[a]n enhanced role for international legal instruments, standard setting, and global norms"); Taylor, supra note 1, at 1 (arguing that "the promulgation of regulations, norms and standards" is a "critical function of future international health cooperation").
arisen in the latter half of the nineteenth century.22 Because of the historical and contemporary importance of this concept, understanding what is meant by the globalization of public health is important in comprehending why international law is central to global public health strategies.

Defining the globalization of public health proves difficult because "globalization" has been defined in many different ways.23 At the risk of oversimplification, a central feature of most definitions of globalization is the erosion of the power of the state to control what happens inside its borders. As Jost Delbrück has described it, globalization "denotes a process of denationalization of clusters of political, economic and social activities."24 The areas regarding globalization that perhaps attract the most attention are the markets for goods, services, and capital. Gordon Walker and Mark Fox have argued that "[t]he key feature which underlies the concept of globalization ... is the erosion and irrelevance of national boundaries in markets which can truly be described as global."25 But globalization affects more than just markets. Jan Aart Scholte has captured the broad human ramifications of globalization by arguing that globalization "refers to processes whereby social relations acquire relatively distanceless and borderless qualities, so that human lives are increasingly played out in the world as a single place."26

The relevance of the concept of globalization to public health is obvious in a period during which public health experts claim that the distinction between national and international health is now anachronistic.27 The blurring of the traditional dividing line between national and international public health suggests that the processes of globalization are undermining the sovereign state’s ability to protect and provide for its
public's health. The globalization processes in the public health context include the following: trade, travel, migration, changes in individual behavior (especially sexual behavior), urbanization, environmental degradation, war, civil conflict and instability, poverty, and the evolutionary powers of pathogenic microbes.

Each of these processes not only represents a channel of globalization but is also itself affected by other processes of globalization. Globalization undermines, for example, the ability of a government to deal with poverty or environmental degradation. The processes of globalization, therefore, have an adverse multiplier effect on public health. Just as the factors that go into the making of a healthy person are many and complex, the processes of globalization that directly and indirectly affect public health represent an awesome and disturbing array of problems facing humankind. For an objective such as public health, which is influenced by many different political, economic, scientific, and cultural factors, globalization seems like a hydra-headed problem.

At the risk of oversimplification, five factors can be identified as capturing the basic dynamics of the globalization of public health. First, the cross-border channels for the spread of disease-causing agents or products have grown in size and speed, rendering populations vulnerable to disease agents or disease-causing products imported from elsewhere. The volume and speed of international trade and travel plays a role, for instance, in the spread of infectious diseases. The liberalization of international trade has also benefitted global trade in disease-causing products, such as tobacco. Liberalized trade in certain food products is also thought to contribute to obesity problems in many countries.

Second, the deterioration or nonexistence of public health capabilities render a government less able to protect its people from either imported disease-related threats or indigenous disease problems. The cross-border flow of disease agents or disease-causing products would be less of a concern if well-staffed and well-funded public health systems existed in most countries; but such public health capabilities do not exist throughout

28. I originally used these five factors in constructing the pathology of the globalization of public health in Fidler, The Globalization of Public Health, supra note 12, at 33-34.

29. See, e.g., INSTITUTE OF MEDICINE, EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE UNITED STATES 77-84 (1992); Fidler, supra note 6, at 794-800; Taylor, Controlling the Global Spread of Infectious Diseases, supra note 12, at 1336-37; Mary E. Wilson, Travel and the Emergence of Infectious Diseases, 1 EMERGING INFECTIOUS DISEASES 39 (1995).


31. On the global obesity epidemic, see Obesity Epidemic Puts Millions at Risk from Related Diseases, WHO Press Release WHO/46 (June 12, 1997).
the international system, thereby exposing populations to more health threats.32

Third, the perceived failure of international health organizations contributes to the problems created by the globalization of public health. While the globalization of public health has positive features—mainly in the form of the work done by international health organizations in spreading scientific discoveries, medical technologies, and health information globally—the recent shake-up at WHO indicates that international health organizations have not been as effective as they need to be given the nature of the threats to human health.33 The concerns about the health performance of international organizations extend beyond WHO to include other organizations, such as the World Bank and the International Monetary Fund (IMF), which have become involved in public health issues.34

Fourth, the negative aspects of the globalization of public health feed off the development within countries of unprecedented levels of deeply rooted social, economic, and environmental problems that provide disease agents or disease-causing products opportunities to cause sickness and death. The public health nightmares affecting, and continuing to descend on, the developing world reflect profound problems in those societies at all levels of human activity. These problems not only make developing countries vulnerable to threats of imported disease but also make these countries breeding grounds for indigenous disease crises. In addition, the economic conditions of many of these countries render it next to impossible for them to fund adequate public health systems.

Fifth, the state faces the four factors identified above with decreased ability to control what happens economically, environmentally, and

32. See NATIONAL SCIENCE AND TECHNOLOGY COUNCIL COMMITTEE ON INTERNATIONAL SCI-
ENCE, ENGINEERING, AND TECHNOLOGY WORKING GROUP ON EMERGING AND RE-EMERGING INFECTIOUS DISEASES, INFECTIOUS DISEASES—A GLOBAL THREAT, 17, 45 (1995) (commenting on lack
of public health infrastructure in many developing countries); Ruth L. Berkelman et al., Infectious Disease Surveillance: A Crumbling Foundation, 264 SCIENCE 368, 368 (1994) (commenting on the poor condition of infectious disease surveillance in the United States).

33. See, e.g., GLOBAL PUBLIC HEALTH COLLABORATION: ORGANIZING FOR A TIME OF RENEWAL I (Susan U. Raymond ed., 1997) (arguing that global health institutions “have not adjusted to the nature and depth of change in the world; they have grown but often they have not evolved”).

34. The World Bank and IMF have, for example, been criticized for causing health problems through their structural adjustment programs (SAPs) in the developing world. See, e.g., Emma Curtis, Child Health and the International Monetary Fund: The Nicaraguan Experience, 352 LANCET 1622 (1998) (analyzing negative impact of SAPs on health in Nicaragua); Carol Riphenburg, Women’s Status and Cultural Expression: Changing Gender Relations and Structural Adjustment in Zimbabwe, 44 AFR. TODAY 33 (1997) (arguing that women’s health in Zimbabwe is in jeopardy because of SAPs); Structural Adjustment Too Painful?, 344 LANCET 1377 (1994) (arguing that SAPs wreaked havoc on the health and welfare of people in sub-Saharan Africa); Angela M. Wakhweya, Structural Adjustment and Health, 311 BRIT. MED. J. 71 (1995) (criticizing SAPs for making health worse for rural people in Africa).
socially within its borders because of the processes of globalization. Even if the political will existed in many countries to confront public health threats, many perceive that the globalization of markets reduces the policy flexibility of governments, which fear scaring away trade and investment by imposing higher standards and thus higher costs on private enterprise. Sometimes the health policy inflexibility is perceived to be demanded by international organizations, such as the World Bank and IMF, through structural adjustment programs.35

C. Public Health in the Anarchical Society: The Need for Law in Confronting the Globalization of Public Health

The picture of the globalization of public health painted above is grim, but states and international organizations are not completely paralyzed in connection with the globalization of public health. Responses to the opportunities and challenges of globalization take many forms, but response patterns can be detected in the diversity. Policy responses to globalization fall into one of three patterns: (1) decentralized difference, (2) decentralized harmonization, and (3) internationalization. These different policy responses often translate into legal action, so these patterns are helpful in understanding the role of law in connection with the globalization of public health.

The pattern of decentralized difference reflects the fact that not all states respond to globalization in the same way. Faced with a similar challenge spawned by the processes of globalization, sometimes states act in diverse ways. In contrast, the pattern of decentralized harmonization represents the adoption by individual states of identical, or nearly identical, policies in response to globalization phenomena.36 Decentralization means that these similar responses are not coordinated formally through international organizations or international law. Decentralized harmonization sometimes occurs through what Slaughter calls “transgovernmentalism”: cooperation between states by subunits of governments (for example securities regulators, banking regulators, and competition law authorities).37 Through transgovernmentalism, states harmonize policies on specific issues without necessarily enshrining such harmonization in international law.

35. See Navarro, supra note 20, at 742 (noting role of IMF and World Bank in imposing policies that result in declines in health care expenditures by governments).


Internationalization involves cooperation between states either bilaterally or multilaterally within the formal frameworks of international law or international organizations. Delbrück has argued, for example, that “[i]nternationalization . . . may be defined as a means to enable nation-states to satisfy the national interest in areas where they are incapable of doing so on their own.” Through the internationalization strategy we can see the structural need for international law to facilitate inter-state cooperation. Internationalization is the predominant response to many so-called “global problems,” such as environmental degradation, because they are problems that no state can properly handle without international cooperation.

While decentralized difference and decentralized harmonization implicate domestic law, internationalization brings international law into the picture. Most of the areas involving major international legal regimes, such as international trade, environmental protection, and human rights, derive from internationalization. Internationalization does not, however, imply that international law always features strongly in efforts to deal with the global problem at hand. WHO’s neglect of international law during its first fifty years does not mean that internationalization was unimportant to global public health issues. Rather, WHO’s internationalization strategy marginalized international law in favor of other forms of international cooperation and coordination.

The recent attention at WHO and in scholarly literature given to national and international public health law suggests a consensus is emerging that the role of law needs to be re-evaluated in the responses to the globalization of public health. In addition, a strong theme in this literature is the leading role WHO must play in improving domestic public health law and in using international law.” This emphasis on WHO points to a more legally oriented strategy of internationalization than has prevailed

38. Delbrück, supra note 24, at 11.
39. See, e.g., New Delhi Declaration, supra note 2, at 423 (listing tasks WHO should undertake to improve the contribution of public health law to global health); FIDLER, supra note 3, at 305-07, 317-35 (proposing consideration of a WHO framework convention on infectious diseases); Fidler, The Future of the World Health Organization, supra note 12, at 1107-15 (analyzing international law and WHO’s future); Fidler, Globalization, International Law, and Emerging Infectious Diseases, supra note 12, at 77-83 (analyzing WHO’s proposed revision of the IHR); Fidler, supra note 6, at 863-67 (proposing WHO framework convention on infectious diseases); L’hirondel & Yach, supra note 11, at 84-86 (discussing how WHO can strengthen and develop public health law); Taylor, Controlling the Global Spread of Infectious Diseases, supra note 12, at 1352-60 (arguing for more WHO monitoring of the revised IHR); Taylor, An International Regulatory Strategy for Global Tobacco Control, supra note 12, at 283-302 (outlining an international regulatory strategy for tobacco control); Taylor, Making the World Health Organization Work, supra note 12, at 301-46 (arguing for more activity by WHO in international law); Taylor, supra note 1, at 1-15 (arguing for more WHO activity on international law).
in the past. A message to take away from this developing shift is the perceived importance of law, national and international, in elevating public health on the agenda of the anarchical society in the era of globalization.

D. Summary of Analysis of Public Health and the Anarchical Society

The structural need for international law in the international political system and the consequences of globalization of public health combine to create an increasing demand for more attention to international law in public health strategies. The perceived importance of reform in national public health law also underscores the central role international law has to play in reorienting the place of law in global public health because international organizations, such as WHO, have to provide legal leadership. While some countries may be able to reform national public health law without leadership from WHO, many other states will require WHO's international legal leadership and guidance in improving their public health laws and conforming them to international legal standards. In addition, controlling infectious diseases and tobacco-related diseases requires, as WHO has recognized, the revision or creation of new international health law in order to enable states and international organizations to address these pressing problems. In short, national law and international law regarding public health are interdependent, and this interdependence is central to the concept of global health jurisprudence developed later in this Article.

Of course, neither the structural need for international law nor the globalization of public health is a new phenomenon in international relations. Just as necessary as understanding the need for more attention to international law in global public health is understanding why WHO neglected international law for its first fifty years. Not surprisingly, the reasons behind WHO's nonlegal approach to internationalization in public health are complex. In Part III, I attempt to explain WHO's historical neglect of international law.

40. See New Delhi Declaration, supra note 2, at 423 ("World Health Organization is encouraged to play a greater role in developing and using international instruments to advance global health . . . ."); Fidler, The Future of the World Health Organization, supra note 12, at 1117 (arguing that international and national legal "discourse has to be fostered and nurtured by WHO as the world's health advocate."); L'hirondel & Yach, supra note 11, at 86 ("WHO should give priority to the development of mandatory and persuasive international instruments and to capacity-building in public health law simultaneously."); Taylor, supra note 1, at 15 (noting "the important contribution that WHO . . . . can make to international health cooperation and improving global health conditions through national and international standard setting and implementation").

41. See infra Part IV.
III. INTERNATIONAL LAW AND THE TRANSNATIONAL HIPPOCRATIC SOCIETY: THE NEGLECT OF INTERNATIONAL LAW BY WHO

WHO's nonlegal approach should not be taken to mean that public health cooperation did not form part of the post-1945 international society. The creation and functioning of WHO indicate that the protection and promotion of health represented one of the common values of states, and states shared in the working of a common institution—WHO—in pursuit of that value. In addition, the WHO Constitution\(^4\) and the WHO-administered International Health Regulations (IHR)\(^5\) represented common sets of rules governing the relations of WHO member states. Public health was, thus, part of international society.

The lack of attention WHO paid to international law does, however, suggest that WHO’s approach to the common value of public health differed significantly from other international society activities, such as trade, human rights, and environmental protection, in which states and intergovernmental organizations used international law extensively. WHO was isolated from general developments concerning international law in the post-1945 period.\(^6\) This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international public health policy. WHO operated as if it were not subject to the normal dynamics of the anarchical society; rather, it acted as if it were at the center of a transnational Hippocratic society made up of physicians, medical scientists, and public health experts. The nature and dynamics of this transnational Hippocratic society led WHO to approach international public health without a legal strategy.

While there has long been a transnational community of doctors and scientists, the transnational Hippocratic society reflected in WHO’s activities is not reflected in earlier international health diplomacy because international law featured extensively in such diplomatic activity. The extensive use of international law during the late 1800’s and the first half of the twentieth century demonstrates international law’s significant role in pre-WHO international public health cooperation. This history of international health law forms the empirical basis for the innovative

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43. International Health Regulations, supra note 5.

44. See FIDLER, supra note 3, at 283-90 (analyzing international legal lessons to be learned from the use of international law by other international organizations); Fidler, The Future of the World Health Organization, supra note 12, at 1094-97 (comparing WHO’s lack of interest in international law with general developments in international law since 1945 and the use of international law by other international organizations).
international legal powers crafted into the WHO Constitution. Why WHO turned its back on this history and its own international legal powers can be found in the nature of the transnational Hippocratic society that formed after WHO’s creation.

A. History of International Law on Public Health

WHO’s attitude toward international law does not reflect the history of international health diplomacy from the mid-nineteenth century until World War II. From the very first International Sanitary Conference in 1851, international law has played a central role in international health cooperation.\(^4\) The convening of the first International Sanitary Conference in 1851 reflected the elevation of disease control from a strictly national issue to a matter of concern for the international system.\(^4\) European states realized in the mid-nineteenth century that they had to cooperate through international law in order to control the spread of cholera and other infectious diseases because such diseases could no longer be independently controlled by a state. The 1851 International Sanitary Conference, and subsequent international sanitary conferences in the latter half of the nineteenth century and first half of the twentieth century, represented the confluence of the dynamics of the international system and the globalization of public health. Out of this confluence came the importance of international law to these early efforts of the anarchical society to deal with international disease threats.

The importance of international law did not diminish as public health continued to be on the agenda of the anarchical society. Infectious disease control in humans was the area in which international law was used most extensively,\(^4\) but treaties also appeared in connection with animal diseases, plant diseases, narcotic drugs, and alcohol.\(^4\) In addition, four international health organizations were created in the first half of the twentieth century: the Pan American Sanitary Bureau (1902), Office International d’Hygiène Publique (1907), the Health Organization of the League of Nations (1923),

\(^{45}\) See Fidler, The Role of International Law, supra note 12, at 58 (arguing that “the critical role of international law in infectious disease control has been recognized since at least the mid-19th century”). For the history of the use of international law in infectious disease control between 1851 and 1951, see Fidler, supra note 3, at 21-57.

\(^{46}\) See Fidler, Microbialpolitik, supra note 12, at 18 (arguing that “disease control did not rise to the level of systemic concern prior to the mid-nineteenth century”).

\(^{47}\) See Fidler, The Future of the World Health Organization, supra note 12, at 1084 (“Every International Sanitary Conference from 1851 to 1938 sought to produce an international agreement of some kind. Many of these conferences succeeded in this objective, producing a plethora of international agreements on infectious disease control by the eve of World War II.”).

\(^{48}\) See infra Table 1.
and the Office International des Epizooties (1924). Table 1 provides a nonexclusive list of treaties negotiated or concluded on public health issues in the period between 1851 and 1945.

**Table 1: Nonexclusive List of Treaties Negotiated or Concluded on Public Health Issues, 1851-1945**

<table>
<thead>
<tr>
<th>Year</th>
<th>Treaty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1851</td>
<td>Convention and Regulations on maritime traffic and the control of plague, cholera, and yellow fever negotiated but never adopted</td>
</tr>
<tr>
<td>1859</td>
<td>Convention simplifying the proposed 1851 Convention and Regulations negotiated but never adopted</td>
</tr>
<tr>
<td>1873</td>
<td>Convention on quarantine negotiated by three South American States but never ratified by any party</td>
</tr>
<tr>
<td>1874</td>
<td>Convention to establish a permanent International Commission on Epidemics negotiated but never adopted</td>
</tr>
<tr>
<td>1878</td>
<td>Convention Respecting Measures to be Taken Against <em>Phylloxera vastatrix</em> ratified by five European countries</td>
</tr>
<tr>
<td>1881</td>
<td>Convention to establish a permanent International Sanitary Agency of Notification negotiated but never adopted</td>
</tr>
<tr>
<td>1887</td>
<td>Convention on quarantine negotiated and ratified by three South American States</td>
</tr>
<tr>
<td>1892</td>
<td>International Sanitary Convention of 1892 adopted</td>
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<tr>
<td>1893</td>
<td>International Sanitary Convention of 1893 adopted</td>
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<tr>
<td>1894</td>
<td>International Sanitary Convention of 1894 adopted</td>
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<tr>
<td>1897</td>
<td>International Sanitary Convention of 1897 adopted</td>
</tr>
<tr>
<td>1902</td>
<td>Pan-American Sanitary Bureau established</td>
</tr>
<tr>
<td>1903</td>
<td>International Sanitary Convention of 1903 adopted, replacing 1892, 1893, 1894, and 1897 conventions</td>
</tr>
<tr>
<td>1904</td>
<td>International Sanitary Convention adopted by four South American countries</td>
</tr>
<tr>
<td>1905</td>
<td>Inter-American Sanitary Convention adopted</td>
</tr>
</tbody>
</table>

49. See Fidler, supra note 3, at 24.
50. Table 1 is the author's compilation (sources on file with author).
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1907</td>
<td>International Office d'Hygiène Publique established</td>
</tr>
<tr>
<td>1912</td>
<td>International Sanitary Convention of 1912 adopted, revising 1903 convention</td>
</tr>
<tr>
<td>1912</td>
<td>International Opium Convention adopted</td>
</tr>
<tr>
<td>1914</td>
<td>International Sanitary Convention adopted by four South American countries, replacing 1904 convention</td>
</tr>
<tr>
<td>1919</td>
<td>Convention Relating to Alcohol Trade to Africa adopted</td>
</tr>
<tr>
<td>1921</td>
<td>Convention Concerning the Use of White Lead in Paint adopted by the International Labor Organization</td>
</tr>
<tr>
<td>1923</td>
<td>Scheme for the Permanent Health Organization of the League of Nations adopted</td>
</tr>
<tr>
<td>1923</td>
<td>Sanitary Convention adopted by Poland and Russian, Ukrainian, and White Russian Socialist Soviet Republics</td>
</tr>
<tr>
<td>1924</td>
<td>Pan-American Sanitary Code adopted, replacing 1905 Inter-American Convention</td>
</tr>
<tr>
<td>1924</td>
<td>Office International des Epizooties established</td>
</tr>
<tr>
<td>1924</td>
<td>Agreement Respecting Facilities to be Given to Merchant Seamen for the Treatment of Venereal Disease adopted</td>
</tr>
<tr>
<td>1926</td>
<td>International Sanitary Convention of 1926 adopted, revising 1912 Convention</td>
</tr>
<tr>
<td>1925</td>
<td>Agreement Concerning the Suppression of the Manufacture of, Internal Trade in, and Use of Prepared Opium adopted</td>
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<tr>
<td>1925</td>
<td>International Convention adopted by the Second Opium Conference</td>
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<tr>
<td>1927</td>
<td>Additional Protocol to the Pan-American Sanitary Code adopted</td>
</tr>
<tr>
<td>1928</td>
<td>Pan-American Sanitary Convention for Aerial Navigation adopted</td>
</tr>
<tr>
<td>1928</td>
<td>Convention with regard to Safeguarding Livestock Interests Through the Prevention of Infectious and Contagious Diseases adopted by Mexico and the United States</td>
</tr>
<tr>
<td>1929</td>
<td>International Convention for the Protection of Plants adopted</td>
</tr>
<tr>
<td>1929</td>
<td>Convention Concerning the Marking of the Weight on Heavy Packages Transported by Vessel adopted by the International Labor Organization, revised in 1932</td>
</tr>
<tr>
<td>1929</td>
<td>Convention Concerning the Protection Against Accidents of Workers Employed in Loading and Unloading of Ships adopted by the International Labor Organization</td>
</tr>
<tr>
<td>Year</td>
<td>Treaty Description</td>
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<tr>
<td>1930</td>
<td>Convention Concerning Anti-Diptheritic Serum adopted</td>
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<tr>
<td>1930</td>
<td>Exchange of Notes Constituting an Agreement Regarding the Measures to be Taken Against Dengue adopted by Syria, Lebanon, and Egypt</td>
</tr>
<tr>
<td>1931</td>
<td>Agreement Concerning the Suppression of Opium-Smoking adopted</td>
</tr>
<tr>
<td>1932</td>
<td>Convention Concerning the Protection Against Accidents of Workers Employed in Loading and Unloading Ships (Revised) adopted by the International Labor Organization</td>
</tr>
<tr>
<td>1933</td>
<td>International Sanitary Convention for Aerial Navigation adopted</td>
</tr>
<tr>
<td>1934</td>
<td>International Convention for Mutual Protection Against Dengue adopted</td>
</tr>
<tr>
<td>1934</td>
<td>International Agreement for Dispensing with Bills of Health, and International Agreement for Dispensing with Consular Visas on Bills of Health adopted</td>
</tr>
<tr>
<td>1935</td>
<td>International Convention for the Campaign Against Contagious Diseases in Animals adopted</td>
</tr>
<tr>
<td>1935</td>
<td>International Convention Concerning the Transit of Animals, Meat, and Other Products of Animal Origin adopted</td>
</tr>
<tr>
<td>1935</td>
<td>International Convention Concerning the Export and Import of Animal Products (Other than Meat, Meat Preparations, Fresh Animal Products, Milk, and Milk Products) adopted</td>
</tr>
<tr>
<td>1936</td>
<td>Convention for the Suppression of Illicit Traffic in Dangerous Drugs adopted</td>
</tr>
<tr>
<td>1938</td>
<td>Convention amending the 1926 International Sanitary Convention adopted</td>
</tr>
<tr>
<td>1944</td>
<td>International Sanitary Convention modifying the 1926 International Sanitary Convention adopted</td>
</tr>
</tbody>
</table>

This long list of treaties does not mean that using international law for public health objectives proved easy or always effective. In the area of infectious disease control, states took forty-one years, from the 1851 International Sanitary Conference until the 1892 International Sanitary
Convention, before they adopted a treaty successfully. Nor does the list give any indication of the efficacy of the various legal regimes on public health issues. What the list communicates, however, is the important role international law played in international health cooperation from the mid-nineteenth century until 1945. Prior to WHO’s creation, international law was a key instrument for the international promotion of health concerns.

B. Nature of WHO’s Legal Authority

Further evidence of the perceived importance of international law to the public health mission can be found in the international legal powers given to WHO at its creation. Through the WHO Constitution, the Organization was given the authority to adopt treaties addressing any matter within its competence and to adopt regulations in five specific areas. Although the Office International d’Hygiéne Publique was involved in drafting and negotiating treaties on public health issues, it did not have the express authority to adopt treaties that WHO received in 1948. The power to adopt regulations was without precedent in international health cooperation and was even more innovative because of the “contracting out” process established for the adoption of regulations. Regulations adopted by the World Health Assembly would become binding on all WHO member states unless they affirmatively opted out of the rules. This reversed the normal way states bound themselves to international agreements, namely having to accept affirmatively the obligations in the agreement. WHO’s regulations authority represented “a quasi-legislative process that was, at the time of WHO’s origins in the late 1940s, a radical approach in international law.”

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51. See supra Table 1; see also Richard N. Cooper, International Cooperation in Public Health as a Prologue to Macroeconomic Cooperation 86 (1986) (“It took over seventy years from the first call for international cooperation in the containment of the spread of contagious disease in 1834 to the time, in 1907, when an international organization was first put in place to deal with the problem; and even that represented only the beginning.”).

52. WHO Const. art. 19.

53. See id. art. 21. The five areas are: (1) sanitary and quarantine regulations; (2) nomenclatures on diseases, causes of death, and public health practices; (3) standards for diagnostic procedures for international use; (4) standards for the safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and (5) advertising and labeling of biological, pharmaceutical, and similar products moving in international commerce. See id.


55. See WHO Const. art. 22 (explaining the “contracting out” procedure).

Article 63 of the WHO Constitution recognizes the importance of national public health law to WHO's mission because it requires WHO member states to "communicate promptly to the Organization important laws, regulations, official reports and statistics pertaining to health which have been published in the State concerned." WHO publishes information received under Article 63 in the long-running International Digest of Health Legislation.

The WHO Constitution thus reflects the perceived importance of international law and national law to WHO's public health mission. Law appears to be central to WHO's mission as viewed through the WHO Constitution, which is consistent with the historical importance of international law in international health cooperation since the mid-nineteenth century. The need for international law created by the confluence of the structure of the international system and the globalization of public health finds recognition in the WHO Constitution, which embedded the importance of law within the formal international organization that would support global public health in the post World War II period.

C. The Neglect of Law by WHO

A theme of current interest in national and international law is WHO's neglect of its legal powers and responsibilities. To date, WHO has adopted no treaty on any matter within its competence. The first effort to use its Article 19 powers came in 1996 when the World Health Assembly instructed the Director-General to develop a framework convention on international tobacco control. The World Health Assembly has only utilized its regulations authority twice in adopting the IHR and the Nomenclature Regulations. In addition, the IHR have long been

procedure).

57. WHO CONST. art. 63.
59. See Fidler, The Future of the World Health Organization, supra note 12, at 1089 ("Since 1948, the potential for international legal activity created by the WHO Constitution has remained untapped."); L'hirondel & Yach, supra note 11, at 84 (noting that "some leading legal scholars and public health professionals believe that the Organization has underused its legislative or quasi-legislative powers"); Taylor, Making the World Health Organization Work, supra note 12, at 326 ("WHO has frustrated the full potential of the Health for All campaign by not using its constitutional powers to encourage states to develop international law that details national obligations pursuant to the right to health.").
61. See Fluss et al., supra note 12, at 20-21 (discussing the Nomenclature Regulations).
considered a failure in their attempt to provide maximum protection against the international spread of disease with minimum interference in world traffic. This neglect of law arises in connection with national public health law as well. Taylor observed that "WHO has traditionally appeared to envision its legislative role as neither active or even reactive, but merely observational."

The lack of interest in, and support for, international and national law on public health has manifested itself in human and financial resource allocations and, perhaps most importantly, in WHO's conceptual approach to global public health. Historically, WHO has not, outside the Legal Counsel's Office, retained lawyers as permanent staff members to work on public health issues. Financially, "WHO has traditionally devoted only a mere fraction of its regular budget to support all of the organization's legislative efforts at the country, regional and global levels." Such allocations of human and financial resources reflect an underlying philosophy or ethos permeating WHO in which law plays no important role. This attitude within WHO shaped the outlook of the post-1945 transnational Hippocratic society toward law and moved this society away from its historical connection with international law.

Critics of WHO have often pointed out its historical penchant for dealing with public health problems within a narrow "medical-technical" approach. WHO has historically been staffed predominantly by physicians, medical scientists, and public health experts; this composition produced "an ethos that looks at global health problems as medical-

62. See Fidler, supra note 16, at 843 ("Both WHO officials and international legal scholars agree that the IHR have failed to ensure the maximum security against the international spread of disease with minimum interference with world traffic."); Taylor, supra note 1, at 7 ("WHO officials have even acknowledged that the organization's past lawmaking efforts in these traditional areas [IHR and Nomenclature Regulations] have been a 'failure.'").

63. See L'Hirondel & Yach, supra note 11, at 84 (noting "global lack of capacity in public health law"); Taylor, supra note 1, at 7 (noting that "WHO has conventionally contributed only modest support to nations to further the development of national public health law").

64. Taylor, supra note 1, at 8.

65. See Fidler, The Future of the World Health Organization, supra note 12, at 1112 ("At present, WHO does not have any permanent or part-time staff members that have primary responsibility for matters of public international law."); Taylor, supra note 1, at 14 ("Currently, there is no specific unit or division at WHO, or even attorneys within any particular division, with the specific mandate to work on the elaboration of national and international health norms."). WHO has, however, recently retained lawyers to work on the framework convention for global tobacco control and the revision of the IHR.

66. Taylor, supra note 1, at 8.

67. See Fidler, The Future of the World Health Organization, supra note 12, at 1099 (citing numerous sources in arguing that "[g]eneral criticism of WHO's performance over the last twenty years frequently homes in on the medical-technical ethos issue").

68. See Taylor, Making the World Health Organization Work, supra note 12, at 336 (noting that WHO's "officials are largely a specialized, professional circle of physicians, scientists, and public health specialists").
technical issues to be resolved by the application of the healing arts.”

This medical-technical ethos did not exhibit interdisciplinary sensibilities about public health problems because its focus was narrow, static, relatively inflexible, and largely nonpolitical. International law fell outside this limited focus because the medical-technical ethos did “not need international law because the approach mandates application of the medical or technical resource or answer directly at the national or local level.” As the influential center of international efforts regarding health protection and promotion, WHO’s medical-technical ethos became the pervading perspective in the transnational Hippocratic society.

The decline in the importance of international law within WHO and the transnational Hippocratic society suggested that public health was being removed from the traditional dynamics of the general anarchical society. The confluence of the structure of the international system and the globalization of public health that earlier produced a significant role for international law no longer had the same impact within WHO. The reason for this change can be found in shifting attitudes toward the globalization of public health, and these attitudes shifted under the impact of scientific progress. In short, the medical-technical ethos arose in connection with major scientific advances and the political consequences of such advances within states.

WHO’s creation and first few decades coincided with enormous scientific advances against infectious diseases. The antibiotic revolution and the development of more and better vaccines “altered the balance of power in the struggle with infectious diseases in the favor of humanity.” The transnational Hippocratic society came to possess weapons against diseases that their predecessors never even dreamed would be possible. Arno Karlen has noted that “in the late nineteenth and early twentieth centuries, hardly a year went by without a major discovery about the cause, transmission, prevention, or cure of infectious disease.” These scientific successes continued through much of the twentieth century. Garrett observed that in the 1950s and 1960s “[n]early every week the medical establishment declared another ‘miracle breakthrough’ in humanity’s war with infectious disease.” Such scientific progress could not help but

70. Id.
71. Id. at 1100.
profundely shape the outlook of WHO and transnational Hippocratic society toward public health:

When public health benefits are perceived to flow from the application of the fruits of modern public health, medicine, and science, those practicing the healing art naturally focus on applying those fruits directly and expansively. From this understandable perspective, international law has only indirect relevance in that it provides the international organizational framework that allows public health officials and doctors to ease human suffering. 74

Scientific advances against disease came, however, to have a double-edged effect on the globalization of public health. On the one hand, the work of WHO, other international organizations, and nongovernmental organizations expanded the geographic reach of the new scientific developments, bringing people in the developing world significant improvements in health. 75 Since 1945, life expectancies have increased globally, providing one measure of the globalization of scientific progress. On the other hand, scientific developments eroded the concern about the globalization of public health in developed states. This erosion was particularly evident in the area of infectious diseases:

Armed with advanced public health systems and arsenals of antimicrobials, developed states had neither a burning interest in, nor prominent international systemic problems with, infectious disease control. The commitment to the common rules of international health law and the common institutions in the form of international health organizations was shallow, particularly in the post-1945 period. 76

Developed states “succeeded in renationalizing public health, in that public health reforms and antimicrobial treatments gave them more control of public health within their borders.” 77

As the globalization of public health faded as a threat to the national interests of developed states, internationalization in public health faded as an issue in the politics of the international system. Developed states did not need WHO or international law to apply successfully the fruits of scientific research. While international health cooperation had never been an issue of “high diplomacy” in the international system, the scientific progress of the post-1945 period helped lower its political profile even

75. See Yach & Bettcher, The Globalization of Public Health, I, supra note 20, at 735 (“The health benefits to developing countries of increased trade, diffusion of appropriate technologies, and acceptance of human rights throughout the world were emphasized by Roemer and Roemer in 1990.” (citation omitted)).
76. Fidler, Microbialpolitik, supra note 12, at 26.
The development of the medical-technical ethos within WHO did not, thus, become a concern in international relations until developed states again felt the globalization of public health threatening the health of their populations. At the same time, the medical-technical ethos found fertile ground in the developing world, which did not "conquer" infectious diseases as the developed states believed they had. Public health internationalization under WHO focused on applying scientific advances directly in developing countries through the "health transition" strategy. Garrett has observed that the health transition strategy was based on the premise that "as nations moved out of poverty and the basic food and housing needs of the populations were met, scientists could use the pharmaceutical and chemical tools at hand to wipe out parasites, bacteria, and viruses." There was, in other words, great demand in the post-1945 period for extensive global application by international organizations of the medical and technical achievements of modern science. Fulfilling this demand required little from international law, as the governments of developing states were generally willing to allow WHO to provide public health assistance in their territories.

These scientific and political factors help explain how the narrow medical-technical ethos became deeply embedded in WHO and the transnational Hippocratic society. Acknowledging these factors provides a better context for WHO's attitude toward international law during its first fifty years. Appreciating the forces that created the medical-technical ethos does not, however, mitigate the damage that the ethos's adoption, preservation, and stagnation has done to WHO. The increasing calls for, and WHO's own realization of the need for, multi-sectoral approaches to

78. See Fidler, Microbialpolitik, supra note 14, at 20-21 (analyzing impact of scientific developments on national interest of developed States in international health cooperation).
79. See Fidler, Mission Impossible? International Law and Infectious Diseases, supra note 12, at 500 (noting that developed states have made emerging infectious diseases an international agenda item because they again feel threatened). For arguments that developed states must re-engage their national interests in global public health, see Fidler, Microbialpolitik, supra note 12, at 50 (discussing importance of the national interests of developed states to the future of international public health); Richard L. Guerrant & Bronwyn L. Blackwood, Threats to Global Health and Survival: The Growing Crises of Tropical Infectious Diseases—Our "Unfinished Agenda," 28 CLINICAL INFECTIOUS DISEASES 966 (1999); Christopher P. Howson et al., The Pursuit of Global Health: The Relevance of Engagement for Developed Countries, 351 LANCET 586 (1998).
80. GARRETT, supra note 73, at 31.
81. See Fidler, The Future of the World Health Organization, supra note 12, at 1103 ("These explanations... do not vindicate WHO's behavior: the medical-technical ethos has damaged not only WHO's interest in international law but also the entire mission of the Organization.").
global public health portend a transformation in the ethos prevailing within WHO and the transnational Hippocratic society.  

IV. HEALTH EMBEDDED: THE PENETRATION OF INTERNATIONAL LAW BY THE VALUE OF HEALTH

Simply focusing on WHO's attitude toward international law in the post-1945 period would produce a distorted picture of the place of health in international law. Despite WHO's nonlegal approach, health protection and promotion is featured in many areas of international law and the efforts of many international organizations. International law reflecting the value of health incorporates concern for both the health of individuals and the health of populations. This is consistent with Guarrant and Blackwood's arguments that "[h]ealth is one of our most unassailable human values. It transcends all geographic, political, economic, and cultural barriers." Surprisingly, the presence of health as an objective of international law has not been widely recognized by either public health experts or international lawyers. Frank Grad has observed that domestically there is no neat package of legislation called "public health law," but rather a vast array of rules from many different legal areas. The same observation holds true for international law and health.

As WHO's attitude toward international law improves, recognizing the penetration of international law by the human value of health will be important for two reasons. First, WHO can marshal this penetration as ammunition in using international law to protect and promote health. Second, this penetration represents the true scope of the international legal challenge to WHO because the challenge is far greater than revising the IHR or adopting a framework convention on tobacco control. As I have argued, "[t]he current situation reveals that WHO faces an international legal tsunami because of the many areas of international law that directly affect WHO's work as an international health organization."

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82. See, e.g., Health for All, supra note 8, at boxes 2, 7 (stressing need for intersectoral approaches to global public health); Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-First Century—Report of the International Conference, WHO Doc. WHO/PPE/PAC/97.6 (Apr. 20-23, 1997).
83. Guarrant & Blackwood, supra note 79, at 966.
A. Health as an Objective of International Legal Regimes

The protection and promotion of human health can be found as a value enshrined in many different international legal regimes. A complete catalog of all the places where international law reflects the value of health is beyond the scope of this Article, but I briefly present six important international legal regimes that prominently feature health. My objective is not to analyze the nuances of these complicated international legal areas but simply to demonstrate the important, but underappreciated, point that the value of health has deeply penetrated modern international law.

1. International Trade Law

International trade agreements that liberalize trade between countries typically recognize that states may restrict trade to protect human health. Under the General Agreement on Tariffs and Trade (GATT), the protection of human, animal, and plant life and health is one of the few general exceptions that allow contracting parties to violate GATT provisions legitimately. Similar provisions exist in other multilateral trade agreements, such as the European Union and the North American Free Trade Agreement.

The right to restrict trade on public health grounds remains a prominent feature of the international trading system for both developed and developing states. Britain, for example, suffered huge economic losses as a result of bans other countries and the European Union imposed on its beef exports because of concerns about bovine spongiform encephalopathy (BSE) causing human disease. The United States and the European Union have engaged in a number of food safety disputes involving millions of dollars in traded products, the most well known of which is the controversy over the European Union ban on hormone-raised beef that has worked its
way through the entire World Trade Organization's dispute settlement system. The United States has also launched a new food import safety initiative to protect public health in the United States from unsafe foreign food. The right to restrict trade for public health reasons also affects exports from developing countries, as indicated by European Union rejections of African meat exports because of poor food control systems in African countries.

The sovereign right to restrict trade in order to protect health is subject under international trade law to scientific and trade-related disciplines, which ensure that health is truly the objective and that the measure taken to protect health does not unduly burden trade. The scientific disciplines exist to ensure that, when states enact health measures restricting trade, the measures are really designed to protect health and do not constitute protectionism disguised behind the fig leaf of health. The trade-related discipline usually takes the form of the requirement that the health measure be the least trade-restrictive measure available so that the damage to trade flows is proportionate to the health risk. The scientific and trade-related disciplines attempt to balance the objectives of health protection and trade liberalization.

While health protection is embedded in international trade law, controversies rage about whether GATT, the World Trade Organization (WTO), and the entire project of trade liberalization harm rather than respect human health. Critics have argued that trade liberalization makes


90. See James Bennet, President Wants F.D.A. to Regulate Foreign Produce, N.Y. TIMES, Oct. 3, 1997, at A1 (reporting on new Clinton administration policy on improving the quality of food imported into the United States); see also U.S. ENVTL. PROTECTION AGENCY, ET. AL., FOOD SAFETY FROM FARM TO TABLE: A NATIONAL FOOD-SAFETY INITIATIVE-REPORT TO THE PRESIDENT (1997).

91. See Meaty Trade Issues, 2 BRIDGES WKLY. TRADE NEWS DIG., Nov. 16, 1998, at para. 4 (reporting on comments of Zimbabwe's deputy minister for health and child welfare "that African meat exports to the EU are being rejected due to weak food control systems in African countries").

92. I have referred to these scientific disciplines as the "science paradigm" in international trade law. See Fidler, supra note 3, at 133-46 (analyzing the scientific disciplines in the SPS Agreement); Fidler, Trade and Health, supra note 12, at 317-22 (analyzing science paradigm under Article XX(b) of the GATT and the WTO's Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement)).

93. For analysis of the application of trade-related disciplines to scientifically justified sanitary and phytosanitary measures under the WTO, see Fidler, supra note 3, at 146-52, and Fidler, Trade and Health, supra note 12, at 339-49.
countries more vulnerable to the importation of unsafe food.\textsuperscript{94} The United States has been criticized for using national and international trade law to pry open developing-country markets for its tobacco exporters, fueling the pandemic of tobacco consumption and related diseases.\textsuperscript{95} Looking at the infectious disease and tobacco-related disease problems confronting the world, and the exacerbation of these problems by international trade, some might see "a Faustian bargain at work for states in the globalization of public health: support international trade and its modern rules and institutions and lose the ability to protect public health."\textsuperscript{96} In addition, the scientific disciplines do not always restrain countries from imposing unjustified restrictions on trade, as countries in East Africa discovered when the European Union banned their fresh fish exports without public health justification during cholera outbreaks in those countries.\textsuperscript{97}

Additional controversies have arisen in the international trade law area in connection with the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).\textsuperscript{98} TRIPS attempts to harmonize protection of intellectual property rights among WTO members using norms developed in industrialized countries. Public health experts have raised concerns that the TRIPS-heightened protection of pharmaceutical patents will adversely affect access to patented drugs in developing countries by raising prices.\textsuperscript{99} Prior to TRIPS, many developing countries did not recognize pharmaceutical patents in order to make drugs affordable

\textsuperscript{94} See, e.g., \textsc{public citizen global trade watch, nafta's broken promises: fast track to unsafe food} passim (1997).
\textsuperscript{95} See Fidler, \textit{Trade and Health}, supra note 12, at 306; Taylor, \textit{An International Regulatory Strategy for Global Tobacco Control}, supra note 12, at 264.
\textsuperscript{96} Fidler, \textit{Trade and Health}, supra note 12, at 308-09.
\textsuperscript{97} After the EU imposed these bans, both WHO and the U.N. Food and Agriculture Organization stated that import bans to protect against the importation of cholera were not justified on public health grounds. \textit{See Director-General Says Food Import Bans are Inappropriate for Fighting Cholera}, WHO Press Release WHO/24 (Feb. 16, 1998); U.N. Food and Agriculture Organization, \textit{Import Ban on Fish Products from Africa Not the Most Appropriate Answer}, U.N. Press Release PR98-21E (Mar. 25, 1998). The WHO Executive Director of Communicable Disease Programmes has stated that the EU "ban is illegal according to the International Health Regulations." Heymann, \textit{supra} note 6. The illegality of the EU fish bans under the IHR and the WTO's Agreement on the Application of Sanitary and Phytosanitary Measures was analyzed in ProMED-mail postings by David P. Fidler on January 13 and 17, 1998 under the heading \textit{Impact on Commercial Fishing—E. Africa}. For further discussion, see also \textsc{Fidler, supra} note 5, at 80.
\textsuperscript{99} See \textsc{Carlos M. Correa, The Uruguay Round and Drugs} 26 (1997) (arguing that the only likely effect of compliance with TRIPS in developing countries is higher prices); \textit{WHO to Address Trade and Pharmaceuticals}, WHO Press Release WHA/13 (May 22, 1999) (noting that some states "fear that TRIPS requirements for intellectual property rights could lead to a higher cost burden for newer, patent-protected essential drugs").
and widely available to their peoples. With TRIPS, developing country members of the WTO must comply with the Agreement's patent provisions or face claims and possibly trade sanctions through the WTO dispute settlement process. Thailand's and South Africa's attempts to utilize compulsory licensing provisions in TRIPS and parallel importing for HIV therapies have met with hostility and threats from Western pharmaceutical companies and the United States government.

WHO became involved in this controversy when its Executive Board recommended adoption by the World Health Assembly of a resolution that urged WHO member states "to ensure that public health rather than commercial interests have primacy in pharmaceutical and health policies and to review their options under the Agreement on Trade Related Aspects of Intellectual Property Rights to safeguard access to essential drugs." Governments in the United States and Europe, along with Western pharmaceutical companies, attacked this resolution in the World Health Assembly. In May 1998, the World Health Assembly sent the resolution back to the Executive Board because it could not be adopted in its present

100. See Bernard Pécool et al., Access to Essential Drugs in Poor Countries: A Lost Battle?, 281 JAMA 361, 365 (1999) (noting that "many developing countries do not fully acknowledge patent protection rights for pharmaceuticals").


102. TRIPS, supra note 98, art. 31.

103. Parallel imports are imports of patented or copyrighted products from one country where the products are cheaper into another country where the prices for the same products are more expensive without the permission of the patent or copyright holder.


The United States, the European Union, and Japan voiced opposition to the Executive Board’s resolution. A WHO Ad Hoc Working Group met in October 1998 to discuss the Revised Drug Strategy resolution and, after “often bitter discussions,” a new resolution emerged that was eventually adopted by the Executive Board and the World Health Assembly in 1999. The revised resolution urged WHO member states “to ensure that public health interests are paramount in pharmaceutical and health policies; [and] . . . to explore and review their options under relevant international agreements, including trade agreements, to safeguard access to essential drugs.” The story of the WHO resolution illustrates that substantial tension exists between the international protection of intellectual property rights and national and global public health objectives.

Another area in international trade law that relates to the value of health is the General Agreement on Trade in Services (GATS). Public health experts see both opportunities for and challenges to public health in GATS. GATS might, for example, benefit public health by increasing developing country’s access to health services and information through telemedicine. GATS may, however, exacerbate a “brain drain” in health services professionals from the developing to the developed world, further eroding health system capabilities in developing countries. There is also concern that GATS might foster the privatization of health care and health insurance in some countries, which might erode universal access to health services and worsen health prospects for the poor and disadvantaged.

I cannot do justice to these various health controversies in international trade law, but their existence at least demonstrates that health affects the dynamics of international trade law and vice versa. It should come as no

107. See World Health Assembly, Third Report of Committee A (Draft), 51st Ass., WHO Doc. A51/41 (May 15, 1998) (“The Committee decided to refer resolution EB101.R24 on ‘Revised drug strategy’ back to the Executive Board, to be further considered . . . , taking into consideration the discussions of this matter in the Committee and in a drafting group.”).
108. See Consumer Project on Technology, supra note 106.
109. Id.
110. See World Health Assembly, Revised Drug Strategy, 52d Ass., WHO Doc. WHA52.19 (May 24, 1999).
111. Id. at No. 1(2)-(3).
113. See, e.g., UNCTAD Secretariat, International Trade in Health Services: Difficulties and Opportunities for Developing Countries, in INTERNATIONAL TRADE IN HEALTH SERVICES 3 (S. Zarrilli & C. Kinnon eds., 1998).
116. See id. at 46.
surprise, then, that scholars have urged WHO to pay more attention to international trade law as part of its mission to protect and promote human health.

2. International Humanitarian Law

Health is also embedded in international humanitarian law, otherwise known as the laws of war. In fact, health has been a core value of international humanitarian law since it began to develop in the mid-nineteenth century. Contemporary international humanitarian law contains detailed rules protecting the health of combatants, prisoners of war, and non-combatants in international and civil armed conflicts. This body of international law imposes health-related obligations on belligerents and grants health-related rights to individuals. For example, international humanitarian law requires that prisoners of war and civilian detainees have access to sanitary living conditions and adequate medical care. Ironically, these wartime rights of access to sanitary living conditions and adequate medical care are more than the so-called “human right to health” currently provides individuals in peacetime; financial constraints are not a basis upon which belligerents can excuse their failure to fulfill their responsibilities. Violations of international humanitarian law protecting health are war crimes punishable by national or international criminal courts.

Like health’s status in international trade law, health’s status in international humanitarian law is not without problems. As illustrated by the air campaigns in the Gulf War, attacking electrical systems as a legitimate military target creates large-scale public health problems in civilian populations. More worrisome are the repeated, massive, and intentional violations of international humanitarian law by belligerents in international and civil armed conflicts. The precarious nature of the “rights” to sanitary living conditions and medical care were most recently exposed in the Yugoslavian war, in which prisoners of war and civilian detainees were subject to appalling treatment. While such violations cast a dark shadow over the health protection offered by international humanitarian law, there is little question that this body of international law

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117. See, e.g., Plotkin & Kimball, supra note 12, at 6.
118. For analysis of international humanitarian law’s protections against infectious disease, see FIDLER, supra note 3, at 233-38.
119. See id. at 236-38.
120. See id. at 238-42.
121. See id. at 234-35.
122. See id. at 237-38.
enshrines, however precariously, health protection as a fundamental objective of international relations.

3. Arms Control

Health is also an apparent value in international law on arms control. International law prohibits, for example, the use of any weapon that causes superfluous injury or unnecessary suffering.\textsuperscript{123} This principle has been behind international legal prohibitions on the use of certain weapons, such as expanding bullets\textsuperscript{124} and blinding laser weapons.\textsuperscript{125} The International Committee of the Red Cross has also proposed a more objective approach to the application of the superfluous injury or unnecessary suffering principle to the development and use of new weapons systems.\textsuperscript{126}

Health has been paramount too in the development of specific international legal regimes that ban the use, production, and stockpiling of certain classes of weapons. In this category are biological weapons,\textsuperscript{127} chemical weapons,\textsuperscript{128} and anti-personnel landmines.\textsuperscript{129} While similar to the bans based directly on the principle of superfluous injury or unnecessary suffering, the biological, chemical, and landmine bans address threats to the health of populations and the environment in addition to addressing concerns for individual health. Arms control is traditionally seen as the province of national security and foreign policy experts, but these


\textsuperscript{126} See International Committee of the Red Cross, The SIRUS Project: Towards a Determination of Which Weapons Cause "Superfluous Injury or Unnecessary Suffering" (1997).


international legal regimes indicate that arms control is also a legitimate
realm for public health experts.

The advisory opinion of the International Court of Justice (ICJ) in
Legality of the Use by a State of Nuclear Weapons in Armed Conflict raised
some interesting and controversial issues in the relationship between public
health and nuclear arms control.130 WHO asked the ICJ for an advisory
opinion on whether the use of nuclear weapons by a state could be lawful
under international law given the adverse health and environmental
consequences of the use of a nuclear weapon.131 The ICJ rejected, however,
the claim that WHO had competence under its Constitution to raise the
question of the legality of the use of nuclear weapons.132 Such an
interpretation of WHO's Constitution cuts against the role of health
protection found in international law generally and other arms control
regimes specifically. In his dissenting opinion, Judge Weeramantry linked
the question of the legality of the use by a state of a nuclear weapon with
state obligations under international law,133 arguing that "[i]t appears
evident that there is here a clear contradiction between State obligations
under international law in relation to health and the use of the nuclear
weapon."134 Judge Weeramantry also argued that use of a nuclear weapon
"would . . . be a breach of State obligations under humanitarian law in
relation to human health, as is clear with chemical, bacteriological or
asphyxiating weapons."135

The ICJ's international legal conundrum arose as a consequence of the
confluence of two facts. While it is hard, if not impossible, to see how a
nuclear weapon could be used in accordance with international
humanitarian law, the production, stockpiling, and use of nuclear weapons
has not been prohibited in international law. This conundrum appeared
more sharply in the ICJ's advisory opinion in Legality of the Threat or Use
of Nuclear Weapons in response to a request from the United Nations
General Assembly,136 which had indisputable competence to request an
advisory opinion.137 Despite acknowledging the horrific health and
environmental effects of the use of a nuclear weapon,138 the ICJ held that

130. Legality of the Use by a State of Nuclear Weapons in Armed Conflict, 1996 I.C.J. 66 (July
8).
131. See id. at 67-68.
132. See id. at 74-84.
133. See id. at 143-45 (Weeramantry, J., dissenting).
134. Id. at 145.
135. Id.; see also id. at 182-84 (Koroma, J., dissenting) (analyzing relevance of health obli-
gations of states found in international humanitarian law).
136. Legality of the Threat or Use of Nuclear Weapons, 1996 I.C.J. 226, 226 (July 8).
137. See id. at 232-33.
138. See id. at 243-44.
international law (1) did not directly prohibit the use of nuclear weapons, and (2) required that any use of a nuclear weapon had to comply with all requirements in international humanitarian law. The ICJ split seven votes to seven on the proposition "that the threat or use of nuclear weapons would generally be contrary to the rules of international law applicable in armed conflict, and in particular the principles and rules of humanitarian law." The ICJ also split seven votes to seven on the issue of self defense: "[The Court] cannot reach a definitive conclusion as to the legality or illegality of the use of nuclear weapons by a State in an extreme circumstance of self-defense, in which its very survival would be at stake." This advisory opinion leaves the relationship between health, nuclear weapons, and international law in a state of confusion.

The public health connection to arms control can also be seen in recent attempts to regulate the international trade in conventional weapons. In 1997, a group of Nobel Peace Prize Laureates launched an effort to bring the problems generated by conventional arms transfers to the world’s attention. The Nobel Laureates stressed the damage conventional arms and arms transfers do to democracy, human rights, and health needs of peoples around the world. This effort stimulated the Organization of American States to draft two conventions regulating aspects of the international trade in conventional arms: (1) the Inter-American Convention Against the Illicit Manufacturing of and Trafficking in Firearms, Ammunition, Explosives, and Other Related Materials; and (2) the Inter-American Convention on Transparency in Conventional Weapons Acquisitions.

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139. See id. at 248-53, 253-55 (analyzing relevant treaty law and customary international law).
140. See id. at 256-60 (analyzing application of international humanitarian law to the use of nuclear weapons).
141. Id. at 266.
142. Id. at 263.
144. See Nobel Peace Laureates' International Code of Conduct on Arms Transfers, supra note 143, at Introductory Memorandum.
4. International Human Rights Law

Health also appears as a significant feature in international human rights law. While the purported "human right to health" seems the most relevant aspect of human rights law, health protection is an objective in other areas of such law. For example, the prohibition against torture\(^\text{147}\) seeks not only to protect individual integrity but also to protect the physical well-being of individuals under government detention. Similarly, the related prohibition against cruel, degrading, or other inhumane treatment or punishment\(^\text{148}\) protects the mental and physical health of individuals under the power of the state. In a recent case, the European Court of Human Rights held that deportation of an individual suffering from AIDS to his native country would constitute cruel, inhumane, or degrading treatment because his native country could not provide adequate medical treatment, which would result in an earlier death.\(^\text{149}\)

International human rights treaties also include specific health-related protections for women and children.\(^\text{150}\)

International human rights law is also important in ensuring that people suffering from diseases are treated appropriately by government authorities. Any public health measure that restricts civil and political rights, such as freedom of movement, must satisfy strict human rights criteria before such measure is considered legitimate.\(^\text{151}\)

\(^{147}\) International law prohibits torture. See Ian Brownlie, Principles of Public International Law 582 (5th ed. 1998).

\(^{148}\) International law prohibits cruel, degrading, or other inhumane treatment of individuals. See id.


\(^{150}\) See, e.g., Convention on the Rights of the Child, Nov. 20, 1989, art. 24, 28 I.L.M. 1456 (declaring states parties' recognition of the "right of the child to the enjoyment of the highest attainable standard of health"); Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, art. 12, 1249 U.N.T.S. 13 (obliging states parties to "take all appropriate measures to eliminate discrimination against women in the field of health care").

\(^{151}\) These criteria are that the restricting measure (1) must be prescribed by law; (2) must be applied in a non-discriminatory manner; (3) must relate to a compelling public interest (for example the protection of health); and (4) must be necessary to achieve the compelling public interest. See Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, U.N. Doc. E/CN.4/1984/4 (1984), reprinted in 7 HUM. RTS. Q. 3 (1985).

\(^{152}\) See Fidler, supra note 3, at 213 ("The international condemnation of HIV/AIDS-related discrimination has . . . allowed international human rights bodies to claim that health falls into the 'other status' language of the ICCPR and other human rights instruments.").
The most obvious health-related human right—the human right to health—unfortunately remains mired in confusion. The meaning and scope of the human right to health remains subject to controversial debate, which to date has left this right rather empty from an international-legal point of view. It constitutes, to borrow a phrase from Winston Churchill, a riddle inside a mystery wrapped in an enigma. In Part III.C, I return to the human right to health in an effort to provide some clarity amidst the confusion.

Like health's role in international trade law and international humanitarian law, the presence of health in international human rights law has not guaranteed the protection of health. Serious problems exist getting states to comply with the international human rights obligations in connection with the prohibition against torture, let alone the fulfillment of the right to health. The HIV/AIDS pandemic produced worldwide violations of human rights by governments, which supported discrimination and actions not justified on public health grounds. These general problems and specific examples of human rights violations only heighten the importance of elevating health on the international legal and political agendas.

5. International Labor Law

The International Labor Organization (ILO) has proved active in developing international legal rules that protect workers around the world. As part of this activity, the ILO has established international rules governing occupational health and safety. The ILO Convention Concerning Occupational Safety and Health and the Working Environment applies to all workers in all economic activities and requires states parties to formulate, implement, and review a national policy on occupational

153. See id. at 181 ("Lamentations about the difficulty of determining the content of the right to health populate the literature on the right to health.").
154. See, e.g., Tomasevski, supra note 12, at 873 (arguing that "the right to health has not conceptually progressed from the time it was first proclaimed, not even to define the core terms health and right in the proclaimed right to health").
155. See id. at 870 (noting that the HIV/AIDS pandemic provoked "an entire gamut of public health measures originating from past centuries, some of which are compulsory, coercive and restrictive").
156. See Virginia A. Leary, Labor, in 1 UNITED NATIONS LEGAL ORDER 473, 473 (Oscar Schachter & Christopher C. Joyner eds., 1995) (noting that "[t]he body of norms on labor adopted within the United Nations constitutes a most complete and detailed international system of rules governing a field traditionally of domestic concern").
health and safety.\textsuperscript{157} The policy’s aim “shall be to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising . . . the causes of hazards inherent in the working environment.”\textsuperscript{158} This Convention illustrates that the ILO has made the protection and promotion of worker health a cornerstone of its international standard-setting efforts. This is an area in which WHO’s international legal efforts would support rather than supplant the ILO’s decades-long international legal endeavors.

Like other areas into which international law incorporates the value of health, the record in the international labor law area is mixed at best. While ILO conventions have helped improve working conditions in some states,\textsuperscript{159} the picture remains depressing in many places. Particularly worrisome is the exploitation of child labor, which threatens the physical and mental health of millions of vulnerable children in many regions.\textsuperscript{160}

6. International Environmental Law

Much of the enormous body of international environmental law seeks to protect human health from various threats caused by pollution and environmental degradation. International legal rules on transboundary air pollution;\textsuperscript{161} transboundary water pollution;\textsuperscript{162} marine pollution;\textsuperscript{163} transboundary shipment of hazardous wastes, chemicals, and pesticides;\textsuperscript{164}
nuclear accidents,\textsuperscript{165} protection of biodiversity,\textsuperscript{166} depletion of the ozone layer,\textsuperscript{167} and climate change\textsuperscript{168} directly relate to the objective of protecting human health.\textsuperscript{169} While protecting human health is not the only objective of international environmental law, it ranks as one of the most important goals of this body of international law. In this realm, the United Nations Environment Programme has taken the international legal lead in developing new international legal norms and working with U.N. member states on national environmental law.\textsuperscript{170} While the effectiveness of the various international environmental legal regimes differs, this great body of law communicates deep concern for the relationship between human and environmental health.

\subsection*{D. Importance of Health's Penetration of International Law to WHO}

Part IV.A's brief and incomplete overview of the penetration of various international legal regimes by the value of health protection and promotion suggests that WHO's historical neglect of international law is even more suspect as a strategy for global public health. Just as domestic public health law cannot be easily contained within a single legal area, international law relating to health spreads across virtually every aspect of international relations. In short, "international health law" goes far beyond what WHO may adopt under its international legal powers and involves diverse international legal regimes developed in different contexts by different international and nongovernmental organizations. From the international legal perspective, health is a multi-sectoral objective. WHO's nonlegal, narrow medical-technical ethos clearly was and is not suited to

\footnotesize\textsuperscript{165} See, e.g., IAEA Convention on Nuclear Safety, IAEA Doc. INFCIRC/449 (July 5, 1994); Convention on Early Notification of a Nuclear Accident, IAEA Doc. INFCIRC/335 (Sept. 26, 1986).


\footnotesize\textsuperscript{168} See United Nations Conference on Environment and Development: Framework Convention on Climate Change, May 9, 1992, 31 I.L.M. 849. For analysis of this Convention, see Nanda, supra note 166, at 113-18.

\footnotesize\textsuperscript{169} On links between these environmental threats and human health, see World Health Org., \textit{Health and Environment in Sustaining Development} (1997); \textit{Climate Change and Human Health} (A. J. McMichael et al. eds., 1996).

handle the challenges that health protection and promotion pose for many areas of international law.

The penetration of international law by the value of health also means that WHO will not be the only, or in some cases even the primary, international organization dealing with health issues. This reality places a premium on WHO's ability to work with other international organizations on health issues. WHO cannot take the lead in all these international legal contexts, but it can improve its ability to support health as an international legal value by working more effectively with other international organizations and nongovernmental organizations in the context of these diverse, complex, and often troubled international legal regimes.

E. Analyzing the Riddle Inside a Mystery Wrapped in an Enigma

Comprehending the penetration of international law by the value of health also might help refocus efforts on the confusing human right to health. At the risk of oversimplification, the debates surrounding the right to health often involve pro and con arguments about whether the right means that individuals have a human right to health care. Also, debates contain arguments about whether the right to health also requires governments to provide not only access to health care but also all the conditions necessary for a healthy life, specifically food, water, housing, education, and employment. While these are important issues, these debates have not advanced the right to health much as a matter of international law. However, any discussion of international law and global public health eventually has to confront the human right to health. In this section, Part IV.C, I approach the human right to health with the understanding that health has penetrated many different international legal regimes. I undertake this analysis not to pretend that it solves the riddle, clarifies the mystery, or dissipates the enigma, but rather to connect the human right to health with other places in international law where the value of health is embedded.


172. See id. (emphasizing intensification of WHO's relationships with other intergovernmental organizations); id. at 1121 (stressing importance of NGO networks to WHO's work).


174. See, e.g., LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 29 (1997) (arguing that government obligations under the right to health go beyond providing health services to include providing sanitation, clean air, clean water, housing, and education).
The discourse about the right to health has suffered from the classification of human rights into two categories: civil and political rights and economic, social, and cultural rights. This distinction is loosely based on the idea that governments are required to refrain from certain actions in protecting civil and political rights, while economic, social, and cultural rights require them to provide individuals with services and resources. In fact, protecting civil and political rights requires governments provide services and spend human and financial capital to ensure respect for civil and political rights. Health is a good example of a human right that falls within both civil and political rights, and economic, social, and cultural rights.

1. Violations of Civil and Political Rights as Violations of the Right to Health

Looking beyond the artificial separation of human rights into two isolated categories helps us see that violations of civil and political rights that protect health in peace or war can also be violations of the right to health. A government’s intentional infliction of mental and physical damage on an individual should be seen as a violation not only of the prohibition against torture, but also of the right to health. The same reasoning applies to violations of the prohibition against cruel, degrading, or other inhumane treatment or punishment.

The fact that the same act can violate two different human rights is not a conceptual obstacle. Nor does appealing to the right to health diminish the importance of the right to be free from torture or cruel, degrading, or other inhumane treatment. Human rights precedents confirm this. Up to 1994, the Inter-American Commission on Human Rights held in eight cases that torture and other cruel and degrading treatment violated the right to health (and other rights) enshrined in the American Declaration of Human Rights. The right to health should mean, at a minimum, that an individual’s mental and physical health should be protected from governmental acts of torture and cruel, degrading, or other inhumane

175. See R. J. Vincent, Human Rights and International Relations 11-13 (1986) (discussing distinction between civil and political rights and economic, social, and cultural rights).
176. See id. at 8, 10 (noting distinction between negative and positive rights).
177. See Molinari, supra note 173, at 47 (noting the right to health has features of both positive and negative rights).
178. See id. ("The right to health . . . includes a negative aspect in that the beneficiaries have a right to expect the State to abstain from any act that might jeopardize their health.").
treatment. International humanitarian law, which contains the same prohibitions, helps underscore this point.\textsuperscript{180}

Violations of other civil and political rights can also be seen as violations of the right to health.\textsuperscript{181} The compulsory isolation or detention of an individual suffering from a disease without a public health justification violates not only the freedom of movement but also the right to health because the isolation or detention serves no legitimate public health purpose. Compulsory treatment of an individual suffering from a disease when the treatment is not medically justified and potentially harmful would also violate the right to health, as well as the right to security of person. Further, any individual subjected to medical or scientific experimentation without his or her free consent suffers violations of civil and political rights and the right to health.

Each of the above examples represents violations of civil and political rights by governments that can also be held to violate the right to health. These types of cases form a conceptual core for the right to health because they build on existing international law relating to health and establish uncontroversial guidelines for government behavior vis-a-vis human health. In addition, the principle of progressive realization applicable to economic, social, and cultural rights does not excuse government violations of civil and political rights.\textsuperscript{182} The scope of the right to health cannot, however, stop with this core. The scope of the right to health expands from this core in a pattern of concentric circles as illustrated by Figure 1.\textsuperscript{183}

\begin{itemize}
\item \textsuperscript{180} See \textit{supra} Part IV.A.2.
\item \textsuperscript{181} See \textit{generally} International Covenant on Civil and Political Rights, \textit{concluded} Dec. 16, 1966, 993 U.N.T.S. 171.
\item \textsuperscript{182} Generally, the principle of progressive realization relates fulfillment of the duty to provide economic, social, and cultural rights to the economic ability of the state. A state is only legally bound to fulfill these rights to the extent its economic resources allow.
\item \textsuperscript{183} See Molinari, \textit{supra} note 173, at 47 (arguing that many human rights move "in the manner of concentric circles" from "areas that are definite" to "others that become increasingly ill-defined the further one moves from the interpretive data").
\end{itemize}
2. Regulatory Failures as Violations of the Right to Health

The next level involves governmental failures to regulate adequately governmental and private activities that pose threats to human health. What I have in mind here is similar to what Gostin and Lazzarini described as minimum content for the right to health: "the state would have a responsibility, within the limits of its available resources, to intervene to prevent or reduce serious threats to the health of individuals or populations." The responsibility to intervene, or to regulate, applies to both governmental services and private enterprises. A government violates the right to health when, for example, it knowingly allows government entities and private companies within its jurisdiction to expose workers to serious health threats. In these instances, the right to health finds synergy with international labor law. Violations of basic health-related standards found in international labor law would, thus, constitute violations of the right to health as well.

184. GOSTIN & LAZZARINI, supra note 174, at 29.
Similarly, regulatory failure can lead to a violation of the right to health by a government knowingly allowing health-threatening pollution, environmental degradation, or economic development to occur without taking or requiring mitigative action. In the *Yanomami Tribe Case*, the Inter-American Commission on Human Rights held that the Brazilian government's road-building program in the Amazon violated, among other rights, the right of the tribe members to preservation of their health enshrined in Article XI of the American Declaration of Human Rights.185 The Inter-American Commission determined that, "in permitting the massive penetration into the Indians' territory of outsiders carrying various contagious diseases that have caused many victims within the Indian community and in not providing the essential medical care to the persons affected,"186 the Brazilian government violated the tribe's right to health.187 The relevance of international environmental law to these types of regulatory failures is clear. The *Yanomami Tribe Case* arguably places the right to health within the framework of the standard of sustainable development in international environmental law.188 Economic development is not sustainable if it triggers environmental degradation that foreseeably threatens human health.189 Governments can take regulatory action to prevent or mitigate such health threats from environmental alteration consistent with the precautionary principle that forms part of international environmental law.190

While the principle of progressive realization plays no role in connection with violations of civil and political rights that damage health, it begins to have an impact in connection with violations of the right to health resulting from failures to regulate against serious, foreseeable threats to health. Thus, arguments that governmental failures to regulate violate the right to health are vulnerable to counter arguments pleading the government's lack of resources to regulate adequately. To avoid having the principle of progressive realization simply excuse governmental failures to regulate, governments should face heightened scrutiny under international human rights law. Governmental failures to regulate that lead to health damage to individuals and groups should be considered prima facie violations of the right to health, unless the actions producing the damage (1) are prescribed by law or at least not prohibited by law, (2) relate to a

186. Id. at 30.
187. See id. at 33.
188. See BIRNIE & BOYLE, supra note 161, at 122-24 (discussing the principle of sustainable development).
189. See id. at 95-97.
190. See id. at 97-98 (discussing the precautionary principle).
compelling public interest, and (3) are necessary to achieve the compelling public interest, meaning that the actions create the least health-damaging effects possible to achieve the public interest in question. This approach borrows, of course, from the disciplines applied to governmental actions that restrict civil and political rights. The approach means that the government could not rebut the prima facie violation of the right to health through arguments claiming resource scarcity alone.

3. Failure to Provide Access to Basic Public Health Services and Information as a Violation of the Right to Health

The next concentric circle involves governmental failures to provide access to basic public health services and health information. When a government grossly and systematically fails to provide its people with access to (1) very basic health services, such as potable water, sewage systems, and immunizations, and (2) basic health information, it violates the right to health. A government would also violate the right to health in discriminating on the basis of race, gender, nationality, or health status in providing access to health services and information.

WHO’s emphasis on primary health care in its Health for All policy provides one benchmark against which to evaluate a government’s provision of basic public health services and information. In its primary health care package, WHO stressed the following: education about controlling and preventing health problems, adequate food and proper nutrition, safe water supplies and basic sanitation, maternal and child health, immunization against major infectious diseases, control and prevention of locally endemic diseases, appropriate treatment for common diseases and injuries, and provision of essential drugs. The thrust behind WHO’s primary health care package was the effort to establish “a health


192. In the Ache Tribe Case, the Inter-American Commission on Human Rights held that Paraguay violated the right to health in the American Declaration of Human Rights by withholding from members of the Ache Tribe medical treatment during infectious disease epidemics. Case 1802, Inter-Am. C.H.R. 36-7, OEA/ser. L/V/11.43, doc. 21 (1977). The Ache Tribe Case “emphasizes the importance of not only the principle of non-discrimination in the right to health but also the fundamental duties of governments in controlling infectious diseases.” FIDLER, supra note 3, at 192.

193. See Taylor, Making the World Health Organization Work, supra note 12, at 315 (summarizing WHO’s Health for All primary health care strategy).
baseline below which no individuals in any country should find themselves."¹⁹⁴

Unfortunately, the principle of progressive realization has more of an impact when the right to health requires the provision of basic public health services and information. While belligerents cannot use economic poverty as an excuse for not providing prisoners of war and civilian detainees with medical care under international humanitarian law, the right to health in the peace-time context has always been qualified by the principle of progressive realization. Thus, the principle of progressive realization undermines the establishment of a universal health baseline of basic public health services and information because the principle renders health standards relative to the availability of economic resources.¹⁹⁵ Other international legal regimes become less helpful at this stage in analyzing the right to health because they generally do not establish standards governing what public health services and information governments should provide.

In his analysis of the International Covenant on Economic, Social, and Cultural Rights, which contains the right to health, Matthew Craven observed that the Committee on Economic, Social, and Cultural Rights favors minimum core obligations that cannot be excused by pleading lack of economic resources alone.¹⁹⁶ As Craven argued, “[t]hese minimum standards should be achieved by all States, irrespective of their economic situation, at the earliest possible moment.”¹⁹⁷ The “minimum standards” approach raises, of course, the question of what the minimum standards for the provision of basic public health services and information are or should be.¹⁹⁸ Should these minimum standards be the package of items in WHO’s Health for All primary health care strategy? Or, should the minimum core be restricted to more specific problems, such as controlling infectious diseases?¹⁹⁹

In the World Health Report 1999, WHO presented the concept of “new universalism” to guide health policy in its member states.²⁰⁰ WHO argued that “classical universalism,” with its emphasis on universal access to

¹⁹⁵. See GOSTIN & LAZZARINI, supra note 174, at 29 (acknowledging that defining health based on the principle of progressive realization “does not ensure a minimal standard of health and allows differential responses to health threats based on the available economic resources”).
¹⁹⁶. See CRAVEN, supra note 191, at 138-41.
¹⁹⁷. Id. at 141.
¹⁹⁸. Craven notes ambiguity in the Committee on Economic, Social, and Cultural Rights regarding the “minimum standards” approach, so I am not claiming that this approach constitutes the state of practice in connection with economic, social, and cultural rights. See id. at 141-44.
¹⁹⁹. I make an argument for a minimum core for the right to health in regards to infectious disease control in FIDLER, supra note 3, at 187-97.
²⁰⁰. WORLD HEALTH REPORT 1999, supra note 3, at xiv-xv, 43.
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comprehensive health services, was no longer a feasible model for health system development. The "new universalism" concept stresses that universal access to health services remains a fundamental principle, but it recognizes that governments cannot provide citizens with universal access to all health services. With this concept, WHO highlighted the economic constraints holding back health system development in many countries. While presented as a new approach to health system development, the concept clearly contains parallels with the right to health and principle of progressive realization. In the World Health Report 1999, WHO did not lay down a minimum core of health services that the "new universalism" requires. Like the right to health, much is left contingent on a country's economic resources.

Even if there were consensus about a minimum core within WHO or in international law, the problem of the lack of economic resources would continue to haunt the right to health. As Craven has pointed out, the "minimum standards" approach focuses critical attention on those countries with the fewest available resources to provide public health services and information. From the perspective of developing countries, such an approach is likely to encourage them to cling even more strongly to the principle of progressive realization and to demand more assistance from the developed world. At this point in the right to health analysis, it becomes very hard to construct clear legal criteria for analysis.

4. Government's Responsibility to Provide Access to Basic Factors Affecting Health

The final concentric circle in this right to health analysis is a government's responsibility to provide nondiscriminatory access to basic social determinants of human health, such as education, housing, and employment. Here the analysis has reached the broadest scope of the possible meanings of the right to health and the level at which the principle of progressive realization has its greatest impact. In essence, the idea here is that the right to health depends on the fulfillment of other economic, social, and cultural rights (for example the right to education, right to housing, right to work), each of which is itself subject to the principle of

201. See id. at xiv.
202. See id. at xv, 43.
203. See id.
204. See id. at xiv.
205. See id. at xv, 43.
206. See id. at 43 ("A benefit package has to be clearly defined in the light of the resources available . . . ").
207. See CRAVEN, supra note 191, at 143-44.
progressive realization. This final concentric circle perhaps represents political aspiration more than it does an ascertainable legal standard against which to hold governments responsible under the right to health.

5. Summary of the Right to Health

The foregoing approach to the right to health attempted to integrate familiar themes from right to health debates with the penetration of the value of health in other international legal contexts. Whether this approach advances the discourse on the right to health I leave the reader to decide, but the approach is not primarily designed to provide a black and white answer to the questions about the meaning of the right to health. While my approach provides one way to look at the right to health, it is also designed to facilitate an international legal approach to the right to health that integrates norms and thinking developed in different areas of international law. While this complicates the discourse on the right to health, I think it also allows us to deepen consideration of health throughout all of international law, not just in connection with the right to health. In the long run, elevating health as a value across the entire field of international law will better serve human health than debating the content of the right to health in the traditional way.

The controversy about whether trade liberalization undermines a state’s sovereign right to protect human health illustrates my arguments. Within this controversy is the accusation that trade liberalization does not respect health concerns and that international trade rules are set up so that trade trumps health. Elevating the profile of health as a value in international law, as well as forcing more discussion about the human right to health, is needed to give health a more powerful resonance in all aspects of international governance. Rather than merely appearing as a disguise for protectionist urges, the sovereign right to protect human health would be connected in powerful ways to a variety of international legal regimes and the right to health. My approach to the right to health seeks to provide one strategy for integrating international legal thinking on health in order to raise its profile in the politics and law of the anarchical society.


An understanding of the future role of international law in global public health also has to take into account the full scope of globalization's impact on international relations. My earlier analysis showed how the globalization of public health, combined with the structure of the
international system, produced a need for international law to play a role in global public health. The emphasis on the structure of the international system and international law's traditional role in facilitating inter-state cooperation might, however, be questioned given the widespread belief that globalization as a general phenomenon is undermining the sovereign state in unprecedented ways. If globalization indeed reduces the ability of a state to determine what happens within its territory, then the state's ability to fulfill commitments made through international law is subject to doubt. Similarly, a state's ability to react to globalization problems through national law also becomes subject to uncertainty. The issue here is not the disappearance of formal sovereignty or territorial jurisdiction because states formally remain sovereign and supreme in prescriptive jurisdiction within their borders. The concern involves the erosion of the state's substantive ability to fulfill international legal commitments and to pursue vigorous domestic regulatory agendas.

Globalization has not destroyed the state as an institution of human organization, but it is transforming the role of the state in international relations. With the transformation of the power and role of the state comes changes in the structure of the international system and the dynamics of the anarchical society. The influence and power of non-state actors, such as transnational corporations (TNCs) and nongovernmental organizations (NGOs), are changing the dynamics of international relations. Experts argue that power is shifting from states to TNCs and to global markets, greatly reducing the freedom and policy flexibility states have in dealing with internal and external problems. (I noted these pressures on state power in the analysis of the globalization of public health in Part II.B above.) The penetration of state power by the processes of globalization undermines the substantive ability of states to deal with public health problems nationally and internationally, but states and

208. See, e.g., Scholte, supra note 23, at 21-22 (analyzing aspects of globalization that undercut state sovereignty).
209. See id. at 22 (noting the challenge to determine "how the growth of supraregional social space is altering the activities and role of the state in contemporary history").
212. See, e.g., Dean T. Jamison et al., International Collective Action in Health: Objectives, Functions, and Rationale, 351 LANCET 514, 514-15 (1998) (arguing that "continuing global integration reduces the control that governments have over a growing number of health-status determinants that derive from the international transfer of risks").
inter-state cooperation remain the channels of dealing with the globalization of public health.\textsuperscript{213} I have argued elsewhere that this creates "a fundamental paradox: globalization jeopardizes disease control nationally by eroding sovereignty, while the need for international solutions allows sovereignty to frustrate disease control internationally."\textsuperscript{214} The problems created by the globalization of public health seemingly outstrip the capabilities of the state, the dynamics of the international system, and the potential of the anarchical society.

Complicating this situation are the political aspects of global public health. International health cooperation has always been marked by the politics of states and of the international system.\textsuperscript{215} In connection with infectious diseases, I have referred to these political dynamics as \textit{microbialpolitik}—the politics of dealing with pathogenic microbes.\textsuperscript{216} Globalization is also not apolitical because it carries with it philosophical assumptions not universally shared and power projections not universally liked. Vicente Navarro has argued, for example, that "[w]hat now passes as globalization is a specific type of internationalization of capital, labor, and knowledge, characterized by an unrestrained and unregulated search for profits."\textsuperscript{217} National and international law operate within intensely political realms affected by the unequal distribution and the exercise of power.

The political and economic impact of globalization on both the state and inter-state relations has profound implications for national and international law. As Alfred Aman has argued, "[t]he conventional view of law is state-centered."\textsuperscript{218} National "[l]aw is analyzed as the product of state processes as if it reflects only the political and economic forces and conflicts of the jurisdiction in which it is produced."\textsuperscript{219} Even though in limited contexts international organizations and individuals are subjects of international law, international law is primarily analyzed as the set of rules governing the relations between states. Globalization's transformation of

\begin{itemize}
\item \textsuperscript{213} See id. at 515 ("Although responsibility for health remains primarily national, the determinants of health and the means to fulfill that responsibility are increasingly global.").
\item \textsuperscript{214} Fidler, \textit{Globalization, International Law, and Emerging Infectious Diseases, supra} note 12, at 83.
\item \textsuperscript{215} See generally \textsc{Gill Walt}, \textsc{Health Policy: An Introduction to Process and Power} (1994) (commenting on the importance of politics and power in health issues).
\item \textsuperscript{216} See \textsc{Fidler, supra} note 3, at 18; Fidler, \textit{Microbialpolitik, supra} note 12, at 5.
\item \textsuperscript{217} Navarro, \textit{supra} note 20, at 743; see also Philip Alston, \textit{The Myopia of the Handmaidens: International Lawyers and Globalization}, 8 EUR. J. INT'L L. 435, 442 (1997) (arguing that globalization is not value neutral).
\item \textsuperscript{218} Alfred C. Aman, Jr., \textit{The Globalizing State: A Future-Oriented Perspective on the Public/Private Distinction, Federalism, and Democracy}, 31 VAND. J. TRANSNAT'L L. 769, 770 (1998) (footnote omitted).
\item \textsuperscript{219} Id. at 770-71 (footnote omitted).
\end{itemize}
the state and the relations between states shakes up traditional perspectives on national and international law. Legal scholars increasingly acknowledge the influence of global forces in the operation of national law and also recognize the limitations of a state-centered framework of international law. The growing prominence of non-state actors, as well as the forces these actors unleash globally, has led to discourse on the emergence of a "global society" that affects the dynamics of the anarchical society of states. Analysis of the global society phenomenon has encouraged arguments that what is emerging from the globalized world is "global law," which compliments and rivals the traditional distinctions between national and international law. Applying these ideas to the public health context means that public health should be a concern not only of the anarchical society but also of the global society, and we should be developing "global health law."  

While there is evidence that public health is indeed a growing issue in the global society, notions of "global health law" are technically inaccurate and too futuristic for present purposes. Even though globalization has an impact on the state and the international system of states, it has not destroyed the basic structures of human political organization. As long as states remain the primary building block of global human interaction, national and international law will remain distinct levels of law. The sources of national law will remain national legislatures. The sources of international law will remain states and their agreements through treaties and customary international law.

Given the nature of the anarchical society, "global health law" does not realistically describe what is happening to law or what needs to happen. However, globalization forces us to recognize the growing interdependence between national and international law and among national legal systems. The processes of national and international law are intertwining rapidly, requiring we see them linked together in mutual dependence. Rather than pretend we have emerging principles of "global health law," I believe we should look at the future of national and international law on public health through the perspective of global health jurisprudence, which the final part of this Article will explain.

220. See, e.g., Philip Allott, The True Function of Law in the International Community, 5 IND. J. GLOBAL LEGAL STUD. 391, 413 (1998) (arguing that "the great task of the coming decades is to imagine a new kind of international social system, to imagine a new role for the United Nations in the new kind of world which is forming so rapidly, and to imagine at last a new kind of post-tribal international law, which extends to the level of all humanity the wonder-working capacity of law").

221. See New Delhi Declaration, supra note 2, at 423 (mentioning "the principles of emerging global health law").
VI. GLOBAL HEALTH JURISPRUDENCE: A LEGAL FRAMEWORK FOR PUBLIC HEALTH IN A GLOBALIZED WORLD

The New Delhi Declaration on Global Health Law states that "global health law" includes: (1) "strengthening institutional and human capacity for law"; (2) developing regulatory and legislative approaches to support "Health for All"; and (3) ensuring monitoring and implementation of health law. These items do not represent principles of law but rather focus on processes and capabilities needed to improve the contribution of national and international law to global public health. What I believe the New Delhi Declaration advocates is not a body of global health law, but rather a process of global health jurisprudence. I have been developing the concept of global health jurisprudence in an effort to think creatively about the legal framework public health requires in a globalized world. In looking at law's role in the era of the globalization of public health, I believe that this concept is more helpful than the notion of global health law.

Global health jurisprudence offers four advantages as a conceptual legal framework. First, it focuses on substantive legal rules, strategies, institutions, and procedures that support public health in all contexts. Second, it is a framework grounded in the interdependence between national and international law and among national legal systems. In this respect, global health jurisprudence recognizes the structural realities of international relations while capturing the need to work on legal rules, capabilities, and strategies at the national and international levels in a more integrated fashion.

Third, in recognizing this legal interdependence, global health jurisprudence invites the intensification of legal cooperation and coordination processes between the international and national levels. Such intensification is what legal and public health experts have been advocating in the recent literature on national and international law on public health.

Fourth, global health jurisprudence recognizes the importance of including both state and non-state actors in the elaboration of substantive rules, as well as recognizing the interdependence between national and international law, and the processes of legal development. Health jurisprudence has to be a global dynamic actively influenced by

222. Id. at 422.
223. I first presented the concept of global health jurisprudence at a WHO Technical Seminar in March 1998, and I have tried to develop it since then in published writings. See FIDLER, supra note 3, at 303-09 (discussing global health jurisprudence); Fidler, The Future of the World Health Organization, supra note 12, at 1116-26 (explaining global health jurisprudence); Fidler, Legal Challenges Posed by the Use of Antimicrobials in Food Animal Production, supra note 12, at 35-36 (discussing the challenges that antimicrobial use in food animal production poses to the development of global health jurisprudence).
governments, international organizations, transnational corporations, and nongovernmental organizations. Global health jurisprudence attempts to capture the need for the legal dynamics of public health to operate on different levels: within the state, among states in the international system, within international organizations as active centers of international society, and among global society participants. While the products will be national and international law rather than "global law," the process itself needs to be truly global in scope and energy.

A. Rules, Procedures, Capabilities, and Strategies

A central objective of global health jurisprudence is to identify the ways that law, at every level, best supports public health. This is what the New Delhi Declaration on Global Health Law advocates by encouraging the development of institutional and human capabilities for law, specific regulatory and legislative approaches to support the Health for All policy, and adequate monitoring and implementation of law. As legal experts have made clear, national and international law are critical of creating the rules, structures, authority, and procedures needed for governments to protect and promote public health. Identifying the best ways that law can support public health will require involvement from lawyers, scientists, and public health experts because the nature of the enterprise is interdisciplinary. A recent study of American public health legislation in developing South-African public health law is an example of what global health jurisprudence encourages and requires. This study identified ten principles gleaned from experience with public health law in the United States that would be useful in guiding public-health-law reform at provincial and national levels in South Africa.

The focus on rules, procedures, capabilities, and strategies does not suggest that global health jurisprudence will produce legal harmonization in all situations because some legal approaches to public health will be

224. See New Delhi Declaration, supra note 2, at 422.
225. See Grad, supra note 84, at 21 (stating that national "[l]aw is essential to public health because public health programmes cannot function without legislative authorization"); L'hirondel & Yach, supra note 11, at 83 ("The need for global cooperation increases the importance of international law in the public health arena.").
226. See New Delhi Declaration, supra note 2, at 423 (calling for use of "legal mechanisms to strengthen intersectoral action for health").
228. See id. at Executive Summary (listing the ten principles).
influenced by local factors not prevalent in other places.\textsuperscript{229} Global health jurisprudence will benefit from multiple legal laboratories in public health, but the benefits will only accrue if there is "a common discourse about the relationship between law and health."\textsuperscript{230}

B. Interdependence Between National and International Law and Among National Legal Systems

Central to the concept of global health jurisprudence is the need to think about law and public health holistically. Global health jurisprudence cannot only be about improving WHO's international legal capacities because the efficacy of international law in the public health context often depends on national law. Illustrating the interdependence between international and national law, Aude L'hirondel and Derek Yach have argued that "[i]nternational instruments are useless without the national capacity to implement them."\textsuperscript{231} At the same time, international legal development often sparks reform in domestic law in both developed and developing countries. In addition, much work remains to be done in reforming many systems of domestic law to comply with existing international legal standards, such as those in the area of human rights.\textsuperscript{232}

Global health jurisprudence is also sensitive to the interdependence among national systems of law. As I have argued, "[n]ational legal reform undertaken without consideration of the global consequences of such action clashes with the spirit of global health jurisprudence."\textsuperscript{233} The lack of global perspective in the proposed, but ultimately unsuccessful, national tobacco settlement in the United States serves as a disturbing example of a national legal reform effort that ignored possible adverse effects on other parts of the world. Similar interdependencies among national systems of law

\textsuperscript{229} See L'hirondel & Yach, supra note 11, at 83 ("[S]ufficient attention must be given to the significant regional and cultural variations which different nations give to law as an element of health policy. The concept of the 'rule of law' varies according to philosophical and cultural traditions.").

\textsuperscript{230} Fidler, The Future of the World Health Organization, supra note 12, at 1117.

\textsuperscript{231} L'hirondel & Yach, supra note 11, at 79.

\textsuperscript{232} This is true with respect to developed and developing countries. A team of legal and public experts evaluated, for example, infectious disease control laws in American states and concluded that reform was needed to bring these laws into conformity with modern concepts of civil and political rights. See Lawrence O. Gostin et al., Improving State Law to Prevent and Treat Infectious Disease (1998); see also Lawrence O. Gostin et al., The Law and the Public's Health: A Study of Infectious Disease Law in the United States, 99 COLUM. L. REV. 59 (1999) (discussing the need for state public health law reform). Human rights concerns were also raised in connection with a proposed new infectious disease law in Japan. See David P. Fidler, Gurōbaru na Kenkō Seisaku to Nihon no Kansenshou Shinpou [Global Health Policy and the Proposed Japanese Infectious Disease Law], 68 KAGAKU 684 (1998).

\textsuperscript{233} Fidler, supra note 211, at 30.
appear in other public health contexts, such as the response to the development of antimicrobial resistance.  

C. Intensification of Legal Processes

Global health jurisprudence requires the intensification of legal cooperation and coordination vertically as well as horizontally at all levels of international relations. Vertical intensification is needed among (1) states and international organizations, (2) international organizations and non-state actors, and (3) states and non-state actors. Also required is horizontal intensification among (1) states, (2) international organizations, and (3) non-state actors in global society. Behind these intensification processes is the goal of elevating public health as both a legal and a political matter at all levels of international relations. A precedent for this aspect of global health jurisprudence can be found in the environmental context, in which the development of national and international law on environmental protection has proceeded in each of the vertical and horizontal relationships noted above. Because of the penetration of the value of health in many different international legal regimes, global health jurisprudence can benefit from vertical and horizontal legal processes already underway in the trade, human rights, humanitarian, arms control, labor, and environmental law areas.

234. See Fidler, Legal Issues Associated with Antimicrobial Drug Resistance, supra note 12, at 175. Because antimicrobial resistance is a global problem, national legal reforms taken in one or a few countries would suffer if other countries did not take similar actions. For example, since drug-resistant pathogens travel easily in today's world, national legal reforms to rationalize antimicrobial use in a few countries might be subverted if such misuse is not curtailed in many other countries. The creation of new international legal duties would likewise be undermined if such duties were not translated into national law. Thus, any legal strategy against antimicrobial resistance must be pursued at both the national and international levels.

235. See New Delhi Declaration, supra note 2, at 423 (advocating that the "World Health Organization should work with its health care providers and expertise within UN system, including the World Bank, World Trade Organization, international NGOs, professional and academic bodies and bilateral agencies in promoting, developing and implementing the use of public health law"); L'hirondel & Yach, supra note 11, at 86 ("WHO headquarters, Regional Offices, UN partners, Member States, NGOs, academic and health and legal professional groups should work together to develop and implement appropriate international and national laws for health.").


237. See id.
D. Global Dynamic

The recognition that global health jurisprudence must involve states, international organizations, and non-state actors indicates that it seeks to be a truly global dynamic rather than one only determined by inter-state politics. Thus, global health jurisprudence recognizes the changes being wrought on international relations by globalization because it sees the future shaped not by states alone or by their interaction in the anarchical society, but through a complicated mixture of public and private actions and forces. Many people recognize how powerfully the processes of economic competition are reshaping international relations, particularly in connection with how the state becomes absorbed by its role in furthering global competition. Just as capitalism has become a truly global dynamic, the protection and promotion of health must also rise to the challenge of the new global order.

E. Summary on Global Health Jurisprudence

The Oxford English Dictionary gives three meanings for “jurisprudence,” each of which the concept of global health jurisprudence seeks to advance. The first meaning of jurisprudence is “a [k]nowledge of or skill in law.” As recent WHO and scholarly attention on legal matters suggests, the anarchical society needs more knowledge of and skills in law and public health in the era of the globalization of public health. The various elements of global health jurisprudence seek to increase such knowledge and improve such skills.

The second meaning of “jurisprudence” is “[t]he science that treats of human laws (written and unwritten) in general; the philosophy of law.” Global health jurisprudence provides one way to foster the science and philosophy of public health law locally, nationally, and globally. Both empirical analysis and ethical discourse will be important aspects of global health jurisprudence. None of this implies that the development of a global health jurisprudence will be simple or uncontroversial, but the need for such development is abundantly clear.

The third meaning of “jurisprudence” is “[a] system or body of law; a legal system.” The ultimate objective of improving knowledge and skill in public health law and of fostering the science and philosophy of public health is to...

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238. See, e.g., Aman, supra note 218, at 773 (introducing “a theory of the state based on states’ new roles in furthering global competitiveness”).
240. Id.
241. Id.
health law is the creation and maintenance of coherent, interdependent bodies of law on public health at the national and international levels.

VII. CONCLUSION

The need for fresh thinking about international law in global public health is an important message now being delivered by legal and public health experts. This Article has attempted to provide analytical support for these arguments by examining the role of international law in the anarchical society, the globalization of public health, the history of international law on public health, the nature of WHO's international legal authority, WHO's neglect of national and international law, and the penetration of international law by the value of health. The analysis has also confronted the difficult but necessary international legal challenge of the human right to health.

As Part V suggested, enthusiasm for international legal activity concerning public health issues has to be tempered by a realization that the state and international relations generally are undergoing change as the processes of globalization permeate human interaction. Global markets impose on states harsh disciplines that are perceived to reduce governmental flexibility in dealing with social, economic, and environmental problems. Power is shifting from states to non-state actors, particularly transnational corporations. This shift disconnects power in international relations from control over territory and from the ability to project military might abroad.

Understanding the changing nature of the state and international relations forces us to think about the place and role of national and international law in human affairs. While futuristic visions of "global law" look appealing, the future of law is more likely to be influenced by working with law at all levels from a global perspective. I offered the concept of global health jurisprudence as one way to reorient legal thinking in the public health context for the global era.

I would be remiss, however, if I did not also emphasize the difficulty of the undertaking sketched in this Article. Neither international law nor global health jurisprudence provides a magic bullet against the public health problems in the world today. Developing countries simultaneously face, for example, the twin public health crises of infectious diseases and tobacco-related diseases. Because law, both national and international,
has been neglected in public health strategies, it is prudent to improve the legal contribution to global public health. But such improvement will not overcome all the obstacles to the betterment of the world's health, and national and international legal developments in this area will be vulnerable to political, economic, scientific, and cultural problems that plague human endeavors everywhere. To pretend that the path to world health could be paved by legal means alone would be a disservice to human health.