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## ACHIEVING GLOBAL HEALTH: A REVIEW OF THE WORLD HEALTH ORGANIZATION'S RESPONSE

*Mark J. Volansky*<sup>†</sup>

### I. INTRODUCTION

As members of a global community, citizens of every country believe in fundamental rights that define who they are and how they shall live in society. Among a varied list of beliefs and ideologies, a recurrent right to health is intrinsic to the way people live and die. However, an extreme diversity exists in the health of the global community. As developing nations continue to struggle toward modern advances in economics, politics, and culture, the demand for the health of nations cannot be ignored. Indeed, as the earth evolves as a global community, the international focus of health is not only beneficial but a necessity.

Fortunately, the international forefathers recognized the need and benefits of global health. The first of numerous historical international discussions on global health began in 1851.<sup>1</sup> In 1945, the United Nations became the international funnel for the majority of global problems. It quickly adopted the World Health Organization (WHO) under Article 57 of the U.N. Charter, delegating international responsibility to take action on emerging health concerns applicable under WHO's Constitution.<sup>2</sup> Today, WHO remains the predominant figure that guides, monitors,

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1. See David P. Fidler, *The Future of the World Health Organization: What Role for International Law?* 31 VAND. J. TRANSNAT'L L. 1079, 1083 (1998). The International Sanitary Conference met in 1851 to discuss quarantine measures due to cholera epidemics. Previously, the quarantine measures by numerous individual European countries severely affected international trade. *Id.* at 1083-84.

2. Agreement between the United Nations and the World Health Organization, Nov. 12, 1948, art. I, VI U.N.T.S. 193, 194.

teaches, and even regulates Member States on global health. Its image is monumental, but its implementation is leading the World Health Organization to a slow death.

From its inception, the WHO Constitution provided the organization with broad international legal powers to further its goals.<sup>3</sup> However, numerous health scholars criticize the resistance of WHO to use its international authority more fully and its lack of enforcement of existing international health regulations.<sup>4</sup> Member States are eager to offer their criticism of the current status of health regulations, but hesitate to accept responsibility for the growing problem. Just as global health is an international concern, the solution will require international cooperation and a new vision to attain the desired outcome.

This comment focuses on WHO and its approach to international health law. Part II examines the fundamental problem of health in a world of differing economies and priorities and Part III examines the organizational components of WHO and how they are responsible for the implementation of health policy. Next, Part IV discusses WHO's specific utilization of international authority, and Part V weighs WHO's effectiveness in the global community. Finally, Part VI looks to the future of global health and the emerging philosophy of global health jurisprudence in rendering a successful outcome, both for the people of the world and for WHO's mission.

## II. A HEALTHY WORLD TODAY?

### A. *Defining Health as a Right*

A clear definition of health and its implications must be established before any discussion on the state of health in the world can begin. Common international understandings of health and an individual's right to health come from a variety of sources.<sup>5</sup> Under the WHO Constitution:

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3. See Constitution of the World Health Organization, *opened for signature* July 22, 1946, art. 19, 21, 62 Stat. 2679, 2685, 14 U.N.T.S. 185, 192-93 [hereinafter WHO Constitution].

4. See David P. Fidler, *Mission Impossible? International Law and Infectious Diseases*, 10 TEMP. INT'L & COMP. L.J. 493, 495-96 n.19 (1996).

5. See generally Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 17-33 (1994). Among the documents that collectively define a right to health in an international perspective are:

[T]he United Nations Charter, the Universal Declaration of Human Rights, the Convention on Economic, Social, & Cultural Rights, the Convention on Civil and Political Rights, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.<sup>6</sup>

Health is a right that must be an essential part of every culture and represents a legal obligation for nations to abide by as a part of fundamental human rights law.<sup>7</sup> The problem, however, is that society recognizes health in a broader context. The right to health needs to reflect the notion that health is more than the mere absence of disease.<sup>8</sup> Individual good health and the right to health care are not synonymous with a right to health.<sup>9</sup> While an Afghan might marvel at disease-free communities or routine vaccinations for children, an American would

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Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child.

*Id.* at 19 (footnotes omitted).

6. WHO Constitution, *supra* note 3, pmb., 62 Stat. at 2680, 14 U.N.T.S. at 186.

7. Allyn Lise Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301, 309 (1992).

8. Jamar, *supra* note 5, at 11.

9. Taylor, *supra* note 7, at 310-11. Recognizing that a right to health does not encompass all commonly understood components. *See id.*

undoubtedly demand much more. To this end, the effective implementation of a right to health is unbalanced. It is noteworthy that the right to health is an evolving concept that changes within societies over time, as do the obligations of governments.<sup>10</sup>

Beyond its constitutional definition, WHO's pronouncements provide little guidance on what a right to health should specifically encompass.<sup>11</sup> However, it has been suggested that health is a human right and states should be legally bound to do something to effectuate that right.<sup>12</sup> Defining each state's particular steps to achieve a right to health is difficult due to the diversity of conditions in the world.<sup>13</sup>

The core right thus includes as primary attributes at least that governments do the following: insure provisions of universal coverage of a base level of medical care benefits; do not prevent access to health information; take steps to educate the public; and act to protect public health through various initiatives . . . .<sup>14</sup>

When a concrete standard to judge a state is established,<sup>15</sup> "the right to health could well give rise to a justiciable claim of a state's violation of its duty."<sup>16</sup>

### B. *Global Health Situation*

The global health situation is undoubtedly better now than in the past.<sup>17</sup> Since WHO began its mission in the 1940s, a general reduction in disease and an increase in overall health is statistically undeniable.<sup>18</sup> For example, in 1975, WHO expected only 60% of the combined population of all its Member States to live past sixty years.<sup>19</sup> In 1995, WHO expected 86% of the combined population of its Member States to live past sixty years.<sup>20</sup> By 2025, WHO projects that 96% of the combined population of

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10. *Id.* at 311.

11. Jamar, *supra* note 5, at 44.

12. *Id.* at 34.

13. *Id.* at 52.

14. *Id.* at 5.

15. *Id.* at 3.

16. *Id.* at 4.

17. *See* Taylor, *supra* note 7, at 304.

18. *See id.* Review of health statistics concerning WHO published in the *American Journal of Law & Medicine* shows an overall increase in the quality of health revealed by increased life expectancy and decreased infant, child, and maternal mortality rates. *Id.*

19. THE WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 1998: LIFE IN THE 21ST CENTURY, A VISION FOR ALL 39 (1998).

20. *Id.*

its Member States will live past sixty years.<sup>21</sup> Additionally, for over fifty years WHO spent considerable efforts on infectious disease control of smallpox, yellow fever, and cholera.<sup>22</sup> While many diseases are of great concern for WHO, the organization heralds among its accomplishments the global eradication of smallpox in 1980 after thirteen years of effort.<sup>23</sup>

Any accomplishments for which WHO is recognized are quickly tempered by the Director-General. On May 14, 2001, the Director-General, Dr. Gro Harlem Brundtland, addressed the delegates to the fifty-fourth World Health Assembly.<sup>24</sup> While the Director-General acknowledged the superior work that WHO and its Member States provide, she urged the Assembly to recognize the continued health problems resulting from infectious diseases such as tuberculosis, malaria, and HIV, the burdens of mental illness and neurological disorders, and the grave impact of tobacco.<sup>25</sup> The victory towards global health appears to be an endless task as newer health problems inhibit universal health for everyone.

WHO recognizes that the health of the world is disturbingly off-balance.<sup>26</sup> The disparity in health between developing countries and advanced countries is marked by ongoing poverty of one-quarter of the world's population.<sup>27</sup>

Low incomes mean limited capacity to save and invest, limited means for obtaining health services, high risk of personal illness, limitations on mobility, and limited access to education, information and training. Poor parents cannot provide their children with the opportunities for better health and education to improve their lot. Lack of motivation, hope and incentives creates a barrier to growth, and poverty is passed from one generation to the next.<sup>28</sup>

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21. *Id.*

22. *See generally id.* at 49.

23. *Id.*

24. Dr. Gro Harlem Brundtland, Address by Dr. Gro Harlem Brundtland, Director-General to the Fifty-fourth World Health Assembly (May 14, 2001), *available at* [http://www.who.int/director-general/speeches/2001/english/20010514\\_wha54.html](http://www.who.int/director-general/speeches/2001/english/20010514_wha54.html) (last visited Oct. 2, 2002).

25. *Id.*

26. *See THE WORLD HEALTH REPORT 1998, supra* note 19, at 136.

27. *See id.*

28. *Id.*

The most tragic victims of health deficiencies in developing countries are children<sup>29</sup> as well as the mothers who bear them.<sup>30</sup> Sharp contrasts between developing countries and advanced countries reveal that only 30% of women in developing countries give birth in medical facilities, where over 90% of women in advanced societies give birth in medical facilities.<sup>31</sup> Such poor health care at birth and extreme poverty are responsible for the high infant mortality rates throughout the world. Furthermore, contaminated water supplies, poor sanitation, limited immunizations, and plentiful diseases add to an already dangerous health situation in impoverished countries.<sup>32</sup> Attaining modern treatment for diseases such as HIV/AIDS in developing countries is completely unaffordable, leading to shorter lifespans among people with HIV/AIDS in developing countries than those in affluent countries.<sup>33</sup>

### III. THE WORLD HEALTH ORGANIZATION

#### A. *Historical Roots*

WHO is currently the predominant international organizer of global health with its international directives, but this has only been the case for the last half century. As a response to the economic impact on trade and maritime commerce, the International Sanitary Conference (ISC) was created in 1851, and met repeatedly until 1938.<sup>34</sup> Although initial strides toward international legal obligations were slow, numerous agreements (generally between North America and Europe) on human infectious disease control and plant and animal diseases were created for the protection of trade routes and reduced the chance of quarantines of incoming foreign products.<sup>35</sup> By 1924, four other international organizations created a system of global health surveillance and formed international agreements based on scientific principles.<sup>36</sup>

29. See Taylor, *supra* note 7, at 304. "[I]n developing countries, 40% of deaths are estimated to occur among children under the age of fifteen, ten times the proportion in developed countries." *Id.*

30. *Id.* at 305-06. "Five hundred thousand women, 99% of them in developing nations, die each year from complications during pregnancy and delivery." *Id.*

31. THE WORLD HEALTH REPORT 1998, *supra* note 19, at 155.

32. See generally *id.* at 154-57.

33. David P. Fidler, "Geographical Morality" Revisited: *International Relations, International Law, and the Controversy over Placebo-Controlled HIV Clinical Trials in Developing Countries*, 42 HARV. INT'L L.J. 299, 300-01 (2001).

34. Fidler, *supra* note 1, at 1083-84.

35. *Id.* at 1084-85.

36. See *id.* at 1085-86. The international health organizations that were formed were: the Pan-American Sanitary Bureau (1902), the International Office of Public Health (1907),

In 1945, the United Nations was chartered with broad international powers.<sup>37</sup> Under Article 1 of the U.N. Charter, one of the organization's purposes is "[t]o achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion . . ."<sup>38</sup> Remaining consistent with this purpose, the United Nations quickly exercised its power under Article 57<sup>39</sup> and chartered the World Health Organization.<sup>40</sup> From these founding principles, WHO, as an international agency dedicated to health,<sup>41</sup> currently gains notoriety due to its regional offices spanning the globe and an annual budget currently at \$1.8 billion dollars,<sup>42</sup> contributed by its 193 Member States.<sup>43</sup>

## B. *Basis of International Authority*

### 1. Functions of WHO

In order to achieve the "state of complete physical, mental and social well-being,"<sup>44</sup> the World Health Organization must provide a variety of health-related functions. Article 2 of the WHO Constitution describes the

the Health Office of the League of Nations (1923), and the International Office of Epizootics (1924). *Id.* at 1086.

37. See U.N. CHARTER arts. 1-2.

38. U.N. CHARTER art. 1, para. 3.

39. U.N. CHARTER art. 57. Article 57 provides:

1. The various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and related fields, shall be brought into relationship with the United Nations in accordance with the provisions of Article 63.

2. Such agencies thus brought into relationship with the United Nations are hereinafter referred to as specialized agencies.

40. See Agreement between United Nations and World Health Organization, *supra* note 2, VI U.N.T.S. at 193.

41. See WHO Constitution, *supra* note 3, pmb1., 62 Stat. at 2680, 14 U.N.T.S. at 186.

42. Allyn L. Taylor, *An International Regulatory Strategy for Global Tobacco Control*, 21 YALE J. INT'L L. 257, 278 (1996); *Proposed Programme Budget 2000-2001* 3, WHO Doc. A52/INF.DOC./2 (Apr. 21, 2002), available at [http://www.who.int/gb/EB\\_WHA/PDF/WHAS2/ewid.pdf](http://www.who.int/gb/EB_WHA/PDF/WHAS2/ewid.pdf) [hereinafter *Proposed Programme Budget*].

43. World Health Organization, *Member States of the World Health Organization*, at [http://www3.who.int/whosis/member\\_states/member\\_states.cfm?path=whosis,member\\_states&language=english](http://www3.who.int/whosis/member_states/member_states.cfm?path=whosis,member_states&language=english) (last visited Oct. 9, 2002).

44. WHO Constitution, *supra* note 3, pmb1., 62 Stat. at 2680, 14 U.N.T.S. at 186.



twenty-two enumerated functions that guide the organization toward providing the basic right to health throughout the world.<sup>45</sup> While not all functions are specifically relevant to the scope of this comment, the most important functions include:

- (a) to act as the directing and co-ordinating authority on international health work;
- (c) to assist governments, upon request, in strengthening health services;
- (g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;
- (k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;
- (v) generally to take all necessary action to attain the objective of the Organization.<sup>46</sup>

With the implementation of such broad international health goals, WHO serves as the primary advocate and leader to nations of the forementioned basic human need and right to health.<sup>47</sup>

## 2. Organizational Hierarchy

The functions of WHO have obvious international impact when WHO properly executes its legal power. WHO is composed of three distinct components under Article 9 of its Constitution.<sup>48</sup> First, the World Health Assembly is composed of specialized national health delegates from each of the Member States.<sup>49</sup> The World Health Assembly meets once every year and gives effect to the international health policies for which WHO has responsibility under its Constitution.<sup>50</sup> The most powerful legislative authority of WHO is in Articles 19 and 21, but are rarely

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45. See WHO Constitution, *supra* note 3, art. 2, 62 Stat. at 2681-82, 14 U.N.T.S. at 187-89.

46. *Id.*

47. Taylor, *supra* note 7, at 302.

48. WHO Constitution, *supra* note 3, art. 9, 62 Stat. at 2683, 14 U.N.T.S. at 190. Article 9 provides that the World Health Assembly, the Executive Board, and the Secretariat shall carry out of the work of the World Health Organization. *Id.*

49. WHO Constitution, *supra* note 3, arts. 10-11, 62 Stat. at 2683, 14 U.N.T.S. at 190.

50. WHO Constitution, *supra* note 3, arts. 14, 18, 62 Stat. at 2683-85, 14 U.N.T.S. at 190-92.

utilized by the World Health Assembly.<sup>51</sup> Article 19 states in part, “[t]he Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization.”<sup>52</sup> Additionally, Article 21 addresses more specific standards and procedures that the Health Assembly can authorize.<sup>53</sup> The broad legislative power under Article 19 and the narrower legislative power under Article 21 will become essential in the subsequent discussion of the effectiveness of WHO’s international power. WHO limits its use of legal power under Articles 19 and 21, and instead issues extensive general recommendations to Member States under Article 23.<sup>54</sup>

The second body of WHO is the Executive Board. The Executive Board consists of thirty-two individuals<sup>55</sup> elected by the Member States, who meet twice a year for a term of three years.<sup>56</sup> The Executive Board advises the World Health Assembly, but at the same time gives effect to the policies of the World Health Assembly and takes emergency action within the constitutional powers of the organization in times of health emergencies such as epidemics.<sup>57</sup>

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51. Fidler, *supra* note 1, at 1089.

52. WHO Constitution, *supra* note 3, art. 19, 62 Stat. at 2685, 14 U.N.T.S. at 192.

53. See WHO Constitution, *supra* note 3, art. 21, 62 Stat. at 2685, 14 U.N.T.S. at 192-93.

Article 21 states:

The Health Assembly shall have authority to adopt regulations concerning:

- (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
- (b) nomenclatures with respect to diseases, causes of death and public health practices;
- (c) standards with respect to diagnostic procedures for international use;
- (d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
- (e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

*Id.*

54. See David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 837-38 (1997).

55. See THE WORLD HEALTH REPORT 1998, *supra* note 19, at 11. The original Constitution under Article 24 only delegated eighteen people to the Executive Board. WHO Constitution, *supra* note 3, art. 24, 62 Stat. at 2686, 14 U.N.T.S. at 193. This has subsequently changed with increased membership in WHO. See THE WORLD HEALTH REPORT 1998, *supra* note 19, at 11.

56. WHO Constitution, *supra* note 3, arts. 24-26, 62 Stat. at 2686, 14 U.N.T.S. at 193.

57. WHO Constitution, *supra* note 3, art. 28, 62 Stat. at 2686, 14 U.N.T.S. at 194.

The third body of WHO is the Secretariat. The Secretariat is the daily functional organ of WHO consisting of 3,500 experts in health-related fields operating at its headquarters in Geneva, in the six regional offices of WHO, and in individual countries.<sup>58</sup> The head of the Secretariat is the Director-General, appointed by the World Health Assembly and is the "chief technical and administrative officer of the Organization."<sup>59</sup> The entire organization has broad ranging abilities and goals, but despite its composition of every major nation on earth,<sup>60</sup> it maintains a high degree of independence to promote its ends.<sup>61</sup>

#### IV. WHO'S UTILIZATION OF INTERNATIONAL AUTHORITY

##### A. *Infectious Disease Control*

WHO, like its historical predecessors,<sup>62</sup> was created largely to control global infectious diseases.<sup>63</sup> It has been suggested that "EIDs [Emerging Infectious Diseases] represent one of the most serious threats to human well-being in contemporary international relations."<sup>64</sup> WHO is proud of its accomplishments in infectious disease control such as the global eradication of smallpox, reductions in plague, and a decline in epidemics worldwide.<sup>65</sup> Similarly, WHO reports significant reduction in numerous other infectious diseases that have killed millions of people over the last several decades.<sup>66</sup> However, in recent years, infectious diseases have returned with a fury.<sup>67</sup> While there is some debate on the extent of infection, experts have identified at least "twenty-nine new infectious diseases and the re-emergence of twenty old infectious diseases since 1973."<sup>68</sup> WHO created the International Health Regulations (IHR) to combat this ongoing dilemma, but they have been ineffective at containing the problem.<sup>69</sup>

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58. World Health Organization, *Governance*, at <http://www.who.int/governance/en/> (last visited Oct. 9, 2002).

59. WHO Constitution, *supra* note 3, art. 31, 62 Stat. at 2687, 14 U.N.T.S. at 194-95.

60. See WORLD HEALTH REPORT, *supra* note 19, at 13.

61. See WHO Constitution, *supra* note 3, art. 67, 62 Stat. at 2692, 14 U.N.T.S. at 201.

62. See Fidler, *supra* note 1, at 1083-85 (discussing numerous international organizations and agreements formed in efforts to combat infectious disease).

63. WHO Constitution, *supra* note 3, art. 2(g), 62 Stat. at 2681, 14 U.N.T.S. at 188.

64. Fidler, *supra* note 4, at 494 (footnote omitted).

65. THE WORLD HEALTH REPORT 1998, *supra* note 19, at 49.

66. See generally *id.* at 49-57.

67. Fidler, *supra* note 4, at 494.

68. *Id.* (footnote omitted).

69. See *id.* at 497.

### 1. Emerging Infectious Diseases

Despite the historical advances made by WHO in infectious disease control, infectious diseases are still responsible for a significant amount of global illness.<sup>70</sup> In 1996, the world's leading cause of death was infectious diseases.<sup>71</sup> Both new and old diseases have emerged due to high levels of travel throughout the world, as well as international commerce that breeds such diseases.<sup>72</sup> Furthermore, over time, many diseases formed natural resistances to the immunity many drugs provide to humans.<sup>73</sup>

While many "emerging infectious diseases" (EIDs) are prevalent throughout the world, health experts consistently recognize several that are most devastating. First, the HIV/AIDS crisis has become a worldwide epidemic recognized by the nations of the world.<sup>74</sup> By the end of 2000, 36.1 million people were living with AIDS worldwide and 21.8 million have died from AIDS since the beginning of the pandemic.<sup>75</sup> Fear from further spread of such a deadly infectious disease leads many nations to turn away infected travelers.<sup>76</sup> As such, a response from WHO has been necessary to limit the impact to AIDS victims.<sup>77</sup> Likewise, tuberculosis (TB) reemerged as the deadliest infectious disease.<sup>78</sup> Experts estimated ninety million new cases of TB during the 1990s.<sup>79</sup> The impact of infectious disease is far greater than the explanations above or the scope of this comment. However, effective international health legislation is the best weapon to effectuate a controlled response to HIV/AIDS, TB, and other infectious disease epidemics worldwide.<sup>80</sup>

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70. THE WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 1999: MAKING A DIFFERENCE 19 (1999), available at <http://www.who.int/whr/1999/en/pdf/Chapter2.pdf> (last visited Oct. 9, 2002).

71. Fidler, *supra* note 54, at 773.

72. *Id.* at 774-75.

73. *See id.* at 786-88.

74. Symposium, *The AIDS Pandemic: International Travel and Immigration Restrictions and the World Health Organization's Response*, 28 VA. J. INT'L L. 1043, 1051 (1988) [hereinafter *AIDS Symposium*]. By the late 1980s, the World Summit of Health Ministers recognized over 75,000 cases of AIDS. *Id.*

75. Fidler, *supra* note 33, at 300.

76. *See AIDS Symposium, supra* note 74, at 1052-55.

77. *See id.* at 1055-57.

78. Brian J. McCarthy, *The World Health Organization and Infectious Disease Control: Challenges in the Next Century*, 4 DEPAUL INT'L L.J. 115, 119-20 (2000).

79. *Id.* at 120.

80. Michelle Forrest, Note, *Using the Power of the World Health Organization: The International Health Regulations and the Future of International Health Law*, 33 COLUM. J.L. & SOC. PROBS. 153, 159 (2000).

## 2. International Health Regulations

### *a. Powers of IHR*

The International Health Regulations (IHR) is one the earliest attempts by WHO to attain a grasp on the evolving world health situation. WHO originally instituted the IHR in 1951 as the International Sanitary Regulations (ISR).<sup>81</sup> As part of an effort to revise the ISR, the World Health Assembly renamed them the International Health Regulations in 1969.<sup>82</sup> “The purpose of the International Health Regulations is to ensure the maximum security against the international spread of diseases with a minimum interference with world traffic.”<sup>83</sup> To accomplish this goal, the IHR describes a comprehensive surveillance program for Member States to monitor and respond to infectious disease in their respective countries, as it pertains to the specific diseases of the IHR.<sup>84</sup>

The IHR is limited to just three diseases. These diseases are: yellow fever, plague, and cholera.<sup>85</sup> The IHR has three fundamental principles that guide health administrations on these problematic diseases. First, surveillance of a disease when initially detected is paramount to contain disease transmission that could, if ignored, lead to the continued spread of the disease.<sup>86</sup> When one of the three infectious diseases is detected, the health administration of a Member State must transmit that information to WHO headquarters.<sup>87</sup> The Member State has only twenty-four hours to relay that information to WHO, which in turn advises other Member States.<sup>88</sup> These requirements provide rapid containment of a health incident in a particular Member State and warns others of potential health dangers. Additionally, international law requires each Member State to

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81. Fidler, *supra* note 54, at 835.

82. *Id.* at 835-36.

83. World Health Organization, *Foreward* to International Health Regulations, at [http://policy.who.int/cgi-bin/om\\_isapi.dll?infobase=Ihreg&softpage=Browse\\_Frame\\_Pg42](http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Ihreg&softpage=Browse_Frame_Pg42) (last visited Oct. 9, 2002) [hereinafter *IHR Foreward*].

84. Fidler, *supra* note 54, at 839.

85. International Health Regulations, *opened for signature* July 25, 1969, art. 1, 21 U.S.T. 3003, 3004-06,

764 U.N.T.S. 3, 4-12 [hereinafter *IHR*]. The original International Sanitary Regulations included several other infectious diseases but were dropped in subsequent revisions. See Fidler, *supra* note 54, at 839 n.344.

86. Fidler, *supra* note 54, at 839-40.

87. See *IHR*, *supra* note 85, arts. 2-13, 21 U.S.T. at 3006-09, 764 U.N.T.S. at 12-20.

88. *IHR*, *supra* note 85, art. 3, 21 U.S.T. at 3006, 764 U.N.T.S. at 12-14.

make weekly reports to WHO during times of epidemics<sup>89</sup> and annual reports relating to any cases subject to the IHR.<sup>90</sup>

Second, the IHR establishes the procedures that individual government health administrations must maintain before, during, and after infectious disease outbreaks.<sup>91</sup> To foster maximum security against infectious diseases, the IHR requires that all ports and airports maintain sanitary conditions, health personnel, and immediate procedures when authorities believe there is a possible infection.<sup>92</sup> The procedures require non-discriminatory evaluation, surveillance, disinfection, and if absolutely necessary, isolation of a visitor to a Member State suspected of disease infection.<sup>93</sup> These protective measures also prohibit infected persons and cargo from departing a given location to minimize the spread of the three IHR diseases.<sup>94</sup>

The World Health Assembly adopted the IHR under the binding regulations of Article 21.<sup>95</sup> As such under Article 21, the IHR became effective for all Member States unless they notified the "Director-General of a rejection or reservations within a certain period of time"<sup>96</sup> under Article 22. The problem argued by legal scholars is that the binding regulations are more of a myth.<sup>97</sup> Since Member States can "contract out" of Article 21 legislation of the World Health Assembly within a certain time period, there is a question as to its effectiveness.<sup>98</sup>

The objective of the IHR is surveillance of a potential health threat relating to the three diseases of the text.<sup>99</sup> However, the language of the legislation itself reveals that as much as the regulations protect citizens of Member States, it is also designed to protect trade and commerce disruptions.<sup>100</sup> Article 29 is a controversial portion of the IHR, as it limits

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89. IHR, *supra* note 85, art. 6, 21 U.S.T. at 3007, 764 U.N.T.S. at 14.

90. IHR, *supra* note 85, art. 13, 21 U.S.T. at 3009, 764 U.N.T.S. at 20.

91. See IHR, *supra* note 85, art. 3, 21 U.S.T. at 3006, 764 U.N.T.S. at 12-14.

92. See IHR, *supra* note 85, arts. 14-20, 21 U.S.T. at 3009-11, 764 U.N.T.S. at 20-26.

93. IHR, *supra* note 85, arts. 25-26, 28, 21 U.S.T. at 3012-13, 764 U.N.T.S. at 28-30.

94. IHR, *supra* note 85, art. 31(1), 21 U.S.T. at 3014, 764 U.N.T.S. at 32.

95. See Fidler, *supra* note 54, at 837. The International Sanitary Regulations was the original name of the International Health Regulations, only to be renamed later.

96. *Id.* at 836; see also WHO Constitution, *supra* note 3, arts. 21-22, 62 Stat. at 2685, 14 U.N.T.S. at 192-93.

97. See Fidler, *supra* note 54, at 836-38.

98. See *id.* at 838.

99. See *id.* at 844.

100. See IHR, *supra* note 85, art. 29, 21 U.S.T. at 3013, 764 U.N.T.S. at 32.

the implementation of a country's emergency power.<sup>101</sup> Article 29 provides:

Except in case of an emergency constituting a grave danger to public health, a ship or an aircraft, which is not infected or suspected of being infected with a disease subject to the Regulations, shall not on account of any other epidemic disease be refused free pratique by the health authority for a port or an airport; in particular it shall not be prevented from discharging or loading cargo or stores, or taking on fuel or water.<sup>102</sup>

Article 47 of the IHR requires that the health authority have "reason to believe that the cargo and goods may have become contaminated by the agent of a disease subject to the Regulations."<sup>103</sup> The language of the Article shows the strong prohibition by the drafters to inhibit trade activities among nations.<sup>104</sup> Furthermore, newspapers, books, and printed material are not subject to any health measure, and postal parcels are only subject to health measures in very specific instances.<sup>105</sup>

In as much as the IHR pertains to commerce and trade, the legislation essentially protects people. But the protection of the IHR is really designed around infectious disease control of foreign visitors and merchants.<sup>106</sup> The provisions of the IHR relate to controlling disease as it enters a country or as it may leave.<sup>107</sup> The IHR permits the removal and isolation of an infected person by the health authority of a country from vehicles or vessels,<sup>108</sup> but it does not extend this isolation and removal beyond the necessary time unless the risk of disease transmission is extremely serious.<sup>109</sup>

#### *b. Failure to Provide Significant Impact*

International scholars and WHO representatives "agree that the IHR have [sic] failed to ensure the maximum security against the international spread of diseases with minimum interference with world traffic."<sup>110</sup> Noted

101. See Forrest, *supra* note 80, at 163-64.

102. IHR, *supra* note 85, art. 29, 21 U.S.T. at 3013, 764 U.N.T.S. at 32.

103. IHR, *supra* note 85, art. 47(1), 21 U.S.T. at 3018, 764 U.N.T.S. at 42.

104. See Forrest, *supra* note 80, at 163-64.

105. IHR, *supra* note 85, art. 49, 21 U.S.T. at 3018, 764 U.N.T.S. at 44.

106. See IHR, *supra* note 85, arts. 14-23, 21 U.S.T. at 3009-12, 764 U.N.T.S. at 20-28 (discussing sanitation, disease control measures, and on-sight medical staff required at ports and airports).

107. See *id.*

108. IHR, *supra* note 85, art. 39, 21 U.S.T. 3016, 764 U.N.T.S. at 38.

109. IHR, *supra* note 85, art. 40(2), 21 U.S.T. 3016, 764 U.N.T.S. at 38.

110. Fidler, *supra* note 54, at 843.

international legal scholar David Fidler has commented extensively on the effectiveness of WHO and its programs over the years.<sup>111</sup> Both his analysis and the analysis of others shed some light on the current status of the IHR. First, Member States do not undertake appropriate surveillance of the diseases in the IHR.<sup>112</sup> The infrastructure of local health administrations in many Member States is limited and ineffective because as infectious diseases subject to the IHR arise, the local health infrastructure lacks effective communication and surveillance to realize when a disease is present and fails to report to WHO.<sup>113</sup>

Second, the IHR only places surveillance and infection procedures on three diseases--yellow fever, cholera, and plague.<sup>114</sup> Health sources reveal that as many as fifty diseases are significant and require monitoring by health organizations.<sup>115</sup> Even one of WHO's recent *World Health Reports* describes twenty-three infectious diseases that currently affect millions of people worldwide and are insufficiently treated.<sup>116</sup> In 1998 alone, WHO calculated 13.3 million people died from infectious diseases.<sup>117</sup> Fidler notes that the reasoning for limiting the IHR is related to outdated understandings of infectious disease transmission.<sup>118</sup> In the past, yellow fever, cholera, and plague were the only three diseases that scientists believed posed an international health threat.<sup>119</sup> Modern health statistics show that infectious diseases have no boundaries and an international health response to the wide range of infectious diseases is essential.<sup>120</sup> It seems apparent that in the modern global community, a modern global response must be imposed upon the broader base of infectious diseases.

Third, the IHR is ineffective because neither the legislative powers of the IHR, nor the powers of the WHO Constitution permit sanctions "against a member state that fails to comply with a binding regulation enacted under Article 21."<sup>121</sup> WHO does not take affirmative action when

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111. See *id.*; David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1 (1999); Fidler, *supra* note 4; Fidler, *supra* note 1.

112. Fidler, *supra* note 54, at 844.

113. *Id.*

114. *Id.* at 845.

115. Forrest, *supra* note 80, at 165.

116. See generally THE WORLD HEALTH REPORT 1998, *supra* note 19, at 49-56.

117. World Health Organization, *Communicable Diseases 2000: Highlights of Activities in 1999 and Major Challenges for the Future 1*, available at <http://www.who.int/infectious-diseases-news/CDS2000/PDF/cd2000-e.pdf> (last visited Oct. 9, 2002).

118. See Fidler, *supra* note 54, at 844-45.

119. *Id.*

120. See Forrest, *supra* note 80, at 163.

121. Fidler, *supra* note 54, at 848.



international health law is violated and at most will subject Member States to dispute settlement procedures under Article 75.<sup>122</sup> Apparently, WHO has realized its weakness in its own rules because over the past fifty years, WHO has limited its legislative power to recommendations.<sup>123</sup> However, as Fidler points out “[w]ithout formal enforcement powers . . . WHO may have no alternative to this nonlegal approach.”<sup>124</sup>

Finally, the goal of the IHR “to ensure the maximum security against the international spread of diseases *with a minimum interference with world traffic*”<sup>125</sup> has produced just the opposite affect.<sup>126</sup> The international perception of infectious diseases causes nations to resist reporting to WHO in accordance with the IHR.<sup>127</sup> A fear of reduction in trade, commerce, and tourism provides strong incentive to many nations from reporting the emergence of diseases.<sup>128</sup> Nations with economic concerns will not take the chance of further injury to themselves from disease reporting.<sup>129</sup> Public perception about infectious diseases produces fear of the possible consequences of contact. The profound economic impact on various Member States such as Peru, Great Britain, and India for reporting infectious diseases in the past leads others to actively conceal disease infection as long as possible.<sup>130</sup> As a response, other “member states impos[ed] excessive measures in direct violation of the Regulations and not justified by the medical situation. These measures included the closing of airports to aircraft arriving from India and banning the importation of Indian foodstuffs.”<sup>131</sup>

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122. *See id.*; *see also* WHO Constitution, *supra* note 3, art. 75, 62 Stat. at 2693, 14 U.N.T.S. at 202.

123. *See* Fidler, *supra* note 54, at 848-49.

124. *Id.* at 848.

125. IHR *Foreward*, *supra* note 83 (emphasis added).

126. *See* Forrest, *supra* note 80, at 166-67.

127. *See id.*

128. *See id.*

129. *See id.* at 166.

130. *See id.* at 166-67. These nations have lost millions of dollars as a result of public perception on infectious disease. Peru is said to have lost \$700 million due to a cholera outbreak in 1991 that severely reduced travel and trade. A plague outbreak in India in 1991 cost \$1.7 billion in trade imbalance and the economic impact on Great Britain's beef industry is still feeling the impact of “mad cow disease.” *Id.* at 166-67. *See also* McCarthy, *supra* note 78, at 126.

131. McCarthy, *supra* note 78, at 126 (footnotes omitted).

### 3. The Revised IHR

In 1995, the forty-eighth session of the World Health Assembly directed a resolution to the Director-General for revisions to the IHR.<sup>132</sup> Revisions to the IHR have been ongoing since that time. Preliminary progress reports advise that the new IHR will consist of major alterations in structure, notification, and increasing the diseases subject to international law.<sup>133</sup> The ongoing changes to the IHR are a response to ongoing criticism of their ineffectiveness.<sup>134</sup> While WHO's Informal Consultation that reviewed the IHR in 1995 noted that the IHR has lived up to the invaluable purpose for which it was conceived,<sup>135</sup> WHO publicly recognized that "[a]s the world has changed and infectious diseases pose new challenges, the IHR no longer meets the complex and ever-growing risks of international spread of infectious diseases and emerging infections."<sup>136</sup> WHO's revision process has not been rapid.<sup>137</sup> The decision to revise the IHR began in 1995, and a draft of the new IHR is intended to be distributed in 2002, with submission to the World Health Assembly in 2004.<sup>138</sup>

There is still much skepticism about the exact content and final product of the revised IHR, but international health commentators consider the following points significant.<sup>139</sup> First, David Fidler draws attention to "syndrome reporting."<sup>140</sup> Syndrome reporting would require Member States to immediately report to WHO defined syndromes that are characteristic of certain diseases of international concern.<sup>141</sup> Thereafter, specific reports follow once health officials isolate the disease.<sup>142</sup> The theory behind this approach is that local health infrastructures would not have to identify diseases at great financial cost, as they would under the current IHR. Syndrome reporting allows for broader resources to

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132. *Id.* at 127.

133. *Id.*

134. See Fidler, *supra* note 54, at 851.

135. *Id.*

136. World Health Organization, *Renewing the International Health Regulations*, at <http://www.who.int/emc/IHR/IHREnglish.pdf> (last visited Oct. 9, 2002).

137. See *id.*

138. *Id.*

139. See Fidler, *supra* note 54, at 851-67; Forrest, *supra* note 80, at 167-77; McCarthy, *supra* note 78, at 126-31.

140. Fidler, *supra* note 54, at 851.

141. *Id.* at 852. The reportable syndromes would include "hemorrhagic fever, respiratory, diarrheal, neurological, [and] jaundice . . . ." Forrest, *supra* note 80, at 167.

142. Fidler, *supra* note 54, at 852.

understand the disease before its exact nature is known.<sup>143</sup> However, concern over the focus of this new legislation arises because it has not addressed the problem of underreporting diseases that the current IHR faces.<sup>144</sup> The broader disease concept of "syndromes" may cause confusion by Member States on what diseases encompass the syndrome approach, or on specific identification procedures.<sup>145</sup>

The broad syndrome approach of the revised IHR arguably ignores urges by the health community to address specific infectious diseases dramatically impacting the global community. The two reoccurring diseases not addressed are TB and HIV/AIDS. The impact of these diseases is rising at such an exponential rate<sup>146</sup> that failure to include them in the revised IHR may seriously undermine its purpose to "ensure the maximum security against the international spread of diseases."<sup>147</sup>

Second, the revised IHR will include the ability for any official within a Member State's government to report syndromes and not be limited solely to health administrations.<sup>148</sup> Furthermore, if Member States refuse to comply with the IHR, WHO can still circulate information obtained from non-governmental sources to all Members.<sup>149</sup> There is concern that giving such broad power to report on syndromes and diseases in noncompliant Member States will cause even greater fear among other nations due to the unfocused sources of information that such secondary organizations may produce.<sup>150</sup>

Third, education on the revised IHR will foster better execution of its goals.<sup>151</sup> The Informal Consultation's education plan includes guidelines for infectious disease management,<sup>152</sup> and a handbook on how to use and apply the revised IHR.<sup>153</sup> Despite the practical uses of such educational measures, the recurrent problem of deficient public health infrastructures in many countries is likely to inhibit the success of these educational goals.<sup>154</sup>

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143. *Id.*

144. *Id.* at 852-53.

145. *Id.* at 853.

146. See Fidler, *supra* note 33, at 300.

147. IHR *Foreward*, *supra* note 83.

148. Fidler, *supra* note 54, at 853.

149. *Id.* at 854.

150. See *id.* at 854-55.

151. See *id.* at 855-56.

152. *Id.* at 856.

153. *Id.*

154. Fidler, *supra* note 54, at 857.

Finally, the revised IHR may eliminate the provisions regulating health resources at airports and ports, since the IHR actually overlaps with other international agreements on this same topic.<sup>155</sup> Fidler argues that removal of these provisions is dangerous because not all international health agreements regulate infectious diseases as their sole priority and any inconsistencies could prove to lower the amount of protection against infectious diseases.<sup>156</sup>

Due to the effects of the current IHR, health scholars publicly express their reservations about the effectiveness of the revised IHR. Many of WHO's problems and specifically the usefulness of international health legislation must be addressed in the context of the greater purpose, structure, and goal of WHO as an international organization.<sup>157</sup> While beyond the scope of this segment on the IHR and revised IHR, WHO faces challenges based on the lack of international enforcement authority, financial constraints, and an ineffectively structured executive body limited to medical knowledge, rather than international legal capacity.<sup>158</sup> Discussion of these topics is highly significant to the status of WHO and will be addressed in Part IV.

#### B. *Communications/Research*

Significant emphasis on WHO's utilization of international authority has been directed toward infectious disease control and the legislative authority of the IHR. Yet commonly held understandings of health do not relate to health care or personal good health.<sup>159</sup> The international impact of health is not likely to be confronted solely with legislation or vaccination. Part of WHO's mission includes maintaining communication and research infrastructure, establishing health surveillance and monitoring developments worldwide.<sup>160</sup> As such, WHO's Constitution requires that functional components of the organization:

- (f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;
- (j) to promote co-operation among scientific and professional groups which contribute to the advancement of health;

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155. *Id.*

156. *See id.*

157. *See generally* Fidler, *supra* note 1, at 1099-1103.

158. *See id.*

159. Taylor, *supra* note 7, at 310.

160. *See* THE WORLD HEALTH REPORT 1998, *supra* note 19, at 26-30 (discussing historical and current policy trends of WHO's global response through communication and research).

(n) to promote and conduct research in the field of health;

(p) to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care . . . .<sup>161</sup>

There are a number of areas of research and communication where WHO effectively uses passive international authority for the betterment of health. First, WHO facilitates the pharmaceutical industry with "International Nonproprietary Names for pharmaceutical substances (INNs)."<sup>162</sup> Since pharmaceutical development and marketing reaches nearly all global consumers, a consistent name in each language is essential to maintain drug safety and communication among health professionals.<sup>163</sup> Second, WHO monitors numerous sanitary factors worldwide and publishes WHO Guidelines for drinking-water quality to facilitate water sanitation, leads a joint Codex Alimentarius Commission to provide health guidelines and maintain appropriate trade practices for food. Furthermore, WHO implemented international regulatory legislation, "International Code of Marketing of Breast-milk Substitutes," which ensures adequate nutrition for infants.<sup>164</sup> Third, WHO serves as both an international monitor and independent resource to the global community for health in general.<sup>165</sup> "From the earliest days of WHO, formal laboratory networks were set up by the Organization for reference, exchange of information and coordination of research programmes, particularly in the area of vaccine research . . . ."<sup>166</sup> Finally, WHO organizes and maintains global health statistics throughout the world.<sup>167</sup> WHO publishes numerous monthly and annual reports on global health conditions, including its annual publication *The World Health Report*.<sup>168</sup> WHO disseminates health information through all mediums including media and journal articles.<sup>169</sup>

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161. WHO Constitution, *supra* note 3, art. 2, 62 Stat. at 2681-82, 14 U.N.T.S. at 187-89.

162. THE WORLD HEALTH REPORT 1998, *supra* note 19, at 23.

163. *Id.*

164. *See id.* at 24.

165. *See id.* at 26.

166. *Id.* Since WHO's inception, "general programmes of work" have been formed to achieve specific limited objectives in a certain area of health during a period of 4-6 years. Thus far, nine of these general programmes of work have met and provided guidance in strengthening national health services, coordinating health research, containing specific health problems, and many other areas of global interest. *See id.* at 26-29.

167. *See id.* at 30.

168. *See* THE WORLD HEALTH REPORT 1998, *supra* note 19, at 30-31.

169. *See id.* at 34-35.

Also, WHO provides access to its library and shares information in several languages through the U.N. network of information distribution.<sup>170</sup>

### C. *Application to Other Types of Law*

The importance of global health is narrowly construed by western thinkers. For non-scholarly audiences, health may be limited to the mere individual. Even legal references define health as “1. [t]he state of being sound or whole in body, mind, or soul. 2. [f]reedom from pain or sickness.”<sup>171</sup> Yet these definitions do not encompass the dimensions of global health worldwide. Health is dynamic and not static. As such, it affects nearly every facet of international law in one way or another.<sup>172</sup> A full analysis of WHO’s international impact on related areas of law would be an infinite task. However, since the Constitution of WHO was originally designed with some of these related fields in mind, a brief sketch of their inescapable interdependence is relevant to WHO’s historical response and its ongoing legal impact.

#### 1. Trade & Commerce Law

As noted earlier, international health law historically concerns itself with protecting economic interests.<sup>173</sup> “International trade agreements that liberalize trade between countries typically recognize that states may restrict trade to protect human health.”<sup>174</sup> Nonetheless, health experts caution that as products from international trade become so pervasive in large economic markets, the ability to protect the public may become a task that is not feasible.<sup>175</sup>

Despite the overwhelming desire for nations to engage in uninterrupted trade, health factors are one of the only factors to affect this desire.<sup>176</sup> The problem is enhanced when nations protect themselves from health threats to an unnecessary or unreasonable extent.<sup>177</sup> Therefore, “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.”<sup>178</sup>

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170. *See id.*

171. BLACK’S LAW DICTIONARY 577 (7th ed. 2000).

172. Fidler, *supra* note 111, at 27.

173. *See supra* note 1 and accompanying text.

174. Fidler, *supra* note 111, at 27.

175. Fidler, *supra* note 54, at 797.

176. *See* Fidler, *supra* note 111, at 27.

177. *Id.* at 28.

178. *Id.*

Due to inadequate health conditions in many parts of the world, international organizations have combined efforts to recognize health concerns in trade.<sup>179</sup> For example, as a result of conflicts between the laws of WHO, the World Trade Organization, and the Food and Agriculture Organization, these influential organizations are attempting to reconcile differences to ease international trade.<sup>180</sup> The binding regulations of each organization are essential to foster their own goals, but they have the potential to cause conflicts since each organization has a unique focus.<sup>181</sup> The goal of meetings between the organizations is to find a way to implement the goals of all three organizations without conflicting with international trade.<sup>182</sup> This is but one example of the growing need for international collaboration due to interdependent goals of nations and international law.

## 2. Environmental Law

WHO has directly and indirectly affected environmental law worldwide as health specialists realize that human health concerns are inevitably the result of human acts.<sup>183</sup> Most notably, urbanization in developing countries facilitates many of the factors that inhibit the betterment of individual and group health.<sup>184</sup> As a result of the rush to urban settings, poverty has befallen countless individuals.<sup>185</sup> “[L]imited successes in improving housing and living conditions, including the provision of safe and sufficient water supplies and adequate sanitation and drainage” are some of the problems associated with impoverished communities in emerging metropolises throughout the world.<sup>186</sup> These conditions are just ripe for the proliferation of infectious diseases.<sup>187</sup> Environmental conditions have high correlation to specific diseases such as malaria and schistosomiasis.<sup>188</sup>

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179. See World Health Organization, *Revision of the International Health Regulations: Public Health and Trade*, WHO WKLY. EPIDEM. REC., June 25, 1999, at 193, available at <http://www.who.int/wer/pdf/1999/wer7425.pdf>.

180. See *id.* The specific legal agreements being debated are: the IHR that pertains to WHO, the Sanitary and Phytosanitary Measures of the World Trade Organization, and the Codex Alimentarius of the Food and Agriculture Commission. *Id.*

181. See *id.* at 201.

182. *Id.*

183. See Fidler, *supra* note 54, at 801-02.

184. See *id.* at 806-08.

185. THE WORLD HEALTH REPORT 1998, *supra* note 19, at 121.

186. *Id.*

187. *Id.* at 123.

188. *Id.*

WHO addressed environmental dilemmas over the past several decades through various programs.<sup>189</sup> For example, the aforementioned International Drinking Water Supply and Sanitation guidelines instruct developing nations on appropriate procedures in rising populations. Additionally, WHO coordinates with nations in their own environmental legislation with:

Conferences of health and environment ministries convened by WHO in the Americas, Eastern Mediterranean and Europe have been instrumental in accelerating the process, and agreements have been reached on deadlines for completing such plans. For example, in Europe, by the end of 1997 more than 50% of all countries had prepared national environmental health action plans.<sup>190</sup>

Beyond local regulations, WHO is responsive to highly sensitive topics that could be very costly to Member States yet undoubtedly concern the health of nations. WHO tested the international powers designated under its Constitution when it realized health systems could not handle a nuclear war catastrophe.<sup>191</sup> The WHO committee that handled the issue of a nuclear catastrophe concluded that WHO should take an affirmative role by submitting to the International Court of Justice a request for an advisory opinion on whether the use of nuclear weapons would violate international law and the WHO Constitution.<sup>192</sup> This action by WHO is controversial because the historical actions of WHO relate to more traditional health issues and acting in its advisory role by making proposals rather than an affirmative regulatory role.<sup>193</sup> Due to heavy internal and external criticism of such a heated issue,<sup>194</sup> WHO is likely to resist taking such dramatic action in the near future.

### 3. Tobacco Legislation

The scientific community no longer disputes that tobacco and tobacco smoke have destructive health consequences.<sup>195</sup> In fact, smoking claims

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189. See generally *id.* at 128 (discussing various international conferences and resolutions to regional governments to improve environmental conditions).

190. *Id.* at 128-29.

191. Martin M. Strahan, Comment, *Nuclear Weapons, The World Health Organization, and the International Court of Justice: Should an Advisory Opinion Bring Them Together?* 2 TULSA J. COMP. & INT'L L. 395, 397 (1995).

192. See *id.* at 402.

193. *Id.* at 406.

194. See generally *id.* at 400-01 (outlining the debates between delegates of the World Health Assembly on whether the issue was within the competence of the WHO Constitution).

195. Taylor, *supra* note 42, at 258.



three million premature deaths every year,<sup>196</sup> making "tobacco consumption a uniquely important public health crisis calling for national and international action."<sup>197</sup> The World Health Assembly enacted numerous resolutions over the past thirty years to prioritize tobacco control among WHO's Member States and to strengthen collaboration between WHO, nongovernmental organizations, and other U.N. organizations.<sup>198</sup> In 1990, WHO adopted the 'Tobacco or Health Programme' which aims at working with Member States to provide advice and support to develop national tobacco regulations,<sup>199</sup> but WHO Member States have not adopted or implemented tobacco control laws thus far.<sup>200</sup>

Due to the growing public awareness of tobacco,<sup>201</sup> WHO is pursuing international legislation as a means to limit the effects of tobacco worldwide.<sup>202</sup> Whether WHO or the U.N. should spearhead international strategy and legislation for tobacco control is debatable to the World Health Assembly.<sup>203</sup> WHO is the favorable entity because "WHO has the legal authority and public health expertise to serve as the platform for the development of an international regulatory approach to tobacco control."<sup>204</sup> The United Nations General Assembly also has the legal capacity to create tobacco control regulations, yet it neither has the expertise nor the time to engage in negotiating the complexities and technical issues that international tobacco regulations necessitate, especially as it affects public health, a topic that is supervised by WHO.<sup>205</sup>

WHO will meet significant challenges fostering an international response to tobacco. At least 120 countries produce tobacco and domestic consumption alone is a large source of tax revenue.<sup>206</sup> For example, in the

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196. *Id.*

197. *Id.*

198. *Id.* at 279-80.

199. *Id.* at 280.

200. *Id.* at 258.

201. Taylor, *supra* note 42, at 258.

202. *Id.* This represents radical change to the ideology of WHO. WHO has consistently been seen as a conservative organization when it comes to using its legal strategies. *Id.* at 282. But because crisis stimulates international attention, "WHO's unconventional consideration of the role that international law and institutions can play in promoting world public health protection policies suggests that WHO's leaders may be rethinking and expanding the organization's traditional scientific, technical approaches to international health." *Id.*

203. *Id.* at 283.

204. *Id.* at 281.

205. *Id.* at 297.

206. *Id.* at 274. The misguided belief by many countries is that tobacco production is a necessary benefit to the national economy. Yet, the "social costs of tobacco production and

United States, Phillip Morris alone paid \$12.9 billion in taxes to the government in 1993.<sup>207</sup> It seems questionable whether WHO, an organization with an annual budget of \$1.8 billion,<sup>208</sup> can counter transnational tobacco conglomerates with extensive economic and political power<sup>209</sup> such as Phillip Morris.

Since tobacco control is a politically sensitive issue<sup>210</sup> and countries are resistant to sacrifice autonomy to international organizations,<sup>211</sup> WHO may need to adopt a strategy over time that will gradually increase governmental concern to a point where countries will support national and international tobacco legislation.<sup>212</sup> The first step in such a strategy is for WHO to encourage passage of a nonbinding intergovernmental resolution by the United Nations General Assembly.<sup>213</sup> "WHO should adopt this strategy to heighten global concern about tobacco control in member states and to promote support for the development of a binding international convention on tobacco containment."<sup>214</sup> Adopting a nonbinding resolution will not demand immediate legal commitments, rather, use of simplified procedures in the U.N. General Assembly (that work quicker than formal multilateral treaties) will raise international attention to the issue rapidly.<sup>215</sup>

With the continuous and systemic approach of normative international standards through U.N. resolutions, WHO may develop a global political consensus for binding international standards on tobacco control.<sup>216</sup> Since a political consensus for global tobacco control would be difficult,<sup>217</sup> a comprehensive and detailed treaty would likely be ineffective.<sup>218</sup> Instead, "WHO could encourage states to adopt a

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consumption include the costs of environmental pollution, deforestation, and most important, tobacco related mortality and morbidity." *Id.* at 274-75 (footnotes omitted). Medical costs to American society in 1984 were estimated at \$53 billion due to tobacco-related causes. *Id.* at 275.

207. Taylor, *supra* note 42, at 263.

208. *Proposed Programme Budget, supra* note 42, at 3.

209. Taylor, *supra* note 42, at 285.

210. *Id.* at 284.

211. *Id.*

212. *Id.* at 286. Tobacco regulation remains weak in many developing countries. *Id.* at 273.

213. The lack of effective domestic regulations provides a ripe target for transnational tobacco countries and provides even more support for international action. *Id.* at 274.

214. Taylor, *supra* note 42, at 287-88.

215. *Id.* at 288.

216. *Id.*

217. *Id.* at 292.

218. *Id.* at 293.

219. *Id.* at 293-94.

comprehensive convention, mandating that states enact extensive tobacco control regulations that encompass all of WHO's recommendations for the last twenty-five years . . . ."<sup>219</sup>

This strategy is more politically feasible and embodies the convention-protocol approach.<sup>220</sup> Distinguishable from a treaty, this approach does not resolve every facet of the problem in a single instrument.<sup>221</sup> The international framework sets the broad goals and parties to the agreement will ideally establish specific ways to implement the goals.<sup>222</sup> This dynamic approach should be facilitated by WHO because it has broad legal authority to encourage Members States to implement "recommendations or convention . . . to any matter within the competence of the organization."<sup>223</sup>

## V. THE GREAT DEBATE OF WHO'S INTERNATIONAL POWER

The review of WHO shows its responsibility for an area of civilization with far-reaching implications. Health encompasses more than absence of physical illness and well-being.<sup>224</sup> It encompasses more than a fundamental responsibility by the global community.<sup>225</sup> The implications of health could easily be debated far beyond any concise definition. Yet the implementation of WHO's health policies in the global community must be systematically and intricately reviewed. While WHO's contributions to global health are significant, they are often overshadowed by observers who desire a more active WHO legalistic response.<sup>226</sup>

### A. Significant Legal Contributions

WHO's significant legal contributions derive from its international composition to specific internal policies. First, WHO is the most dynamic

219. Taylor, *supra* note 42, at 294.

220. *Id.* The convention-protocol approach has been successful in implementing international agreements on environmental matters. In 1979, the "Convention on the Conservation of Migratory Species of Wild Animals" used this approach. Other successes using this approach are: "the Vienna Convention for the Protection of the Ozone Layer, the Montreal Protocol," and the Framework Convention on Climate Change. *Id.* (footnotes omitted).

221. *Id.*

222. *Id.*

223. *Id.* at 297.

224. See Taylor, *supra* note 7, at 310.

225. Jamar, *supra* note 5, at 67.

226. See generally Fidler, *supra* note 1, at 1107-1115 (recognizing philosophical and practical deficiencies in WHO's international legal activity).

and influential health power to date.<sup>227</sup> However, its leverage on Member States can largely be attributed to its organizational legitimacy.<sup>228</sup> The Member States create this legitimacy because the collective mentality comprises mutual individual values.<sup>229</sup> Most WHO Member States identify with the goals of the organization, which in turn provides stability for the collective against negative influence.<sup>230</sup> Furthermore, WHO's recognition as a global health leader facilitates individual nations' health policies and supports WHO's own policies.<sup>231</sup> "WHO's country programs involve working directly with individual ministries of health, thereby strengthening the nations' capacity to plan, analyze, monitor, and manage available state resources in conformity with domestic Health for All strategies."<sup>232</sup> Goodwill and cooperation between government leaders and WHO officials further legitimate to the impact of WHO's trusted name.<sup>233</sup> Even many non-governmental health agencies admit their own accomplishments are largely rooted on WHO's constitutionally mandated policies and programs of coordinating international health work.<sup>234</sup>

Second, WHO's passage of the IHR was a remarkable step in international legal authority over previous treaty-based agreements.<sup>235</sup> The theory behind the IHR gave the World Health Assembly the ability to maintain current scientific standards in the IHR without having to continually resort to cumbersome treaty changes.<sup>236</sup> Certainly, the discussions in this comment thus far have described the subsequent revelation of the IHR's ineffectiveness. However, in an attempt to learn from its historical errors, the proposed revisions are hopeful to correct its ineffectiveness and "continue to serve the principles under which they were conceived."<sup>237</sup> The failures of the IHR are undeniable but the founding philosophy behind them is nevertheless still alive.

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227. See Taylor, *supra* note 42, at 278-79.

228. Taylor, *supra* note 7, at 320.

229. *Id.* at 320-21.

230. *Id.* at 321.

231. *Id.* at 321-22.

232. *Id.* at 322.

233. *Id.*

234. Taylor, *supra* note 7, at 322.

235. Fidler, *supra* note 54, at 836.

236. *Id.*

237. *The International Response to Epidemics and Applications of the International Health Regulations: Report of a WHO Informal Consultation* 13, WHO Doc. WHO/EMC/IHR/96.1 (Dec. 11-14, 1995), available at [http://whqlibdoc.who.int/hq/1996/WHO\\_EMC\\_IHR\\_96.1.pdf](http://whqlibdoc.who.int/hq/1996/WHO_EMC_IHR_96.1.pdf).

B. *Criticism of WHO's Limited Approach*

1. International Legal Philosophy

It is a well-known principle that “[i]nternational law . . . lacks its own ‘muscle’; its own ability to force the parties to do something that they don’t want to do.”<sup>238</sup> WHO is not immune from this principle because it cannot even sanction Member States who do not comply with its binding regulations.<sup>239</sup> So what is the background of this conception that international law lacks muscle and how does that impact international enforceability of policies? Two broad schools of thought offer differing perspectives on international law.<sup>240</sup> One school believes a formalized central system of enforcement is required to attain international law; the other school views the current informal norms observed by nations as a subtle attainment of international order.<sup>241</sup> The global community desires that international law bring both peace and prosperity for the attainment of common human goals.<sup>242</sup>

Certainly more people find their lives twisted by the effects of poverty than by the direct effects of war. The effects include the health consequences of malnutrition and preventable diseases, the psychological costs of illiteracy, the physical burden of constant labor just to earn enough to stay alive, and the general emotional sense of fatalism and disempowerment that often accompanies the awareness that, through no fault of one’s own, one’s life is destined to be very hard indeed.<sup>243</sup>

International law provides a forum for the discussion of common issues among nations.<sup>244</sup> This is highly representative of the fact that WHO and other international health organizations were created for their ability to deal with common international trade and commerce impairments caused by health-related issues.<sup>245</sup> Ideally, modern international legal regimes still operate under this cooperative theme where the mutual needs of nations intersect and international law is the consensus of mutual

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238. Lea Brilmayer, *International Justice and International Law*, 98 W. VA. L. REV. 611, 622 (1996).

239. Fidler, *supra* note 54, at 848.

240. Brilmayer, *supra* note 238, at 612.

241. *Id.*

242. *Id.* at 615.

243. *Id.*

244. *Id.* at 620.

245. *See* Fidler, *supra* note 1, at 1083-84.

interests.<sup>246</sup> However, when countries fail to comply with international standards, the “application of pressure” is a legal strategy that may be available.<sup>247</sup> Sanctions assessed by other international actors make compliance with international law more desirable due to the increased cost of sanctions.<sup>248</sup> “Sanctions can include trade boycotts; withdrawing ambassadors; banning a violator from participation in international sports, scientific, or cultural activities; refusing to sign an unrelated agreement that the violator wants; and various other signs of international disapproval.”<sup>249</sup> The theory of sanctions is only beneficial to the extent that those who enforce the sanctions will not incur costs to themselves.<sup>250</sup> Often, sanctions are very hurtful to international actors.<sup>251</sup> For example, trade sanctions during the Persian Gulf War severely injured the economies of surrounding nations.<sup>252</sup>

The only other alternative to the aforementioned approaches to the implementation of international law is direct force.<sup>253</sup> Skeptics of international law emphasize that international legal institutions have little power to “*directly enforce* international decisions,”<sup>254</sup> enhancing WHO’s view to avoid the use of law to effectuate its ends.<sup>255</sup> Truly uncooperative nations know that the use of direct force is scarcely used and will often take the chance of violating international law knowing that no force is likely to be inflicted on them.<sup>256</sup> Direct force was taken to an exceptional level during the Persian Gulf War as nations united to protect Kuwait and economic oil interests.<sup>257</sup> It is interesting to note that by the United Nations Charter discouraging use of direct force to enforce international law, the international community has essentially “deprived itself of a very forceful remedy for international wrongs.”<sup>258</sup>

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246. Brilmayer, *supra* note 238, at 621.

247. *Id.* at 622.

248. *Id.*

249. *Id.*

250. *Id.*

251. *See id.*

252. Brilmayer, *supra* note 238, at 623.

253. *See id.* at 624.

254. *Id.* (emphasis added).

255. Taylor, *supra* note 42, at 282.

256. Brilmayer, *supra* note 238, at 624-25.

257. *Id.* at 624.

258. *Id.* at 625.

## 2. Implementation Problems

Beyond the above-mentioned principles of weak international legal structure, WHO has not effectively exercised its legal muscle under Articles 19 and 21 of the WHO Constitution.<sup>259</sup> The scope of WHO's international legal authority under Article 19 authorizes WHO to "have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization."<sup>260</sup> Given the lengthy functional provisions of WHO under Article 2, Article 19 provides WHO with overwhelming legal powers. Nevertheless, WHO has not utilized its broad powers in many facets of its policy implementation.<sup>261</sup> The most obvious example is that international health directives possess no enforcement powers,<sup>262</sup> a victim of the aforementioned international legal philosophy. Violations of binding health law can only be remedied within the powers of dispute settlement procedures established by WHO.<sup>263</sup> Unfortunately, since Members States rarely use dispute settlement procedures, the creation of international health law can be characterized as unenforced recommendations, at best.<sup>264</sup>

## 3. Internal/Structural Problems

While WHO suffers from macro-level problems such as the effects of international legal philosophy as well as constitutional implementation of its power, WHO also receives criticism for its limited organizational make-up. First, no WHO permanent or part-time staff members has primary responsibility for public international legal issues.<sup>265</sup> Legal counsel for WHO constantly responds to legal matters of the Executive Board and the World Health Assembly,<sup>266</sup> yet WHO lacks a formal legal office that works with the Director-General to assure integration of WHO policy as international law.<sup>267</sup> It has also been suggested that to foster its legal capacity, WHO should establish legal links with other specialized agencies of the U.N. that have experience with international legal involvement.<sup>268</sup> There is high expectation that "[i]ncreasing WHO's international legal

259. See Fidler, *supra* note 54, at 837.

260. WHO Constitution, *supra* note 3, art. 19, 62 Stat. at 2685, 14 U.N.T.S. at 192.

261. See generally Fidler, *supra* note 1, at 1089-1095 (discussing examples of WHO's failure to respond to global health with international regulations).

262. *Id.* at 1090.

263. *Id.*; see also Fidler, *supra* note 54, at 848.

264. Fidler, *supra* note 1, at 1090-91.

265. *Id.* at 1112.

266. *Id.*

267. *Id.* at 1113.

268. *Id.* at 1114.

activity beyond the revised IHR and the tobacco control convention will demand even more international legal commitment from WHO” in the future.<sup>269</sup>

Despite external pressures, WHO remains reluctant to develop international legal regimes beyond its response to global infectious disease.<sup>270</sup> In 1989, even WHO’s legal counsel reasoned that international law was an ineffective tool to deal with global health problems since international law is often too slow to deal with rapidly evolving health concerns.<sup>271</sup> However, in recent years, the validity of that reasoning has been undermined with increased volume and the accelerated speed at which global health problems grow worldwide.<sup>272</sup> Additionally, the logic of WHO’s General Counsel fails because the root of WHO’s very existence is based on international law and international relations.<sup>273</sup> The powers of WHO come from its Constitution, which is backed by U.N. legislation. Through international legal power, WHO can transform international public health if it so desires.<sup>274</sup>

A major reason for WHO’s resistance to engage in international law and policy-making comes from its medical philosophy.<sup>275</sup> WHO’s personnel is dominated by professionals trained in public health and medicine.<sup>276</sup> This background “produces an ethos that looks at global health problems as medical-technical issues to be resolved by the application of the healing arts.”<sup>277</sup> A medical-technical approach does not facilitate the use of international law, but rather it advocates that local and national medical resources, not law, can resolve health situations.<sup>278</sup>

## VI. THE FUTURE: GLOBAL HEALTH JURISPRUDENCE

The background of how and why WHO has become what it is has been laid out in the preceding sections. Many scholars point out the weaknesses and rationales for WHO’s actions and inactions pertaining to international health law. Much focus has been directed at legislation, but

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269. *Id.* at 1109.

270. Fidler, *supra* note 1, at 1106.

271. *Id.*

272. *Id.* at 1107.

273. *Id.*

274. *See id.*

275. *Id.* at 1099.

276. Fidler, *supra* note 1, at 1099.

277. *Id.* (footnote omitted).

278. *Id.*



it is naïve to place reliance solely on international legislation by WHO.<sup>279</sup> Michel Bélanger believes that the general objective of international health law "is to support, guide, and coordinate national health law."<sup>280</sup> Achieving such a legal framework in a globalized world is fundamental to the emerging philosophy of global health jurisprudence.<sup>281</sup> "Global health jurisprudence can be defined as that body of rules, strategies, and procedures that allows law in all its forms to support public health. The objective of developing a global health jurisprudence is to identify concepts, standards, and approaches that best promote public health."<sup>282</sup>

It is undeniable that the complexities of global health jurisprudence is due to vast diversity among the world's cultures, but global health jurisprudence aims to create a common discourse how law and health relate to one another.<sup>283</sup> Such a discourse is rooted in numerous international agreements and laws<sup>284</sup> but only WHO, as the recognized advocate for world health, can develop it into a global paradigm.<sup>285</sup>

David Fidler has been one of the staunchest advocates of global health jurisprudence and offers a four-part rationale for its implementation.<sup>286</sup> First, the public health context is so broad that an effective framework of rules and strategies is essential.<sup>287</sup> Second, the theoretical framework is based on the interdependence of national and international law as an integrated system.<sup>288</sup> Third, this national and international interdependence reflects the desire of public health experts and legal experts for the need to cooperate at all levels.<sup>289</sup> Finally, global health jurisprudence will not be solely interdependent on laws, but it will include state and non-state actors such as public and private organizations, transnational corporations, and governments who implement global health

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279. Fidler, *supra* note 1, at 1116.

280. Michel Bélanger, *The Future of International Health Legislation*, 40 INT'L DIG. HEALTH LEGIS. 1, 2 (1989).

281. See Fidler, *supra* note 172, at 52.

282. Fidler, *supra* note 1, at 1117.

283. *Id.*

284. *Id.* Global health jurisprudence will be reflective of "treaties, international regulations, international recommendations and standards, international soft law norms, customary international law, national statutes and administrative regulations, and cases settling disputes." *Id.*

285. *Id.*

286. See Fidler, *supra* note 111, at 52.

287. *Id.*

288. *Id.*

289. *Id.*

at all levels.<sup>290</sup> These rationales are a bit simplistic of the global health jurisprudence ideals but are recurrent themes throughout a discussion of the concept.

While global health jurisprudence is legal in nature, it is more accurately described as forming global public health policy.<sup>291</sup> Global public health policy does not come without a price. Traditional sovereign states need to rethink territorial-based governance to adapt to a more relevant global framework.<sup>292</sup> Creation of global policy requires a partnership between state and non-state actors to answer the ongoing challenges faced by countries.<sup>293</sup>

Cooperation to achieve global health jurisprudence requires the development of both horizontal and vertical relationships.<sup>294</sup> “[V]ertical relationships among international organizations, states, and NGOs [non-governmental organizations and] . . . horizontal relationships between international organizations, governments, and non-state actors,”<sup>295</sup> makes public health a legal and political matter through every facet of international relations.<sup>296</sup> By recognizing vertical and horizontal relationships, global health jurisprudence will benefit from these same relationships in other areas of law such as trade, labor, and environmental law that already recognize health as an important value.<sup>297</sup>

Global health jurisprudence will inevitably improve WHO's international legal capacity to achieve its goals, but the only strategy to actually implement international law and policy is through the support of national law.<sup>298</sup> International law often sparks reform in domestic law, both in advanced and developing countries to attain accepted international standards,<sup>299</sup> but international legal instruments need the power of national legal capacity.<sup>300</sup> Global health jurisprudence recognizes that national legal reform that acts without consideration of global consequences defies the purpose of the ideology.<sup>301</sup> For example, national legal measures that

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290. *Id.* at 52-53.

291. Fidler, *supra* note 1, at 1118.

292. *Id.*

293. Wolfgang H. Reinicke, *Global Public Policy*, FOREIGN AFF. 127, 132 (Nov./Dec. 1997).

294. *See* Fidler, *supra* note 1, at 1119; *see also* Fidler, *supra* note 111, at 55.

295. Fidler, *supra* note 1, at 1119; *see also* Fidler, *supra* note 111, at 55.

296. Fidler, *supra* note 111, at 55.

297. *Id.*

298. *Id.* at 54.

299. *Id.*

300. *Id.*

301. *Id.*

resulted in settlements in U.S. tobacco cases failed to recognize adverse effects on other countries.<sup>302</sup>

An objective that is central to global health jurisprudence is to find ways that the complexities of law can effectively support public health.<sup>303</sup> This will occur through regulatory and legislative approaches that support health policy.<sup>304</sup> "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."<sup>305</sup> Implementing such rules, structures, authority, and procedures for the benefit of public health will involve health experts, lawyers, and scientists because global health jurisprudence is interdisciplinary.<sup>306</sup> A formula of rules and procedures will certainly not create legal harmony to all problems of global health due to diversity from place to place, but the common discourse between law and health will benefit ongoing acceptance of the philosophy of global health jurisprudence.<sup>307</sup>

In summary, global health jurisprudence recognizes that society's needs demand more knowledge and skills in law and public health since the impact of health has become a global issue.<sup>308</sup> Global health jurisprudence seeks to: (1) increase the knowledge and skills relating to law and health,<sup>309</sup> (2) provide a means "to foster the science and philosophy of public health law locally, nationally, and globally,"<sup>310</sup> and (3) implement interdependent bodies of law at national and international levels.<sup>311</sup>

## VII. CONCLUSION

A fundamental right to health exists in the world that gives other rights meaning and value.<sup>312</sup> The right to health is broader than other rights because it touches on "many fundamental aspects of social welfare and even ultimately what it means to be human."<sup>313</sup> Yet achievements in

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302. Fidler, *supra* note 111, at 54.

303. *Id.* at 53.

304. *Id.*

305. *Id.* (footnote omitted).

306. *Id.*

307. *Id.* at 53-54.

308. Fidler, *supra* note 111, at 56.

309. *Id.*

310. *Id.*

311. *Id.* at 56-57.

312. Jamar, *supra* note 5, at 67.

313. *Id.* at 58 (footnote omitted).

global health are overwhelmed by the burden of disease on the world's disadvantaged populations.<sup>314</sup> As the globalization of health issues reach countless areas of humanity,<sup>315</sup> international law must now incorporate the value of health not only for the health of individuals but also for the health of populations and the planet as well.<sup>316</sup>

WHO plays a crucial role in promoting health policies and fostering universal access to health.<sup>317</sup> WHO attempts to encourage the principle that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."<sup>318</sup> WHO's legal ability to enact international legislation and recommendations under the WHO Constitution gives the organization broad legal authority to any matter within its scope.<sup>319</sup> WHO spends much of its resources in an effort to combat ongoing and newly emerging infectious disease throughout the world,<sup>320</sup> yet the IHR and other legal maneuvers are too limited in scope to make a significant difference. While the revised IHR provide some hope of increased effectiveness and protection for the future, there is still an aura of doubt that its provisions will actually beat the ongoing and deadly threat of infectious disease.

WHO's responsibilities are not solely limited to international health legislation. In addition to its research and communication of health matters worldwide to Member States, WHO directly and indirectly affects how health is an integral part of other legal matters. Member States' trade and commerce woefully yield to human health concerns<sup>321</sup> because historically health crises impaired the economic well-being of States.<sup>322</sup> Likewise, environmental concerns resulting from urbanization and poverty demand an even greater response to meet the health standards of the world. Finally, WHO is gaining strength in the battle of international tobacco control. Fostering international policy on tobacco will require a delicate balance with nations' autonomy,<sup>323</sup> yet WHO can prepare a

314. THE WORLD HEALTH REPORT 1999, *supra* note 70, at 13.

315. See Fidler, *supra* note 111, at 10.

316. *Id.* at 26.

317. Taylor, *supra* note 7, at 303.

318. WHO Constitution, *supra* note 3, pmbll., 62 Stat. at 2680, 14 U.N.T.S. at 186.

319. See WHO Constitution, *supra* note 3, arts. 19-23, 62 Stat. at 2685, 14 U.N.T.S. at 192-93.

320. See generally THE WORLD HEALTH REPORT 1998, *supra* note 19, at 49-57.

321. Fidler, *supra* note 111, at 27.

322. See Fidler, *supra* note 1, at 1083.

323. Taylor, *supra* note 42, at 284.

common tobacco control doctrine that will be applicable despite cultural and health differences.<sup>324</sup>

Despite WHO's efforts to attain more effective health measures and a right to health throughout the world, it is still susceptible to greater demands than WHO should fulfill alone. As an international organization, its powers are generally limited to indirect pressures on a violator of international policy as opposed to direct force to ensure compliance with the goals of the majority.<sup>325</sup> It is understandable then that WHO limits its legislative powers to act on controversial issues since the global populous can so easily refuse to abide by a particular directive. However, a change in WHO's international policy-handling requires internal refinement away from a solely a medical perspective<sup>326</sup> and encouragement of its legal potential through policy-making.

WHO must take a more effective approach to global health problems because of the unique forum it provides, especially its legal framework.<sup>327</sup> Due to WHO's past failures to utilize its unique international capacity, an effective framework of global health jurisprudence is required. Global health jurisprudence must encompass interaction between national and international law<sup>328</sup> between state actors, non-state actors, and international organizations on health priorities<sup>329</sup> to achieve a cooperative, unilateral direction to better serve the health needs of the global community.

This comment has outlined the progress and setbacks of global health and WHO. In a recent speech before the American Public Health Association, Dr. Gro Harlem Brundtland cited nearly all of these very issues discussed herein as significant to the continuing challenges of WHO.<sup>330</sup> Important health issues not only reflect external actors' concerns but also show recognition by WHO's leadership to rectify problems that inhibit health. Also, *World Health Report 2001* focuses attention solely on new mental health concerns and the dangers that will persist if it continues

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324. *Id.* at 296-97.

325. See Brilmayer, *supra* note 238, at 629-30.

326. See Fidler, *supra* note 1, at 1099-1100.

327. Taylor, *supra* note 7, at 345.

328. Fidler, *supra* note 1, at 1116.

329. See Fidler, *supra* note 111, at 55.

330. See Dr. Gro Harlem Brundtland, Address by Dr. Gro Harlem Brundtland to American Public Health Association Annual Meeting – "One World: Global Health" (October 22, 2001), available at [http://www.who.int/director-general/speeches/2001/english/20011022\\_aphaatlanta.en.html](http://www.who.int/director-general/speeches/2001/english/20011022_aphaatlanta.en.html) (last visited Oct. 9, 2002).

to go untreated.<sup>331</sup> This recognition by WHO shows that the scope of global health does not diminish; it continues to enlarge. Past problems are still present, and the problems of today are likely to be here in the future. WHO will have to expand the scope of its power, policy, and legal capacity to deal with evolving global health. However, while WHO may be the channel for global health concerns, the advocates of global health jurisprudence are correct that an interaction between national and international law through state actors, non-state actors, and international organizations, specifically WHO, are essential to deal with the future of global health. WHO has a duty as reflected herein to promote the highest level of health for all people but strengthening its philosophy through mutual international cooperation of nations is the only way to achieve an acceptable global level of health for all.

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331. See THE WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 2001: MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE* (2001), available at <http://www.who.int/whr/2001/main/en/pdf/index.htm>.

