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HEALTH LEGISLATION AT THE DAWN OF THE XXI\textsuperscript{ST} CENTURY

WORLD HEALTH ORGANIZATION
The International Digest of Health Legislation, published quarterly in two separate editions, English and French, contains a selection of national and international health legislation, studies on current problems in health legislation, a NEWS AND VIEWS section, a BOOK REVIEWS section, and an IN THE LITERATURE section. The Digest, which has been restructured as of Volume 32, provides a continuation of the section entitled "Lois et Règlements sanitaires" of the Bulletin mensuel de l'Office international d'Hygiène publique, which was published from 1909 to 1946.

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INTERNATIONAL DIGEST OF HEALTH LEGISLATION

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HEALTH LEGISLATION AT THE DAWN OF THE XXIst CENTURY

WORLD HEALTH ORGANIZATION
The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 190 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of human resources for health, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member States; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases including tuberculosis and leprosy; coordinating the Global Strategy for the Prevention and Control of AIDS; having achieved the eradication of smallpox; promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards of biological substances, pesticides, and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Statistical Classification of Diseases and Related Health Problems; and collecting and disseminating health statistical information.

Reflecting the concerns and priorities of the Organization and its Member States, WHO publications provide authoritative information and guidance aimed at promoting health and preventing and controlling disease.

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Health legislation expresses and formulates health policies and provides governments with a regulatory framework for their implementation. Today, in increasingly incorporating elements of public debate, health legislation intervenes in order to balance the interests of different social groups. For the benefit of all citizens, it serves as a tool for furthering health protection and promotion, equity in access to health care, and respect for ethical principles. Through its standard-setting role, legislation keeps pace with technological advances and responds to new environmental problems. On a world scale, the standards and guidelines endorsed by the international community provide a framework for cooperation and health legislation makes it possible to promote health as a fundamental part of development.

* Dr Hiroshi Nakajima, Director-General, World Health Organization.
In 1948, in taking over from the Bulletin Mensuel de l'Office International d'Hygiène Publique, the aim of the International Digest of Health Legislation was to address all concerned with the study of the legislative and administrative aspects of public health issues. Since then, under the guidance provided by WHO’s governing bodies, the Digest has collected, presented, and published relevant legislation, thereby making available to Member States the information that could help them to develop appropriate health legislation adapted to their national needs. This worldwide dissemination of information has made it possible for Member States to pool their experience in the field of health legislation, to compare this experience, and take decisions with full knowledge of the facts. It has helped to avoid duplication of effort in formulating legislation and finding solutions to common problems.

The year 1977 marked a decisive turning point in WHO’s health legislation activities, which originally were primarily centred on the transfer of information. In its resolution WHA30.44, the World Health Assembly called for the strengthening and complete reorientation of the global health legislation programme to ensure its full concordance with the goal of Health for All and the primary health care approach defined by the Declaration of Alma-Ata. Thus, the programme now combines technical cooperation and information transfer. It plays a distinctive role, strengthening national capabilities with regard to both the formulation and implementation of legislation to support health policies.

Over the years, the programme has endeavoured, at global and regional levels, to support countries in their legislative efforts to protect and promote the health of their populations, implement their health policies and measures, reduce inequities in health, mobilize expertise and resources, and implement and evaluate health legislation itself. This legislative work also helps to support the quality assurance of health products and practices. Since it is long-term in nature, it contributes to the continuity and coherence of health activities. At the same time, it must permit sufficient flexibility for it to be receptive to the evolution of concepts such as that of health or patients’ rights, to reforms in the health services, to advances in research and technology, and to the consideration of new diseases.

In helping countries to strengthen their national capabilities in this field, WHO’s Health Legislation Programme has contributed significantly to the worldwide harmonization of health legislation and standards in health sectors concerned with, inter alia, AIDS, organ transplantation, mental health, and pharmaceuticals. The growing inter-dependence of countries today calls for ever-closer international cooperation in health legislation, in order to draw up common standards and evaluate existing international instruments in the health field and related sectors.
Health for All remains the central vision of our Organization beyond the horizon of the year 2000, and a process for the renewal and updating of health policy was initiated nearly five years ago in order to bring us closer to this objective. The aim of this updated health policy is to help countries prepare themselves for the health problems that will be raised during the course of the next century by the demographic, economic, technical, and epidemiological developments that are already in progress. Health is the combined result of both the internal and external determinants affecting the health sector properly speaking. Our new health policy takes account of this reality, the cultural dimension of health and social action, and the values based on human rights. Given the global challenges confronting us in the 21st century, our action for health may take the form of three fundamental approaches: making health central to development; establishing health systems that are efficient and sustainable; and offering a normative framework that is consonant with our health policy and with values that are intelligible to all, irrespective of culture.

Health legislation is one of the essential public health elements. It must help, in a practical and realistic manner, to translate into public health terms the ideal of making health accessible to all. WHO will continue to explore ways of providing increasingly better service to public health through appropriate standard-setting and through the formulation or dissemination of examples of legislation, regulations, and enacting terms of texts that can meet the needs of countries or regions.

The question now arises as to whether, as a next stage, our work of collection and analysis should also encompass legislation drawn up at regional level, thereby permitting its functional co-existence at global level. Moreover, we must be aware that, if we are to make the harmonization of health legislation coherent and effective, we must not limit it to certain sectors or products and ignore, for example, the sectors concerned with services and professional qualifications, particularly in a world where exchanges are assuming global dimensions. Whether dealing with legislative work or the work of health development, it is always necessary to start from reality and concrete situations in order to progressively overcome any difficulties and contradictions. Pragmatism is one of the prerequisites of efficacy.

Through its policy of Health for All, WHO has committed itself to the service of human and sustainable development. It will consolidate this commitment through its standard-setting work and by suggesting to governments a legislative framework to support their efforts to improve the health of populations and reduce inequities. It is hoped that the articles contained in this Special Issue will...
help pave the way for such a legislative strategy, at both country and global level, so that we may all be ready to take up the challenges of the 21st century and assure the development of Health for All.

Dr Hiroshi Nakajima, M.D., Ph. D.  
Director-General  
World Health Organization
In my capacity as the Belgian Minister responsible for Public Health, I particularly welcome the opportunity to write the Foreword to this Special Issue of the *International Digest of Health Legislation*, published in celebration of the 50th anniversary of the World Health Organization.

It was indeed a Belgian, Dr Jean de Moerloose, who, 50 years ago, became the first Chief of WHO's Health Legislation Unit in Geneva. After Dr de Moerloose's retirement, the then Secretary-General of the Belgian Ministry of Public Health and Family Affairs, Professor Samuel Halter, contributed a great deal, through his financial and moral support and also his enlightened advice, to the establishment, within WHO's Regional Office for Europe in Copenhagen, of the Health

*Marcel Colla*, Minister of Public Health and Social Benefits of Belgium.
HEALTH LEGISLATION - 21st CENTURY

Legislation Unit, under the leadership of Miss Geneviève Pinet.

In 1984, Dr Pierre de Schouwer, Secretary-General of the same Ministry from 1981 to 1986, Professor André Prims, WHO co-workers, and the Ministry’s International Relations Department set up the first international course in health legislation under the aegis of WHO. The first session, held at the Catholic University of Leuven, was opened by Mr Jean-Luc Dehaene, then Minister of Social Affairs and currently Prime Minister of Belgium.

The creation in Belgium, in 1995, of a network of national experts with the object of supporting WHO’s Health Legislation Programme was a logical follow-up to previous achievements. Today, the existence of a unit within WHO capable of providing those responsible for the health of our population with effective instruments in the form of exemplary legislation is clearly of prime importance.

New diseases continue to emerge; others we believed we had eradicated are making a comeback. The impact on our evolving societies is considerable. All these phenomena arouse passionate debate within our communities and demand the attention of legislators at the highest level.

I consider that the activities of WHO’s Health Legislation Unit are indispensable for the attainment of the objective of Health for All for the 21st century. Hence my greatest wish is that this Unit continue and even strengthen its activities, notably through active collaboration with Member States.

Marcel Colla
Minister of Public Health and Social Benefits of Belgium
INTRODUCTION

This Special Issue of the *International Digest of Health Legislation* has been prepared in celebration of WHO's fiftieth anniversary. This anniversary provides the opportunity to call to mind a half century of major achievements in the field of health worldwide — achievements to which legal instruments have contributed a great deal. It is a commemoration that is also a starting point for reflection, offering an opening with regard to innovative health policies that express an eagerness to take up the challenges of a new era. In view of the constant mutations affecting our societies throughout the world, a predominant place should be accorded to the right to health in order to give impetus to the renewal of these policies and ensure the progress of action for health.

The initiative of this publication has been taken for a number of reasons. First, in order to make health law better known and trace its development; secondly, to instil awareness of the role of health legislation as an instrument of health policy; and, finally, to highlight certain fields that deserve particular attention both because of current trends and also because they form part of a future perspective.

Thus, this Special Issue comprises three parts: the first deals with the general principles of health law (concepts and definitions, the scope of health law, its evolution, its teaching, its links with other fields of law, bioethics, and the policy of socioeconomic development, the observance of the right to health, and, finally, its ever-widening mission to respond to progress in public health); the second describes the role of health legislation as an instrument of health policy (its possibilities, the obstacles it encounters, its internationalization, historical background, and its role in the policy of Health for All); the third presents legislative action within the context of certain specific fields of worldwide interest. It builds on the first two parts by demonstrating the advantages to be derived from the support provided by legislative instruments to the major public health priorities, and suggests new legislative approaches to meet the challenges of the 21st century (it is concerned, in particular, with the determinants of health,
actions directed at prevention and health promotion, the health of the environment, the control of communicable diseases, the progress and risks of new technologies, the observance of patients' rights, and the right to health of women, children, and the elderly).

Internationally renowned experts in the field of health law who have made substantial contributions to the development of the WHO health legislation programme over the past decades have been approached to participate in the elaboration of this commemorative issue of the International Digest of Health Legislation. It is my pleasure to introduce each of these distinguished writers in the order in which their articles appear in this Special Issue.

Herman Nys is Professor of Medical Law and Co-Director of the Centre for Biomedical Ethics and Law at the Catholic University of Leuven, Belgium. He is the Editor of the International Encyclopaedia of Laws and Medical Law and the author of numerous books and articles on biomedical law in Dutch, English, and French.

His article appears under the title “Medical law and health law: from co-existence to symbiosis?”.

Frank Grad is Chamberlain Professor Emeritus of Legislation and Former Director of the Legislative Drafting Research Fund at the School of Law, Columbia University, New York. He continues to teach subjects in the fields of environmental and public health law. His bibliography includes his Public Health Law Manual (2nd edition, 1990, APHA) and his eight-volume Treatise on Environmental Law (Matthew Bender, 1972-1997).

His article appears under the title “Public health law: its form, function, future and ethical parameters”.

Patrick A. Molinari has taught in the Faculty of Law at the University of Montreal, Canada, since 1977 and has been a Vice-Rector of this University since 1995. He has been Dean of the Faculty of Law (1992-1995), Vice-Dean of Research and Higher Education (1986-1992), and Director of the Centre for Research in Public Law (1985-1989). The author of a number of works and articles on health law and the organization of health care systems, he is the founding President of the Society for Medicine and Law of Quebec and an expert consultant to numerous bodies connected with the health sector.

His article is entitled “The right to health: from the solemnity of declarations to the challenges of practice”.
Michel Bélanger has been Professor of Public Law at the Montesquieu-Bordeaux IV University since 1989, having successively held the posts of Assistant Lecturer, Lecturer, and Senior Lecturer. Director of the Centre for Study and Research in European Health Law (CERDES) (established at two sites: Nantes in 1990 and Bordeaux in 1996, respectively), he has been Secretary-General of the French Association for Health Law since 1991. Professor Bélanger is the author of numerous publications on international health law, including *Droit International de la Santé* (1983) and *Droit International de la Santé par les Textes* (1989).

His article is entitled “Training in health law”.

Henk J. J. Leenen, formerly director of a national health organization and secretary of a physicians’ association, was appointed in 1970 as Professor of Social Medicine and Health Law in the Faculties of Medicine and Law at the University of Amsterdam. He was the founder of the Dutch Association of Health Law, the *Tijdschrift voor Gezondheidsrecht*, and the *European Journal of Health Law*. He has served on many committees (notably, governmental committees on the reorganization of health care), is President of the Governmental Committee on Patients’ Rights, and Vice-President of the State Committee on Euthanasia. He has published books on health law, health care, and environmental health law, as well as many articles in national and international medical and legal journals. His books in English include: *Trends in Health Legislation in Europe* (1986, in collaboration with G. Pinet and A. Prims) and *The Rights of Patients in Europe* (1993, in collaboration with J. Gevers and G. Pinet).

His article appears under the title “Health law and health legislation: possibilities and limits”.

Ruth Roemer, J.D. is Adjunct Professor Emerita, School of Public Health, University of California, Los Angeles, and Past President, American Public Health Association. She is the author of numerous publications, including *Legislative Action to Combat the World Tobacco Epidemic*, first published by WHO in 1982, with a second edition in 1993. In 1989 Dr Roemer was awarded the “WHO Tobacco or Health Medal”. In 1991 the American Public Health Association conferred on her its most prestigious honour, the Sedgwick Memorial Medal for distinguished service in public health.

Her article appears under the title “Health legislation as a tool for public health and health policy”.

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Henriëtte Roscam Abbing is Professor of Health Law at the Faculty of Law of the University of Utrecht, the Netherlands. She is also Counsellor on Health Law to the Netherlands Minister of Health. Her interest in (international) health law stems from her time with the Public Health Division of the Council of Europe (Strasbourg, France). Her doctoral thesis was on the right to health care and international organizations in Europe. She was a member of the drafting group of the European Convention on Human Rights and Biomedicine (1996, Council of Europe) and is an Editor-in-Chief of the European Journal of Health Law.

Her article appears under the title “Health, human rights, and health law: the move towards internationalization, with special emphasis on Europe”.

After university studies in Edinburgh, Cambridge (Trinity Hall), and the University of Wisconsin-Madison, and five years’ professional work in Cambridge, Mr S. S. Fluss joined WHO’s Health Legislation Unit in October 1965. He served as Chief of the Unit from March 1984 to February 1995. A member of the editorial boards of various journals in the field of medical and health law, Mr Fluss is an Honorary Member of the Czech Medical Association and holds a Special Professorship in the Faculty of Medicine and Health Sciences of Nottingham University. He is Special Adviser to the Secretary-General of the Council for International Organizations of Medical Sciences (CIOMS), having formerly been Programme Manager for Human Rights, Office of Health Policy in Development, WHO, Geneva.

His article is entitled “The role of WHO in health legislation: some historical perspectives”.

Geneviève Pinet has been Chief of WHO’s Health Legislation Unit, Geneva, and Editor-in-Chief of the International Digest of Health Legislation since 1995. She was formerly Senior Legal Officer, Office of the Legal Counsel, WHO, Geneva (1990-1995), Regional Officer for Health Legislation at the WHO Regional Office for Europe (1978-1990), and consultant to the same Regional Office (1976-1978). Author of several books and articles in various fields of health legislation, she is also one of the Governors of the World Association for Medical Law (Ghent, Belgium), a member of the International Council of Environmental Law (Bonn, Germany), a member of the Editorial Board of the Harvard School of Public Health journal Health and Human Rights, a member of the Editorial Board of the European Journal of
Health Law, and a permanent correspondent of UNESCO’s International Bioethics Committee.

Her article appears under the title “Health challenges of the 21st century: a legislative approach to health determinants”.

Jean Martin is a Swiss public health physician. After completing his clinical training in his own country and having obtained a diploma in tropical medicine, he worked in a hospital in Peru. This experience led him to the field of public health, which he studied at the University of North Carolina at Chapel Hill, before working for WHO in South-East Asia and then Cameroon in a bilateral context. Now back in Switzerland, he is Cantonal Medical Officer of Health for the Canton of Vaud and is a privat-docent and agrégé at the Faculty of Medicine, Lausanne University, where he teaches social and preventive medicine. He is particularly interested in current medicolegal and medico-ethical issues and has published several books.

His article is entitled “The proper use of legislation in the promotion of health and prevention: experience and appraisal of a public health physician”.

Alexandre Kiss is Emeritus Director of Research at the National Centre for Scientific Research (France) and teaches at the Robert Schumann University, Strasbourg, France and the University of California at Santa Clara. His field is international environmental law and he has published numerous books and articles, including Droit International de l’Environnement (1989) and Traité de Droit Européen de l’Environnement (in collaboration with D. Shelton (1995)). A recently published work, Les Hommes et l’Environnement : Quels Droits pour le XXIe Siècle — Études en Hommage à Alexandre Kiss (1998), rightly acknowledges the scope of his contribution to human rights and environmental law. A consultant to most international organizations concerned with the environment, he is President of the European Council of Environmental Law.

His article is entitled “Health legislation and the environment”.

Lawrence Gostin, J.D., LL.D. (Hon.) is Professor of Law at Georgetown University and the Co-Director of the Johns Hopkins/Georgetown University Program on Law and Public Health (USA). He is also a member of the Advisory Committee of the United States Centers for Disease Control and Prevention. He is the Health Law and Ethics Editor of the Journal of the American Medical Association (JAMA) and was a member of the President’s Task Force on National Health Care Reform. Professor Gostin received the Rosemary Delbridge
Memorial Award in the United Kingdom for the person “who has most influenced Parliament and Government to act for the welfare of society”. He also received the Key to Tohoko University (Japan) for distinguished contributions to human rights in mental health.

His article appears under the title “Health legislation and communicable diseases: the role of law in an era of microbial threats”.

**Bartha Maria Knoppers, Ph.D.** (Sorbonne, Paris I) is Full Professor at the Faculty of Law, University of Montreal, Senior Researcher at the Centre for Public Law Research (C.R.D.P.), and Counsel to the law firm McMaster Meighen. Her research and teaching interests include human genetics, genetic epidemiology, biotechnology, biodiversity, comparative law, and children and the law. Professor Knoppers serves as an expert on WHO committees in Geneva, as well as those of the National Institutes of Health (NIH) in Washington, DC. She is currently Chair of the Ethical, Legal and Social Issues Committee of the Human Genome Organization (HUGO ELSI), member of the International Bioethics Committee of UNESCO, and Co-Director of the Research Institute for Population Studies (IREP). Consultant to the Ministry of Industry (Ottawa), she was recently appointed to the Standing Committee on Ethics of the Medical Research Council of Canada (MRC).

Her article appears under the title “Towards a reconstruction of the ‘genetic family’: new principles”.

**Michel Manciaux** is Emeritus Professor of Social Paediatrics and Public Health at the University of Nancy, France. He was formerly Regional Officer for Maternal and Child Health at WHO’s Regional Office for Europe (1968-1970) and Director of the International Children’s Centre in Paris (1974-1983). He is a member of the WHO Expert Committee on Maternal and Child Health and the WHO Advisory Committee on Health Research, and an honorary member of several learned societies, in France and elsewhere. He is the author of a dozen or so books on social paediatrics and public health and numerous scientific publications.

His article is entitled “Children’s rights: their development in the light of the protection and promotion of child, family, and community health”.

**Rebecca J. Cook** is a Professor in the Faculty of Law, the Faculty of Medicine, and the Joint Centre for Bioethics at the University of Toronto. She specializes in the international protection of human rights and in health law and
ethics, and is Director of the International Human Rights Programme at the School of Law. She has taught at the School of Public Health at Columbia University (USA), and is a member of the Scientific and Ethical Review Group of WHO’s Special Programme of Research, Development and Research Training in Human Reproduction. She was recently appointed to the Executive Council of the American Society of International Law. She serves on the editorial advisory boards of several journals and is an occasional adviser to the Commonwealth Medical Association, the Ford Foundation, and Profamilia Legal Services for Women. Her publications include over 75 books, articles, and reports in the areas of international human rights, the law relating to women’s health, and feminist ethics. She is the author of Women’s Health and Human Rights (Geneva, WHO, 1994), and is the Editor of Human Rights of Women: National and International Perspectives (Philadelphia, University of Pennsylvania Press, 1994).

Her article appears under the title “State accountability for women’s health”.

**Pierre Vellas** is an Emeritus Professor at the University of Toulouse I where, in 1958, he founded the Institute of International Studies and Development, which he directed until 1995. A specialist in international economic and social law, he fulfils numerous consultant, expert, and conciliatory functions on behalf of the Organizations of the United Nations System, and WHO in particular, and vis-à-vis some 30 governments. He is a member of WHO’s International Committee on Health Legislation and has been President of the French Society of Hygiene, Social Medicine and Sanitary Engineering, Founding President of the International Association of Universities of the Third Age, President of the National French Commission on the Aging of Man and Society, and the representative for France on the Preparatory Committee for the United Nations Conference on Aging (1982). He is also a Doctor Honoris Causa of the University of Neuchâtel, and an Officer of the Legion of Honour.

His article is entitled “Health legislation and the elderly”.

WHO would like to express its gratitude to these contributors who, like many of the Digest’s readers, are ideally placed to influence the future of health legislation. I would like to add my own personal thanks to the contributors to this Special Issue and also to the many authors who have over the years prepared articles on a regular basis for the International Digest of Health Legislation. Finally, I should like to express my appreciation to our health
legislation counterparts in the WHO Regional Offices whose advice and cooperation in the preparation of this Special Issue have been a constant source of inspiration.

Geneviève Pinet
Chief, Health Legislation Unit
INTRODUCTION

It is with great pleasure that I have accepted the invitation of Geneviève Pinet, Chief of the Health Legislation Unit of the World Health Organization, to write the introductory chapter for this Special Issue of the International Digest of Health Legislation on the occasion of WHO's 50th anniversary.

In 1980 I wrote the introductory article, dealing with the difference between medical law and health law,† for the first issue of the newly established Flemish journal of health law. This contribution is a thoroughly updated and expanded

* Professor H. Nys is Co-Director of the Centre for Biomedical Ethics and Law and Professor of Medical Law at the Catholic University of Leuven, Belgium.

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version of that article.

It is not the purpose of this article to write the history of medical law and health law, or to provide definitive answers. Drawing upon my knowledge of the literature, my personal experiences, and my contacts with colleagues in many countries, it is my intention to describe and analyse the current state of development of medical law and health law. I have divided this article into three parts. The first, which presents a broad picture of medical law, covers: the concept, different approaches to it, its recent and classic origins, its (lack of) conceptual unity (to which I shall return in the third part), and its relation to bioethics (bioethics law) and the life sciences (biomedical law). The treatment of health law in this part is implicit. It becomes explicit in the second part, drawing particular attention to the differences and similarities between medical law and health law and highlighting their different origins. The third part is an endeavour to trace the broad outlines of a future comprehensive approach to medical law and health law.

1. MEDICAL LAW

(a) No generally accepted definition

The term “medical law” is nowadays used throughout the world to indicate the area of law that governs the practice of medicine. There is, however, no definition of this branch of law that is accepted worldwide. As far as I can see, there has never even been an attempt to provide such a definition. In my opinion, this is a justifiable omission, since any attempt would inevitably be doomed to failure. A definition is not neutral. It is influenced by cultural, historical, moral, scientific, and legal differences between different countries and these cannot all be reflected in one authoritative definition.

It is perhaps somewhat surprising that even the World Association for Medical Law has, to the best of my knowledge, made no attempt to reach agreement on an all-encompassing definition of medical law. This Association was founded by Professor R. Dierkens, Secretary General of the Congress, on the occasion of the First World Congress on Medical Law, held at the University of Ghent, Belgium, in August 1967 “to secure a permanent link between those interested in medico-juridical problems, and to promote the study of medical law on a world level”. Because the World Congresses organized by the Association “cannot consider themselves representative of countries or groups of countries”, these Congresses have never adopted, and will never adopt in the future, normative conclusions and resolutions. This conviction of “non-interference” in “local” matters may explain why the Association has not attempted to unite its members in the acceptance of a common definition of medical law.
(b) Different approaches to medical law

As I have said, it is not my ambition to write a history of medical law. Nonetheless, an understanding of the different approaches to medical law at different times and in different places may shed some light on its future.

The classic approach: the law of the physician

One of the most famous definitions of medical law is more than 40 years old. In their standard work on the subject, Savatier and his colleagues defined medical law as “the study of the juridical relations to which the physician is a party”. This definition is widely accepted.

In the traditional French approach to medical law, the physician stands at the centre. Medical law is the study of the rights and obligations of the physician vis-à-vis his patients and his colleagues. Medical law in this respect is essentially a branch of professional law. The close links between medical law and so-called medical deontology or medical professional ethics are so strong that the differences between medical law and medical professional ethics become insignificant. In a recent book on medical law, Gérard Mémeteau, one of the most respected medical lawyers in France, defines medical law as the rules of conduct governing health professionals in their professional activities and the sanctions to enforce these rules, inspired by the principles of professional medical ethics that constitute one of the sources of medical law.

A different approach: the law of medical activities

Savatier’s definition has been criticized as too narrow in various respects. An original critique was formulated by Tomkin and Hanafin. For them, the importance of the physician-patient relationship may be marginal, when, for example, the physician is required to give an opinion pursuant to legislation about a person’s mental or physical condition for the purpose of hospitalization or eligibility for a benefit, or when the physician is acting for an insurer and assessing the person’s condition for the purposes of ascertaining risk or benefit. In their view, medical law has to be taken as the application of the Constitution, legislation, and case law (and such international and supranational laws as apply in Ireland) to the physician-patient relationship, the environment in which this operates, and any consequences necessarily associated therewith. It embraces not only the regulation of therapeutic intervention and advice, but also that of health care provision generally.

In this approach to medical law, it is not the physician in relation to his patient who is central, but his professional activities. An echo of this approach is also found in the definition given by Chalmers, according to which medical law is an area of law that concentrates not on actions (crimes and wrongs) or institutions
(contracts and constitutions), but on the activities of, and relationships created with, a medical practitioner. This point is also made by Van Oosten, who argues that the term “medical law” is difficult to define, one reason for this being that the principles and practice of medicine embrace an extremely wide range of topics and activities. Although the differences between these two approaches — and the others discussed below — should not be exaggerated, they should not be ignored either. This should become apparent in the following section.

(c) Medical law: as old as Hippocrates or a recent subject?

This difference in approach may indeed explain why some authors regard medical law as an area of law that already dates back many years, while others regard it as a “comparatively young subject.” Both viewpoints are correct in their own way. If medical law is chiefly regarded as the law of the medical profession, of the rights and duties of physicians, and as part of, or even a synonym for, medical professional ethics or so-called medical deontology, then the origins of medical law go back many centuries. Professional medical ethics are intrinsically interwoven with and have a continuous influence on the physician-patient relationship. What the rules of medical ethics demand of a physician will, at the same time and to a large extent, also be the legal obligation that has to be fulfilled. The Hippocratic Oath, for example, is then in a certain sense to be considered as a source of medical law.

To read that the discipline of medical law is “a relatively recent one. Its emergence and rise as an area of practical concern and scholarly study is largely a phenomenon of the last decade or so” or that “medical law is still very much in its infancy and this... not only in England but also in many a country” may therefore be a bit surprising for European medical lawyers. Much more than other authors, Grubb and Kennedy relate the development of medical law to the emerging problems posed by medical technology. In one sense, there is nothing new in recent developments such as in vitro fertilization, the freezing of embryos, genetic engineering, or kidney transplantation and kidney dialysis. There is a continuum of development and refinement of medical technology and medical skills, from the knife, the leech, and the potion to surgery, antiseptics, and anaesthetics. What then, Kennedy asks, is new about what is happening now? Is there anything which warrants giving special attention to recent developments in medical technology. All of the developments mentioned here have brought moral and legal questions in their wake. But it was arguably only recently that they were recognized as legal questions. Legal, as well as moral problems, were always involved in medical developments, but only recently, perhaps, have they been perceived as such, as questions which could be taken to the courts for decision. What has changed, suggests Kennedy, is the social climate in which these developments are taking place and in which medicine is now practised. Until
recently, such matters were left for private decision between the physician and his professional organization, between the physician and the relative, and between the physician and the patient. In other and my own words: they were left to medical professional ethics or medical deontology. In the United Kingdom (as in all European countries) there was a tradition of leaving the regulation and control of medical practice largely to the medical profession. Although he does not make the point explicitly, it seems correct to conclude that Kennedy, unlike French authors, does not assign to the realm of medical law this traditional legal approach of leaving difficult questions to the medical profession. If he did, he would not consider medical law to be relatively recent. Nowadays, he writes, we are no longer prepared to leave such matters merely to private agreement and regulation. Once society is convinced that these problems cannot be left to physicians alone, medical law makes its appearance. In this respect, medical law is a recent discipline, not only in the United Kingdom but in any country.

(d) Is there a conceptual unity in medical law?

There is no consensus on a definition of medical law. What is worse — owing to the different approaches involved — there is no agreement on the basic concepts of this law. Kennedy and Grubb see medical law as having “some conceptual unity. The unifying legal theme is, to us, that of human rights. In our view, therefore, medical law is a subset of human rights law. This is what provides its intellectual coherence”. In another article, Kennedy explains that he has always been guided by the approach adopted in the USA: “there the conceptual framework has consistently been that of constitutional rights or human rights.” The recently adopted Convention on Human Rights and Biomedicine seems to indicate that Kennedy was right. But this human rights discourse is not appreciated by all medical law scholars. Mémeteau finds that to confuse medical law and human rights would be going too far.

This difference of opinion may be traced back to another closely related difference. For Kennedy and Grubb, medical law is a distinct subject, made up of other areas of law, in particular tort law, criminal law, and family law. It is, however, more than the sum of these parts. For Mémeteau, a “pure” medical law only exists exceptionally: medical law is a synthesis of traditional legal disciplines such as contracts, tort, and labour law and a synthesis of medical and legal thinking. The prime rule of medical law is respect for the human person and his body. This rule is derived from civil law; there was no need for medical law to await the intervention of the legislature or the birth of bioethics to reach this conclusion.

(e) From medical law to biomedical law (or biolaw)

If the unifying object of medical law is not the practice of medicine or the relationship of the medical practitioner with his patient, but medical technology
and the way society at large decides to use this technology, then, in the view of some authors, the designation "medical law" becomes obsolete. Romeo-Casabona et al. define medical law initially as "the parts of the legal order which concern themselves with Medicine, that is, the medical profession and, by extension, other health or health-related professions ... However, in view of the constant widening of the scope of actions affecting health, nowadays Medical Law includes also the legal implications of the application to human beings of the so-called Biomedical Sciences, that is not just medicine, but also biology (e.g. genetics), biochemistry, biophysics, etc.". They use the term "biomedical law", stating that this discipline and bioethics together study the biomedical sciences and how they affect human beings: the former from the legal and the latter from the ethical viewpoint. The word "medicine" pertains to the "healing arts" and the prefix "bio" relates it to "life", having the same meaning as in "biology" and "biography". It adds an existentialist dimension to medicine. Biomedical law addresses the concepts of both law and medicine and, through such areas as genetic engineering, the biological sciences. It is the interaction of these sciences with medicine and law that forms the subject of the study of biomedical law.

(f) The relationship between law, ethics, and the life sciences: what is the relationship with "bioethics law"?

The above section brings us to another matter on which opinions diverge widely, and which relates directly to the subject and method of medical law: its relation to ethics and, more specifically, to so-called bioethics. Different approaches can be distinguished concerning the relationship between law and ethics with regard to their links with medicine and the life sciences. The commonest approach is found with Kennedy and Grubb, for whom medical law co-exists with medical ethics: "medical law ... is a complex subject. It co-exists with any equally intricate and important areas of study that sheds light on the issues — medical ethics". It has to be recognized that law and ethics are separate disciplines: they are different and their differences must be emphasized and celebrated. Too often, Kennedy adds, a competence is claimed in ethics and law.

A second approach is the North American one. "American bioethics", Annas writes, "draws both its strengths and weaknesses from the fact that it is rooted in and dominated by American law". Capron is less outspoken. For him, the relationship between law and bioethics is complex and multifaceted. The law has been strongly influenced by the methodology of bioethics, the central focus of bioethics, and the values of bioethics. "Law and bioethics" (or bioethics law) has become a separate field of study of increasing interest. Law and bioethics can be seen as a subset of health law that deals with, *inter alia*, medical decision-making, genetic and reproductive technology, and human subject research. But this one-dimensional view of the relationship between law and bioethics does not fully capture the way in which bioethics is generally perceived. By the early
1960s, long before health law emerged as a separate field, courses dealing with bioethics were being taught at American law schools. And although people looking at the topic "law and bioethics" from the perspective of the latter field are likely to view it as a legitimate area of scholarship and practice, it is largely unrecognized among lawyers at large, who treat it neither as one of the distinctive "law and..." interdisciplinary fields nor as a distinct special application of law ("bioethics law") akin to labour law, sports law, and the like.

One of the main characteristics of this American bioethics law is its domination by references to rights. The law has offered bioethics a long tradition of protecting people from harm by the assertion of their rights; a rights orientation seems inherent in the law's perspective on the relationship of the health care system to patients and research subjects. Capron draws our attention to an interesting difference between France and the USA: although revolutions in both countries in the late 18th century drew on the same sources in articulating basic rights, the Declaration of the Rights of Man and Citizen in France in 1789 — unlike the Declaration of Independence in the USA in 1776 — emphasized that individuals have duties as well as rights. This difference, which persists to this day, has important implications for bioethics law.

This brings us to a third approach to the relationship between law and ethics — the French one. This may be called the "from ethics to law" approach. After a decade or so of intense ethical debate on biomedical matters, France has equipped itself with comprehensive bioethical legislation, consisting of three laws (the so-called bioethics laws) promulgated on 1 and 29 July 1994. According to Michaud, the National Ethical Consultative Committee for the Life and Health Sciences (CCNE) played an important role in ensuring that Parliament act in line with the Committee's opinions on the various issues examined. The CCNE has been established longer than any other committee of its kind anywhere. The 1983 Decree setting up the CCNE defines its functions as "to give its views on ethical problems raised by research in the fields of biology, medicine, and health, irrespective of whether these problems concern man, social groups, or society as a whole". The CCNE has not confined itself to throwing light on ethical issues and weighing up the various points of view. It has asked for, and sometimes insisted on, legally binding rules whose content had to be in line with its own point of view. It should be pointed out that the CCNE's opinions are not binding in any way and that the legislator is not compelled to take them into consideration. However, it is generally accepted that its opinions do have an impact on the development of medical law in France. Although members of the CCNE and its successive Presidents have continuously declared that the Committee would not become a legislative body, its growing influence on medical law is undeniable. In this respect, its Opinion No. 18 deserves special mention. This Opinion is prefaced by a set of "general remarks" in which the CCNE bemoans the slow progress made in acting upon its previous Opinions. The CCNE was clearly
thinking in terms of a legislative follow-up, for it applauded the decision of the French Government to instruct the Council of State to study the problems raised by the “transition from ethics to law”, to propose solutions, and to table a bill on the life sciences and human rights. This is a view shared by the Committee's “founding father”, the late President Mitterrand. On the Committee's tenth anniversary, he declared that the approval of the three bioethics laws by the House of Representatives [Chambre des Députés] was the best proof of the fundamental role played by the CCNE.35 Not every French commentator is pleased with this development. Mémeteau once called the CCNE a “surrogate legislator” which legitimized specific practices such as medical experiments, genetic engineering, and embryo research by means of its opinions, thus presenting the true legislator with a fait accompli. It is not easy for an outsider to make an accurate assessment of just how much influence the CCNE exerts on the development of French medical law, but it is an inescapable fact that ever since 1983 the idea that bioethical issues should be governed by law has been gaining more and more support in France. This is evidenced in various reports recently commissioned by the French Government. One example is the 1988 Report of the Council of State entitled “From ethics to law”. The Introduction refutes the suggestion that it is too early in the day for such legislation by stressing how most of the CCNE's opinions have urged and proposed legislation. Even clearer in this respect is the so-called Mattéi Report on biomedical ethics. Given that various negotiations on international and European standards are in progress, there is an urgent need for French thinking on bioethics to be converted into law.

In the French approach, it is clearly bioethics that has influenced the making of bioethics law, and not the reverse. Another way in which the French and North American approaches differ is that French bioethics law is much less rights-oriented, a characteristic that Capron has already demonstrated. French bioethics law is chiefly a translation of fundamental human values under the heading “respect for the human body” (in particular, the primacy and dignity of the individual and the inviolability and non-patrimonial nature of the body) into strict legal requirements with regard to the application of biomedical techniques, such as medically assisted procreation, prenatal diagnosis, and the removal of organs, cells, tissues, and products of the human body. In this respect, French bioethics law is more of a codification of generally accepted norms applicable to biomedical techniques than a modification of existing practices and rules.

The recently approved European Convention on Human Rights and Biomedicine to a large extent presents the same characteristics. This Convention develops some of the principles enshrined in the European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950.34 Its drafting reflects a need to make a greater effort to harmonize existing standards.35 The text is a mix of law and ethics. It is clearly informed by ethical principles and explicitly incorporates ethics into specific rules for certain fields of biomedicine.
The concept of human dignity constitutes the essential value to be upheld. It underlies most of the values emphasized in the Convention. I have my doubts as to whether “it looks as though self-determination has been overvalued while the principle of inviolability, of physical integrity has been lost”.

2. HEALTH (CARE) LAW

(a) Medical law and health law: variations on the same theme?

In the literature, medical law and health care law (or more simply, health law) are often used side by side, as if both terms were synonymous or at least overlapped each other. According to Van Oosten, it “seems to be evident that the term ‘health law’ which is often used in this context and which overlaps with the term ‘medical law’ has a wider meaning than the term ‘medical law’. Since medical law is not necessarily related to the principles and practice of medicine, the former includes the latter but the opposite is not necessarily true”. Leenen also regards medical law as part of health law, because in health law there is a large range of juridical relations in which the physician is not involved.

In the Netherlands, there was an interesting discussion at the end of the 1960s on the use of “medical law” or “health law” to define the newly developing field of study. As the result of the establishment of the Association of Health Law in 1968, this discussion was closed and “health law” is now the generally accepted term. In the USA too, it has become common practice in recent years to refer to “health law” or “health care law”, rather than “medical law”. In some countries (France and Germany, for example) the equivalent of the term “medical law” (droit médical; Medizinrecht) is still widely used, while in others “medical law” and “health law” are used side by side.

In the United Kingdom, the discussion concerning which term is the more appropriate to indicate this field of study is still going on. In line with a commonly accepted opinion, Kennedy views medical law as a narrower concept than health care law. But he does not seem prepared to use both terms side by side or simply consider medical law as part of health care law. The reason is that medical law is a new subject seeking its place under the sun. A way must be found to organize the subject so as to reflect some sort of coherent conceptual framework. For medical law, such a framework could be the emerging area of human rights. Advocates of health law would have to identify its conceptual underpinning. This is the challenge accepted by Montgomery in his recent book. He admits that no consensus has yet been reached as to the proper scope of health care law. For him, the scope of health care law can be defined by the international obligations of the United Kingdom Government in relation to health matters. The most detailed exposition of the obligations of the United Kingdom to tackle health issues is set out in the European Social Charter of 1961, an important human rights document. In this respect at least, Montgomery is in agreement with Kennedy.
(b) The different origins of medical law and health care law

Whether or not medical law and health care law are interchangeable terms has become largely an academic matter. What is more important is that we should bear in mind that medical law and health care law quite often have different origins. Traditionally, medicine and law intersected in civil or criminal cases in which the proof of medical facts was at issue. On the medical side, those involved were usually pathologists who had become specialists in "forensic medicine". On the legal side, they were mainly lawyers interested in legal problems surrounding autopsies, the legal status of the dead body, and, in a later phase, such issues as the determination of death, organ removal, and transplantation. They described their expertise as encompassing "medical law". Some authors therefore regard forensic medicine as the parent of medical law. In some countries medical law has, therefore, long been confused with legal medicine. It is now beyond discussion that forensic medicine is a part of medicine, namely, that part which is used as an auxiliary instrument in the administration of justice, while medical law is clearly a distinct branch of law. This origin of medical law explains why its early adherents were mainly interested in criminal law and why it was developed in medical schools, especially the institutes of forensic medicine, and not in law schools.

In North America, but less in Europe, it was medical negligence, as well as forensic medicine, that provided a major point of intersection between law and medicine. This may explain why many people, especially physicians, identify medical law with medical litigation and all its negative connotations. Of course, it would be very short-sighted to regard medical law and medical negligence as synonymous. Nonetheless, medical negligence is, according to Grubb, an important part of medical law in practice and even central to medical law. In his view, it is "quite unrealistic" to devote the greater part of a treatise on medical law to criminal law.

In addition to the civil (tort) and criminal law origins of medical law, there is another important contributing factor to its development. In certain countries, medical law has developed at another intersection between law and medicine, namely, where law intervenes to regulate the financing and organization of the provision of medical services and to protect public health by preventive measures. The Netherlands in archetypical in this respect. According to Rang, a graduate of the Institute for Social Medicine at the Free University of Amsterdam and one of the first professors of health law to be appointed in the Netherlands, physicians active in the field of public health were the first to become interested in the legal aspects of their practice. One such physician was Mertens who, on the occasion of the First World Congress on Medical Law, delivered a remarkable contribution (unfortunately only in Dutch) on the teaching of medical law to students of social medicine. It is no surprise that Leenen, the founding father of medical law (or
rather health law) in the Netherlands (and in many other parts of the world),
started his professional career in health insurance and that he has taught not only
health law but also health care organization. From the outset, this medical law,
which emerged from the crossroads of law and social medicine, has focused on
such issues as the right to health care, equal access to health care, and the role of
human rights in health care.

One cannot deny that medical law represents two different fields of study.
Law at the intersection of law, forensic medicine, and medical litigation (the
"old" medical law) is different from law in relation to social medicine, health
insurance, the financing of health care, and so on. To differentiate between these
two approaches, the second is commonly referred to as health law or health care
law. The study of health law includes areas of health care delivery, health care
financing and cost control, organization and management of health care
institutions, and the access of the poor to health care. The focus has shifted from
law and medicine to law as it affects the health care industry as an integrated
whole.53

3. TOWARDS A SYMBIOSIS OF MEDICAL LAW AND HEALTH LAW

Proponents of health law have criticized medical law as being no more than an
auxiliary to (forensic) medicine, or an instrument for medical practitioners who,
for one reason or another, experience difficulties with the legal system. Health
law in its turn has been criticized as being merely instrumental and at the disposal
of, inter alia, health economics, medical sociology, and hospital management.
Savatier, for instance, defined health law ("droit sanitaire") as a series of
obligations incumbent upon the health administration.54 One commentator has
observed that "although cases involving ethical dilemmas are the ones that draw
public attention, they are the exception for most health lawyers, who are more
likely to spend their time drafting contracts for the purchase of goods and
services; bargaining about reimbursement; preparing staff bylaws; checking
professional peer activities; negotiating with Government agents about licensing,
taxation, and environmental controls".55 Few devoted disciples of medical law
would identify with this image of a health lawyer.

If medical law and health law are to develop further, or even survive, as
disciplines of law (and not merely as "auxiliary sciences"), then a strategy for the
future is urgently needed. In what follows, I shall attempt to sketch the broad
outlines of such a strategy. I shall use Kennedy's opinion as a starting point.
Medical law and health law must remain two distinct but closely related
disciplines of law, because otherwise the conceptual unity of medical law would
never be guaranteed. In Kennedy's words: "the health law advocate argues that if
I include the doctor-patient relationship, why not also include the control of
pollution or environmental law. To which the response can be made, if them, why
For medical law to be preserved as a separate study and for it to transcend its role as a humble servant to (forensic) medicine, there has to be consensus on the concept that unifies medical law. For Kennedy and Grubb, that unifying legal theme is human rights. They regard medical law as a subset of human rights law. This is what provides its intellectual coherence. An obvious criticism is that the concept of human rights is in itself too vague and that all disciplines of law have to be permeated by human rights. For Kennedy and Grubb however, the idea of human rights in the context of medical law has a specific meaning. Under the heading of human rights there are common issues permeating all the problems that arise in medical law: respect for autonomy, consent, truth-telling, confidentiality, respect for personhood and persons, respect for dignity, and respect for justice. All of these ethical issues run throughout the field. According to Kennedy and Grubb, it is these ethical issues that may hold medical law together. This is more than a mere “rights-oriented” enumeration. Grubb poses the question whether a more theoretical base for medical law may be devised, and concludes that a scheme offering such a base “would need to take account of any underlying themes in the law reflecting the ethical principles which are very much in play in helping to define and delinate the scope and content of the doctor-patient relationship.” What makes medical law unique, compared to other disciplines of law, is this enrichment of legal analysis with “life-and-death dramas”. If we reach agreement on this approach, medical law will not only survive but will expand further. Both ethics and law will profit from it. Ethics, because medical law will contribute to the development of bioethics; law, because medical law will contribute to the humanization of law in general.

Not only medical law, but health law as well, will profit from this approach. Health law will never be accepted as a separate discipline as long as there is no unifying theme underlying it. The preservation and restoration of health is nowadays one of the most important individual and societal objectives. Almost all disciplines of law may contribute, or not, to this objective. Fair tax rates, non-discrimination rules, noise control, and sanitary housing conditions, for example, may all in a certain sense be labelled as health law. But no one would defend such an absurd position. Describing a lawyer who advises a physician on tax matters as a “health” lawyer would be equally absurd. It is becoming increasingly obvious that ethical problems linked to medicine are very closely related to the way the health care system is organized and financed. Equal access to health services, equitable selection of patients, equitable distribution of scarce resources (not only equipment, but organs as well), and population screening, to name but a few, are ethical dilemmas at the macro-level that influence medical decisions at the micro-level. These and other ethical issues might create a unifying basis for health law. It may, of course, be argued that this would make the difference between medical law and health law negligible. I agree and I even hope that such
a symbiosis between medical law and health law comes about. In some countries, such as the Netherlands, this is already the case. But as long as the limitlessness of health law threatens the very existence of medical law as a separate discipline, I would prefer that the relationship of medical and health law continue to be one of co-existence.
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2. My contacts as Editor of the *International Encyclopaedia of Medical Law* have been particularly fruitful in this respect.


8. MEMETEAU, G. *Droit Médical*. Paris, Les Cours de Droit, 1996, p. 16; in the original version the text is as follows: “Le droit médical a pour objet de définir les règles de conduite des professionnels de santé dans le cadre de leur activité professionnelle et de prévoir la sanction à des manquements sous l'inspiration des principes de la morale médicale qui en constituent une des sources”.


15. Giesen, D., supra ref. 13, at p. 691.


17. Although it is interesting to note that at one place Kennedy uses the term "developed medical law", based upon legislation, suggesting that there is such a thing as "under-developed" medical law; see supra ref. 16, at p. 11.

18. Supra ref. 12, at p. 3.


21. Supra ref. 8, at p. 17. In the original French version: "une confusion entre le droit médical et les droits de l'homme constituerait un excès".

22. Supra ref. 12, at p. 3.


25. Jacob, J. Biomedical law: lost horizons regained. Modern Law Review, 46(1): 21 et seq., note 2 (1983). How difficult it is to reach general conclusions as to the definition and method of (bio)medical law is again demonstrated when one reads this article. Jacob leans much more than Kennedy on the traditional (French) approach to medical law. To Jacob, "biomedical law is not a separate discipline; indeed it is essentially only a specific way of using other disciplines; only one way of looking" (p. 23). See also p. 34: "this review has been at pains to assert that biomedical law is not a distinct discipline". He also criticizes Kennedy and Giesen for underrating the importance of codes of medical ethics, such as the Hippocratic Oath. They would prefer rather that guidance consisted of both clear and detailed prescriptions and they distrust these rather vague largely sanctionless codes. To Jacob, "in a sense, a part of biomedical law is concerned with the meaning and effect of sanctionless norms" (pp. 27-28). As the title of his article suggests, biomedical law is not a recent topic: "the continent is not new but lost. With all its landscapes and horizons, it is like Atlantis: it has long haunted the subconscious of our culture; but, unlike Atlantis, it is available to be gained afresh" (p. 38).

26. Supra ref. 12, at p. 22.
27. Supra ref. 19, at p. 17.


30. Supra ref. 29, at p. 1333.


35. Ibid., Section 4.

36. De Wachter, M. A. M. The European Convention on Bioethics. Hastings Center Report, 27(1): 13-23 (1997); furthermore, the doubts as to the appropriateness of the consecration of the so-called Anglo-American concept of self-determination that in practice, if not in theory, tends to reduce the person to an act of volition of which the human body is only an object, seem to be inspired by a one-sided reading of the Convention. Other (Anglo-Saxon) comments go in the opposite direction and deplore the absence of articles covering abortion, euthanasia, and assisted reproduction; see Nicholson, R. H. One law for all? Hastings Center Report, 25(2): 4 (1995).

37. Supra ref. 11, at Section 49.

38. Supra ref. 6, at p. 60.


43. Ibid., p. 20.

44. Ibid., p. 3.

45. In an editorial in the first volume of the European Journal of Health Law, the President of the World Association for Medical Law expressed the idea that “the title of the new Journal symbolises the change which occurred during the last decade or two, as Health Law occupies the position of Medical Law”. CARMI, A. Health law towards the 21st century. European Journal of Health Law, 1(3): 225-228 (1994).


48. The origin of medical law in my country (Belgium) is almost archetypical in this respect. R. Dierkens, the founding father of the World Association for Medical Law, started his academic career in the Institute for Legal Medicine, at the University of Ghent; his doctoral thesis was entitled “Body and corpse: at the crossroads of medicine and law”.


50. Ibid. Other authors however have doubts as to the importance of medical negligence for medical law. See ROTHMAN, D. J. Strangers at the Bedside. A History of How Law and Bioethics Transformed Medical Decisionmaking. New York, Basicbooks, 1991, p. 232: “Quinlan sparked a new and more sustained involvement of lawyers and judges in medical decisionmaking. It had little in common with compensation-minded malpractice litigation, which only looked back on events to see whether harm has occurred. It was closer to the type of law inspired by human experimentation, especially the substantial case law and legal analyses devoted to informed consent”.

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53. *Supra* ref. 10, at Section 40.

54. *Supra* ref. 5. In the original French version: “une série d’obligations à la charge de l’Administration”.

55. *Supra* ref. 29, p. 1331.

56. *Supra* ref. 19, at p. 18.

57. *Supra* ref. 12, at p. 3.

58. *Supra* ref. 49, at p. 244.

59. *Supra* ref. 29, at p. 1329; see also from a different perspective **VAN DER BURG, W.** Gezondheidsrecht en bio-ethiek: op naar een nieuwe verhouding [Health law and bioethics: towards a new relationship]. *R & R*, 25(3): 192 et seq. (1996). In the English summary following this article, the author writes: “[Dutch] health law is quite unique because it is strongly connected to bioethics, more strongly than other fields of law. The cooperation has been stimulated by some factors, the most important one being that both use the same conceptual framework”. An extended version of this article has recently been published: **VAN DER BURG, W.** Bioethics and law: a developmental perspective. *Bioethics*, 11(2): 91-114 (1997).

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*Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.*
The 50th anniversary of WHO presents an opportunity to review the recent past of public health law and to speculate, and perhaps to plan, for the future of this all-encompassing, all-absorbing field to which many have devoted their professional lives. "The mission of public health is fulfilling society's interest in assuring conditions in which people can be healthy".1

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The legal basis, scope, and purpose of public health law

In the USA, public health is advanced and regulated under the so-called "police power", a plenary power of the States to provide for the health, safety, and welfare of the people. At the Federal level, the Constitutional basis for public health regulation is the power to regulate foreign and interstate commerce and the power to tax and spend. The USA is not unique in this respect. In most modern countries, the advancement of public health is one of the main purposes of government, and many, if not most, governmental activities may be regarded as activities to advance and protect the health of the people.

Both nationally and internationally, the field of public health and the execution of public health powers and services depend on public health law. The reach of public health law is as broad as the reach of public health itself. "Public health and public health law expand to meet the needs of our society." The scope and reach of public health have expanded enormously during the past 50 years and continue to expand today. In its early history, public health and its legal regulations covered communicable disease prevention and environmental sanitation. It included some limited control of the disposal of human and other wastes, some concerns for water purity and the hygiene of housing, a limited interest in food and milk sanitation, some incipient school health controls, and very little else.

Today, at the end of the 20th century, the field encompasses sophisticated concerns for physical and mental health, including, in most parts of the world, a system for the medical care of the elderly and the indigent, either as a Government system or a system of social insurance. Public health law has also expanded to cover broad environmental concerns such as the control of air and water pollution, the control and disposal of ordinary as well as toxic and hazardous waste, the control of pollution by ionizing radiation, and the control of the safety and wholesomeness of foods and drugs. It is also concerned with many aspects of human reproduction, including elements of population control, and the control of the uses of addictive substances such as alcohol, narcotics, and tobacco.

Not only has the scope and subject matter of public health law and public health controls expanded greatly, but the field has also changed in other ways. Some years ago, public health programmes in most countries were largely regulatory. To protect health, government told industry, businesses, and people generally what to do and what not to do. Today, public health and public health law do a great deal more. Although many public health programmes are and must
still be regulatory, depending on “command and control” orders, more public health programmes are service oriented. They seek to enhance public health not only by prohibiting harmful activities or conditions, but also by providing preventive and rehabilitative services to advance the health of the people. Instead of regulating, policing, and prohibiting unwholesome conduct or conditions, public health law establishes services to create a more healthful environment and provides the facilities and trained professionals to prevent and treat disease, to educate people to protect themselves, and to improve their condition.

In the area of communicable disease prevention, for example, immunizations started out as a mandatory regimen, and failure to abide by immunization requirements would lead to criminal prosecution. Today, many immunization programmes still work by way of mandatory requirements. In many parts of the USA, for instance, there is no requirement that children be immunized against certain diseases, but there is a requirement that if they are not immunized, they may not attend school. Since school attendance is mandatory, the immunization requirement becomes mandatory too. On the other hand, governments increasingly provide immunizing agents, and school health programmes provide for the administration of immunization. In the area of mental health, too, while there are protective controls for the mandatory treatment of mentally ill persons who cannot take care of themselves, or who may present a danger to the public, there are also numerous voluntary community programmes to provide mental health services to persons who need them.

Both regulatory and service programmes depend on the law. Law is essential to public health because public health programmes cannot function without legislative authorization. Public health agencies receive legislative authority for their activities and functions, and they also depend on legislative appropriations to fund their activities.

Public health law does not come in a single, neat legislative package marked “PUBLIC HEALTH LAW”. It consists of many different types of legislation which have little in common except the benign purpose of advancing public health. To provide a few examples, public health in cities, worldwide, depends on a reliable supply of potable water, and on decent sanitary provisions, sewer lines, and the sanitary disposal of human and other waste. It also depends on adequate provisions for the disposal of waste and the management of household and industrial waste. Worldwide, what makes our cities wholesome and livable are adequate provisions for street cleaning and the transportation and disposal of waste, including the management of hazardous and insanitary waste. Hence, we need laws to assure that these necessary conditions are met. Much public health
law is contained in housing and building codes, plumbing codes, codes regulating sewers and water pipes, and other infrastructure controls, and much of this regulation is found in municipal and local law. In most parts of the world, public health is advanced not only by more adequate and sophisticated medical care, but perhaps even more so by the general improvement, during the last century, of the physical and sanitary conditions of populous cities and the elimination of the obscenity of open sewers.

Public health has also depended on the availability of decent and wholesome housing, with adequate sanitary facilities. Building codes and housing legislation should also provide adequate space to allow for family activities and home life, and provide protection against the elements. Housing legislation should also prohibit overcrowding to protect against the spread of communicable disease, particularly tuberculosis and other pulmonary diseases, which is significantly enhanced by crowded living quarters without adequate ventilation. Adequate housing is clearly needed to raise children and to give them a healthful and safe personal environment as well as a sound social and psychological beginning in life.

Aside from the protection of health in the home, there has been increasing concern and regulatory involvement in the protection of the health of workers in the workplace. The growing field of occupational safety and health has assumed a significant role in the panoply of public health protection, and with increasing realization of the hazards in the workplace, both mechanical and chemical, is likely to assume an ever larger role.

In addition, public health law has addressed the regulation as well as the licensing of health services and health providers, such as hospitals, nursing homes, clinical laboratories and providers of blood and blood products, and other services such as X-ray and other highly technological services. It also regulates the public health hazards created by certain industries. For example, in many parts of the world laws have been enacted to protect against nuclear contamination from nuclear power plants and to reduce the risk of catastrophic incidents.

When we think about the breadth and depth of public health law and the various legal subjects it now encompasses, we are compelled to note the interdependence and linkages of the field with many other fields. Public health law relates to the field of social welfare when it comes to the provision of medical services for the elderly and poor, to the field of labour relations and labour law when considering occupational safety and health and the safety and health of persons in the workplace; and to the field of housing, planning and infrastructure.
development when considering the relationship of decent housing to health and the relationship of the city environment and of population centres to health. There is also the relationship of environmental law and the control of industrial and automotive pollutants to public health and the relationship of mental health to public health, including aspects involving the control and treatment of persons who may pose a danger to themselves or to others. Also related to public health are: the control of habit-forming and narcotic substances, such as alcohol, narcotics, and nicotine; human fertility and the problems of demographics and population growth; and genetics and the new genetic insights gained in part from the international Human Genome Project, genetic disabilities and illness being considered as deserving of the same public health concern as has traditionally been accorded to communicable disease. Public health concerns and public health law show far-reaching interrelationships with other areas of law and policy development. It should be noted here that, at international level, WHO has long provided leadership and guidance with regard to many of these areas of public health and their other policy concomitants. This role of WHO and of other international organizations forms a part of the subject of this paper.¹⁴

Public health policy — issues of law, economics, and ethics

Public health law and regulations invariably reflect a tension between the protective impulses of society and the State and the concerns of industry and others interested in economic development — as well as of the State itself in the exercise of budgetary controls. Public health legislation, including legislation to limit industrial pollution, such as air pollution and water pollution, is often challenged on the grounds that it is too expensive and goes too far, and that the degree of protection it provides is out of line with the cost of the regulatory effort.¹⁵ Such conflicts may be regarded as a matter of public health politics, as matters of budgetary control, or as matters of social ethics. In many fields, such as that of unwholesome environmental pollution, the issue has been raised as to how clean is clean, i.e. must a former toxic waste deposit be cleaned up to drinking-water standards, and at what price and other social costs should environmental and public health protection be procured. The many competing social needs raise a number of issues, such as the question of how valuable is health and life, or how valuable is each human life and at how great a cost should it be protected when dealing with toxic or hazardous substances in the environment.¹⁶ When the removal of carcinogens in the environment, or the removal of potentially carcinogenic pesticide residues in food will save some
lives at enormous expense, questions of cost-benefit calculations and the
determination of public policy have a nasty habit of turning into ethical issues
with few answers and little comfort for the policy-maker or the public.17

In the regulation of public health, legislators and administrators invariably
make rules with significant ethical implications. Many public issues which are
characterized as public welfare issues or as issues relating to balancing the
nation's or the State's budget turn out to have significant public health
consequences with a retinue of ethical problems. Cutting back on funding for the
relief of poverty results in malnutrition with adverse public health consequences
and with devastating results on the development of children and infants in the
poorest families. Cutting back on public support for medical and hospital care
will not affect economically secure persons, but it will hit the poor and their
children by depriving them of health care or, at the very least, depriving them of
good health care. The impact of reduced spending on health is currently a matter
of political debate in many developed countries, including the USA. A recurring
issue is the impact of the reduction of preventive services. What is the effect of
cutting back on funding for prenatal services and clinics? Should the legislature
and the law make sure that prenatal services are provided, or rather spend the
funds on medical care for the elderly? These are agenda items for the legislator
and public health planner as well as for ethicists.

Ethicists have long addressed life and death issues that arise in providing health
care. But it was only relatively recently, some 30 or 35 years ago, that ethicists
became regular members of the health team in hospitals in the USA and some
other western countries. The recurring ethical problems in the provision of health
care are not new, but the creation of a system to deal with such problems with the
help of an in-house ethicist is a relatively recent development.

Certain ethical issues are recurrent. The issue of personal autonomy is an ever­
present one, because of the principle, now fully accepted, that the patient has the
ultimate right to determine what is to be done to his or her body, and has the right
to be informed of treatment choices so as to be able to provide fully informed
consent to whatever procedures and invasive manipulations he or she will be
subjected. Compulsory medication, or unconsented medical or surgical
interventions, or medical experimentation are not permissible.18

Another recurring ethical issue is the use of one person's body to benefit
another. We exercise great caution in removing the kidney of a fatal accident
victim for purposes of transplantation to a patient who needs a kidney. Again, we
must make sure that the donor is dead, and we must proceed on the basis of full
information and fully informed consent. We examine with great care various
schemes which have been launched to secure more organs, more working parts for persons who need them, whether or not they can pay for them.\(^6\) We also may not use genetic information derived from the examination of one person to treat another, such as a close relative, without consent and appropriate protection of the person’s privacy.\(^7\) We use similar cautions in the area of genetic manipulations, particularly with regard to sperm and ovum donations, to make sure that the donors’ interests and the incipient, inchoate personhood implicit in the sperm and ova used in the process are not adversely affected.

Ethical issues in the provision of health care frequently arise at the beginning or the end of life. The birth of a severely defective and ill neonate will create questions relating to a physician’s obligation to apply heroic measures to secure the survival of the newborn, raising an issue also as to whether such an infant’s future quality of life ought to be considered in fighting for its survival. At the end of life, there arises the recurring issue of “pulling the plug”, i.e. disconnecting the respirator when a patient in extremis cannot be maintained except in a vegetative state. Once, these were all physicians’ issues, to be determined by the physician with whatever help he or she could get from the patient’s family, or from particular physicians’ committees within the hospital. Health care in the USA became a matter for State involvement in the payment of services with the advent of Medicare and Medicaid in 1965. This entailed State supervision over the quality and kind of services to be paid for by the State or the third-party payer and ethical problems of the kind referred to became increasingly the concern of such third parties, and commonly the concern of the State itself.\(^8\) The result has been to involve third parties, including the Government, in the ethical decision-making process. In consequence, what used to be ethical issues have increasingly become legal issues regulated by legislators and administrators acting in pursuance of State legislation.\(^9\)

The preceding discussion of ethical issues in public health really addresses different kinds and dimensions of ethical issues. The smaller issues — we might refer to them as microethical issues — refer to recurring ethical judgements involved in the process of physicians’ and hospitals’ decision-making in patient care. Similar microethical issues are involved also in the field of genetics in making decisions relating to the administration of genetic tests and in genetic manipulations involving patients or involving genetic materials, used in artificial insemination, or in in vitro insemination used in fertility enhancement procedures. Though of overwhelming importance to patients, they have less impact on the broader task of public health. The broader kind of ethical problems referred to earlier could be characterized as macroethical issues, which need to be resolved in
the making of public policy, in the passage of legislation, and in the setting of standards and regulations at the administrative level. These larger issues of governmental ethics in the public health field are ubiquitous, and cannot be resolved by the appointment of an ethicist to advise physicians in the hospital in providing patient care at the beginning of life or at its end. The resolution of ethical issues in public health planning and in policy development is difficult and is likely to involve the future agenda for the public health field at national and international levels and include the efforts of WHO.

**WHO and the right to health**

Public health law imposes protective obligations on the State and it also imposes obligations of compliance on the individual. In addition to articulating legal protection and obligations, public health law and practice create ethical concerns on the part of physicians and other public health practitioners. As noted earlier, many ethical obligations have been “codified” and become legal obligations. The right to health itself has now been incorporated into public health law, at least at the international level. It is fair to say that most nations have not articulated or granted a “right” to health, but the right to health is articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights and has been ratified by many nations. Though not a legally enforceable entitlement, there is a “right” in some jurisdictions to enforce specific provisions of law to benefit from particular medical insurance or cost reimbursement provisions, such as Medicare in the USA. This is not a constitutionally recognized right, except insofar as there is a right to equal treatment with respect to access to legally established programmes.

Article 12 of the International Covenant on Economic, Social and Cultural Rights reads as follows:

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*  
   (a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*  
   (b) *The improvement of all aspects of environmental and industrial hygiene;*
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(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all access to all medical service and medical attention in the event of sickness.

Under Article 12, the Parties recognize the right to physical and mental health which had been earlier referred to in Article 25 of the Universal Declaration of Human Rights, the American Declaration of the Rights and Duties of Man, and the European Social Charter. Article 12 does not define “health”, but the Commission on Human Rights which helped to prepare the draft relied on the definition in the WHO Constitution: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. WHO provided technical help in drafting Article 12, and no definition was included because the argument had been made that the detail of the definition would be out of place in a legal text of this kind, particularly since no other definitions were included in other Articles of the Covenant.

In paragraph 2 of Article 12, the Parties agree upon steps to be taken in striving for “the highest attainable standard of physical and mental health” referred to in paragraph 1. The steps to be taken are aimed at the accomplishment of some of the agreed-upon benchmarks in the advancement of public health. These include the reduction of the stillbirth rate and infant mortality and steps for the healthy development of the child. WHO’s report to the United Nations Secretary-General pursuant to Article 18 of the Covenant notes that the appropriate steps to curb infant mortality should particularly include those promotive and preventive actions which are oriented to meet the specific needs of mothers and children at various stages in the reproductive process and the growth and development of the child. The WHO report indicated that in 1979, the Thirty-Second World Health Assembly (resolution WHA32.42) had urged Member States to promote specific Government regulations and laws to provide free health services at least during periods of high-risk pregnancy, delivery, and the first years of life, when breast-feeding, immunization, and treatment of infectious and parasitic diseases are crucial for survival. The resolution also emphasized the development of primary health care programmes with concrete plans for maternal and child health care and its essential component that includes care during pregnancy and childbirth, family planning, infant and child care with appropriate focus on improvement of nutrition, prevention of infections, promotion of physical and psychological development of the child, and education for family life. Member States were also urged to develop, as appropriate, health and related social services such as day-
care services, school health services, services for adolescents, and relevant social legislation in support of mothers and children.  

The enormous protective charge of Article 12 is further explicated in subparagraph (b), which calls for the improvement of all aspects of environmental and industrial hygiene. Though environmental and industrial hygiene are not defined in the Article itself, WHO’s report concerning Article 18 helps to supply the meaning. The report refers, inter alia, to two major aspects identified in WHO’s Programme for the Promotion of Environmental Health: the provision of water supply and sanitation, with emphasis on rural and underserved populations, in accordance with the targets established for the International Drinking-Water Supply and Sanitation Decade (1980-1990); and the assessment of adverse effects on human health of chemicals in the environment and the control of the pollution of air, water, food, and land.  

Relying on other resolutions of the 1979 World Health Assembly, the WHO report also expressed concern for the uncontrolled introduction of some industrial and agricultural processes with physical, chemical, biological, and psychosocial hazards. The 1979 World Health Assembly further urged Member States to develop and strengthen occupational health institutions and to provide measures for preventing hazards in workplaces.  

The reference in subparagraph (c) to the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases was also clarified in the WHO report which referred to such chronic diseases as cardiovascular diseases and cancer in the developed world, and communicable diseases, such as diarrhoeal diseases, sexually transmitted diseases, respiratory diseases, and malaria in developing countries and placed significant emphasis on biomedical research and immunization. There is some evidence that the mention of occupational diseases, which is redundant with Article 7(b) of the preparatory work, was included to emphasize the States’ duties to protect workers.  

Subparagraph (d) calls for the creation of conditions to assure to all medical services and medical attention in the event of sickness. The preparatory record of Article 12 does not define the “conditions” which Member States must create. The drafters apparently did not contemplate any one particular system to meet the requirements of the subparagraph. The WHO report notes that the right to health is dependent upon “the development by each Member State of a health system that is both accessible and acceptable to the total population, suited to its needs and to the socio-economic conditions of the country”. This report, in spite of the vagueness of subparagraph (d), was not intended to dilute a vigorous commitment to “primary”, essential health care for a given community or country. The Declaration of Alma-Ata, adopted by the International Conference on Primary
Health Care, outlined the fundamental components of such care in 1978. This Declaration actually grew out of Article 12. "Primary health care," the Declaration noted, addresses the main health problems in the community by the provision of preventive, promotive, curative, and rehabilitative services, including education to control health problems through prevention. All sectors of national development are therefore involved in primary health care, including agriculture, education, public works, and the further development of the health services infrastructure. Primary care goals are to be accomplished through community organization, planning, and the work of community health care workers, especially in rural locations. The Declaration of Alma-Ata calls on governments to formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system. The WHO report [to the United Nations Economic and Social Council] consequently urges governments to implement primary health care as an integral part of the national health system within overall socioeconomic development, and with the involvement of all sectors concerned.

Note that Article 12 of the International Covenant on Economic, Social and Cultural Rights contains no safeguards to limit the power of the State to impose medical treatment on the individual in the belief that the problem is addressed at least in part by Articles 4 and 5, as well as by Article 7 of the International Covenant on Civil and Political Rights, which prohibits States from subjecting anyone to medical or scientific experimentation without that individual’s free consent. This, of course, leaves open the question as to whether a person may be subjected to treatment which is not experimental without his or her free consent, and it is hoped that this is adequately provided for in covenants and laws which protect individual autonomy, if not as a matter of law then as a matter of accepted medical ethics.

Article 12 imposes a powerful mandate and a broad agenda on all Member States. In the USA, the nation’s agenda for health protection has been disseminated in reports pertaining to “Health for All 2000”, which set a target date at the end of the second millennium for the attainment of such difficult accomplishments as the control of fatal diseases, the increase of life expectancy for older persons, and the achievement of a significant reduction in infant mortality. Initiatives begun in 1978 at Alma-Ata reached a highpoint in the Americas in 1981 when PAHO (the Pan American Health Organization — WHO’s Regional Office for the Americas) approved the plan of action for implementing regional strategies for health for all by the year 2000.

The right to health is a very broad right, and even countries with very
substantial resources will find it difficult, both in theory and in practice, to make sure that every person is provided good health — which is difficult to define fully. Fluss notes that the European Social Charter, in item 11 of Part I, gives fuller meaning to the right to health in stating that everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable, that anyone without adequate resources has the right to social and medical assistance, and that it is the obligation of the Contracting Parties to remove as far as possible the causes of ill-health, to provide educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health, and to prevent as far as possible epidemic, endemic, and other diseases.37

The right to health is difficult to define as a legal right.38 While the attainment of good health may be difficult, society has an ethical obligation to assure equitable access to health care for all.39 While it may be difficult to vindicate a legal right to health, it is clearly possible, as has been done in a number of international covenants and in a number of expressions of ethical views on the right to health, to enumerate and designate the conditions that sovereign States must fulfil to relieve the threats of ill health, to support conditions which make for good health, and to assure equitable access to the services, the environmental conditions, and the professional know-how which must be put to the service of good health of persons, regardless of their economic standing.

The recognition, internationally, of a right to health is a significant milestone in the protection of human health worldwide. Since international covenants are not self-executing, the right to health depends for its vindication and realization on the nations and States that have adopted it. It is fair to say that the adoption of the right to health as a human right is still a promise, but it is a promise likely to generate major efforts towards its accomplishment.

Where are we and where are we going?

The extent to which care is provided is still largely a matter of economics. It is still true that to be poor is to be ill: this is true even in highly developed countries. There is a vast discrepancy between life expectancy at birth of an infant in the highly developed western countries and infants in developing countries elsewhere.40 There are also vast differences in life expectancy and state of health in most countries, including the western countries, between the more affluent and the poorer parts of the population.41 There are also significant differences in the
state of health and life expectancy between different ethnic and racial groups. Such differences largely depend on the economic well-being of each group. In the USA and Australia, the difference between the indigenous peoples (Native American Indians and Australian aborigines) and the economically dominant Caucasian component of the population is vast. The disadvantaged group suffers more from communicable diseases and inadequate prenatal care, includes more persons addicted to alcohol, narcotics and other habituating substances, is immunized less regularly, and suffers more extensively from malnutrition and diseases related to other deprivations. The list of discriminations and deprivations also extends to the area of housing and protected habitations, with more persons in the less favoured group inhabiting substandard and unwholesome housing with inadequate bathing and sanitary facilities. In many countries, including highly developed ones, the lack of housing and decent habitation has swelled the ranks of the homeless who suffer the consequences of exposure or, where mass shelters are provided, the consequences of unwholesome congregate facilities that contribute to the spread of communicable disease.

However, while the right to health and good health for all may as yet be a future goal rather than a current reality, there has been considerable progress. The state of health in developed countries is appreciably better than it was 50 years ago when WHO was founded. In spite of inexcusable differences in different parts of the world and between different economic groups in individual countries, the state of health, including morbidity and life expectancy, has improved significantly, in part in consequence of significant and trail-blazing medical discoveries and advances. Among the great achievements is the eradication of smallpox, led by a major WHO programme. The ongoing eradication of polio, and the reduction and approach to elimination of many of the communicable childhood diseases that reduced life expectancy so greatly some 50 years ago, is very significant. The availability of immunizing agents and antibiotics has significantly reduced the toll of diseases in childhood and early adulthood. Middle ear infections, resulting from extended colds, giving rise to operations for mastitis, are practically a matter of the past, with major surgeries having been replaced by available antibiotic treatment. Similarly, scarlet fever has become so unusual and infrequent that many paediatricians will find it difficult to diagnose. Treatment of sexually transmitted diseases with penicillin has not only relieved a major problem, but has also made armies more fully operational.

The continuing role of WHO in international infectious disease control under the International Health Regulations (IHR) must be noted and observed. WHO has authority under Article 21 of its Constitution concerning: (a) sanitary and
quarantine requirements and other procedures designed to prevent the international spread of disease; (b) the nomenclatures with respect to diseases, causes of death, and public health practices; (c) the standards with respect to diagnostic procedures for international use; (d) the standards with respect to safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and (e) advertising and labelling of biological, pharmaceutical, and similar products moving in international commerce.46

People are also better off nutritionally. Not only is there better nutritional education available, but public health regulations assure that the slaughter of animals is conducted in a sanitary manner, leaving fewer illnesses related to contaminated proteins. In addition, the pasteurization of milk became firmly established a little earlier than 50 years ago, effectively putting a stop to milkborne diseases among infants and the population at large. The general protection of our water supply, the advance of sewer-connected housing, and the decent control of the sources of our water supply have resulted in the very significant reduction, if not the full elimination, of waterborne diseases.47

Lest we become too complacent, there are new public health challenges of a major and threatening nature, such as the sudden emergence in the 1980s of HIV/AIDS which, worldwide, affects more than 30 million people. In many fields of public health, we have acquired the means and the knowledge to deal with public health issues and to deal with human illness. That good health is still a distant goal rather than an accomplished fact in many parts of the world is partly a matter of economics and policies, being largely dependent on the political will to apply the known remedies to widespread problems and to help populations for whom good health has remained a hope for too long.
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5. WHO’s considerable range of activities and involvements in international public health protection cover these wider concerns and broadly reflect the interests and concerns of the Governments of its Member States. For an analytical and panoramic view of international public health law, see Fluss, S. S. The development of national health legislation in Europe: the contribution of international organizations. European Journal of Health Law, 2: 193-237 (1995).

6. Supra ref. 2, at p. 9. Such public health services include the provision of well baby clinics, family planning clinics, community mental health programmes, and a variety of government-sponsored research institutions that are tied to the provision of special services as part of their research tasks. See Grad, F. P. The philosophy of public health law. Encyclopedia of Bioethics. New York, W. T. Reich, 1995, Vol. 4, pp. 2173-2178.


8. An example of a far-reaching immunization programme was the 1976 Swine Flu Program. It was a significant example of the ability of public health authorities to mobilize against a threatened endemic. An outbreak of influenza caused by the swine influenza virus occurred in a military camp in the USA. There was general scientific agreement that there was a need to develop a vaccine incorporating this new influenza strain, generally referred to as the Swine Flu. The Federal Government underwrote the production of a supply of vaccine sufficient to meet national needs. The Government also insured the manufacturers against possible liability claims. Some 42 million people were immunized but the programme was stopped after some three months because a number of cases of Guillain-Barré Syndrome (GBS) had appeared. A massive programme involving national and State Governments as well as voluntary health groups was mobilized. The swine
flu epidemic fortunately did not materialize, but the incident represents a significant indication of governmental capacity to meet major threats of this nature. DULL, H. B., KENDALL, A. P. & PATRIARCHA, P. A. Influenza. In: Last, J. M., ed., supra ref. 4, pp. 138-147, at p. 146.


10. On the coverage of public health law, see generally GRAD, F. P. Public health law. In: Last, J. M., ed., supra ref. 4, Chapter 64, pp. 1849-1865.


12. The importance of occupational safety and health has been recognized and pinpointed as an area for necessary development in Article 12 of the International Covenant on Economic, Social and Cultural Rights (see infra text at ref. 27). Item (b) of paragraph 2 of that Article calls for the improvement of all aspects of environmental and industrial hygiene, while item (c) calls for the "prevention, treatment and control of ... occupational and other diseases". See also text at ref. 30 infra, which emphasizes the States' duties to protect workers.

13. For regulation of the hazards of nuclear power production and other nuclear risks to human health, see GRAD, F. P. Treatise on Environmental Law. Chapter 8 (Radiation (1972-1997)). On the international side, a number of conventions and treaties have been adopted to achieve the purpose, following the Chernobyl nuclear power plant disaster in 1986, by the International Atomic Energy Agency (IAEA), established by the United Nations, by the Nuclear Energy Agency (NEA) of the Organisation of Economic Co-operation and Development (OECD), and by the European Atomic Energy Community (Euratom). IAEA negotiated two conventions, namely the IAEA Convention on Early Notification of a Nuclear Accident, concluded at Vienna and New York on 26 September 1986 (which entered into force on 27 October 1986). IDHL, 37(4): 906-909 (1986); and the IAEA Convention on Assistance in the Case of Nuclear Accident or Radiological Emergency, concluded at Vienna and New York on 26 September 1986 (which entered into force on 26 September 1986). Ibid., 903-906.

14. Sev S. Fluss, former Chief, Health Legislation Unit, WHO, who has had vast experience in his many responsible roles in WHO, emphasizes the interrelationship of public health with other areas of human concern in the following article: supra ref. 5, at pp. 194-195. He refers to the "most fundamental" provision on health and
health-related matters, which is contained in paragraph 1 of Article 25 of the Universal Declaration of Human Rights (1948). This paragraph asserts that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. This paragraph established the connection made earlier between public health and social welfare.

15. Currently, in 1997, such a public discussion is taking place in the USA. The current Administrator of the Environmental Protection Agency (EPA), with the backing of President Clinton and Vice-President Gore, has announced the promulgation of more stringent controls of particulate emissions, including control of smaller particles of such emissions. The proposal has met with significant opposition in Congress, largely from representatives with substantial support from major industries, urging that the proposed regulations are excessive in their regulatory controls and in their costs. The proposed regulations are intended to benefit children and the elderly, groups which are most likely to be affected by particulate emissions in their breathing, and by emphysema and other pulmonary problems. The regulations are likely to be enacted but their effective dates will probably be postponed for some time.

In environmental regulation, we often face the problem of incremental cost. The clean-up of 95% of the pollutants discharged by automobiles is very substantial but the clean-up of the last 5% of emissions of lead, volatile organic compounds (VOCs), ozone, and other dangerous and carcinogenic emissions may cost many times more than the clean-up of the first 95%.

16. Section 112 of the United States 1990 Clean Air Act Amendments requires the Administrator of the EPA to make risk assessments for hazardous air pollutants. The Administrator is directed to consult with the Surgeon General and hear public comment in investigating and reporting to Congress on a number of issues concerning public health risks. The report must include recommendations for legislation to address risks remaining after application of the regulatory scheme is implemented. If Congress does not act on the Administrator’s recommendations, the Administrator must promulgate the standards necessary to provide an ample margin of safety to protect the public health after promulgation of standards for each category or subcategory of sources listed in the Act. The Administrator must go beyond the standard of “ample margin of safety” in promulgating emission standards if the existing emission standards applicable to sources emitting a pollutant or pollutants classified as a known, probable, or possible human carcinogen do not reduce lifetime excess cancer risk to the individual most exposed to such source emissions to less than one in a million.
17. The 1996 Amendment of the United States Federal Food, Drug, and Cosmetic Act, which was amended together with the Federal Insecticide, Fungicide, and Rodenticide Act, prohibited the presence of pesticide residues on food unless a special tolerance or exemption has been issued by the EPA. The tolerance provided must assure that the pesticide chemical residue will be lower by an ample margin of safety than the level at which the pesticide chemical residue will not cause or contribute to any known or anticipated harm to human health. The Administrator will interpret the ample margin of safety to be a hundredfold safety factor applied to the scientifically determined "no observable effect" level and the data are extrapolated from animal studies. A tolerance will be considered to provide a "reasonable certainty of no harm" if any increase in lifetime risk, based on quantitative risk assessment, using conservative assumptions, will be no greater than "negligible". In quantitative risk assessment practices, the EPA interprets a negligible risk to be a one in a million lifetime risk. For discussion, see GRAD, F. P. Treatise on Environmental Law, Chapter 8 (Pesticide Regulation under the 1996 Amendment of the Federal Food, Drug, and Cosmetic Act (FFDCA)), at p. 19.


22. One such issue involves the so-called "Right to Die" - i.e. the refusal of a patient to accept further life-sustaining treatment or the question of keeping alive a person in a vegetative state. See, for example, Matter of Quinlan, 70 N.J. 10, 355 A.2d 434 (1987), involving ethical issues which are now legal issues. See, generally, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (USA). Deciding to Forgo Life Sustaining Treatment. Washington, DC, U.S. Government Printing Office, 1983.

23. See supra ref. 14, at p. 194, where Fluss refers to the "micro-ethical" and macro-ethicalse scope of aspects of bioethics, much in the sense in which it is used here. See also LAPPÉ, M. Ethics in public health. In: Last, J. M., ed., supra ref. 4, pp. 1867-1877. Lappé differentiates between "medical ethics" and "public health
ethics”, here referred to, following Fluss, as microethics and macroethics. A recent instance involved the challenge in the United States Supreme Court of two State statutes which had legislated on the propriety of physician-assisted suicide. The basis for the challenge of the State legislation had violated a number of Constitutional protections, including the right to due process and the equal protection of the law. The Supreme Court held that the particular laws involved did not involve such constitutional violations, but the Court did not make a final determination on the constitutionality of such physician assistance. Washington v. Glucksberg and Yacco v. Quill, - US - (1997).


25. Ibid., at p. 3.

26. Ibid., at p. 4.

27. Ibid., at p. 5.

28. Ibid.

29. Ibid., at pp. 5-6.


31. See supra ref. 24.

32. See supra ref. 24, at p. 7.


34. See supra ref. 24, at p. 7.

35. Supra ref. 18, at pp. 1875-1876.


37. See FLUSS, S. S., supra ref. 5, at p. 196.

38. It is reminiscent to some extent of the provision in the State Constitution of the US State of New Jersey that every person “has the right to pursue and attain happiness”. There are no cases on record of any person having taken legal action asserting that he or she has not attained happiness.


41. “People in developing countries and those in developed areas of the world share a common health history. The relatively short time lag between health improvements in affluent industrial countries and developing countries is frequently forgotten. Children born in most developing countries today have a lower risk of infant mortality and have a higher life expectancy than persons born in the U.S. or western Europe at the beginning of this century.” See Last, J. M. & Foege, W. H. Need for international health programs, travel and interchange and developmental aspects in developing parts of the world and their relationship to the communication of communicable diseases. In: Last J. M., ed., *supra* ref. 4, Chapter 61 (Table 61-1), at p. 1793.

Tables on Variations in Infant Mortality Rates in Place and Time show for instance that New York State in 1900 had a rate of 159.8 and in 1980 of 12.6. Sri Lanka had a rate of 43 in 1981 and Malaysia a rate of 30.

Table 61-2 (*ibid.,* Table 61-2, at p. 1797) shows the direct relationship of infant mortality to per capita income and to adult literacy rates. Similar relationships between income and life expectancy at birth can also be observed. In developing countries, problems of rapid urbanization and uncontrolled population growth also add to infrastructure problems and to the increase of health problems (*ibid.,* at p. 1799).

42. Australian aborigines make up 2-3% of Australia’s population of 18 million. Based on data from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, the Governor General reported that life expectancy for aborigines is 15 to 20 years lower than for the white population; infectious disease is 15 to 18 times more likely to kill, and babies are up to four times more likely to die at birth. Comments noted the prevalence of diabetes, heart disease, and kidney disease, as well as problems created by excessive use of marijuana, heroin, and cigarettes. See Farnsworth, H. In a land of plenty, good health still eludes the aborigines. *The New York Times International,* 1 June 1997, at p. 6.
43. For a good account of the story of smallpox eradication and WHO's role in it, see Henderson, D. A. The eradication of smallpox. In: Last, J. M., ed., supra ref. 4, pp. 132-138. The account emphasizes the international mobilization and coordination of resources necessary to achieve this milestone in the eradication of a deadly disease. It calls attention to the major efforts necessary to arrange for adequate amounts of vaccine and for the development of a method of administering vaccinations which would make possible effective mass vaccination programmes, as well as the development of adequate programmes of surveillance to interrupt the train of transmission from person to person in a given household, taking advantage of the two- to three-week interval between each generation of cases.

44. For an illustration of the decline in the incidence and mortality from selected communicable diseases in the USA (1900-1980), see Myers, B. A. Social policy and organization of health care. In: Last J. M., ed., supra ref. 4, pp. 1639-1702, at p. 1691, which reproduces a table from the United States Department of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, Annual Summary 1982. This shows the significant decline of cases and deaths for smallpox, diphtheria, polio, and measles. By 1975, for instance, the number of cases of polio had declined to eight and the number of deaths to nine for the entire USA. But there were still 13,506 cases of measles and 11 deaths in 1980.

45. The role of WHO in international infectious disease control, with special reference to experience under the International Health Regulations and both progress under IHR and defects in national enforcement of IHR are analytically discussed in the following source: Taylor, A. L. Controlling the global spread of infectious diseases: toward a reinforced role for the International Health Regulations. Houston Law Review, 1997, pp. 1328-1860. A strengthening of IHR is proposed through the development of an international monitoring institution, established by WHO, which could effectively strengthen the enforcement of the regulations in the light of national self-interest in limiting the international spread of infectious disease.

46. See Fluss, S. S., supra ref. 5, at p. 197.

47. These have been significant improvements, even in developed countries. In the USA, the Safe Drinking Water Act (see IDHL, 27(1): 212-216 (1976) was significantly improved by Amendments in 1996, which included new scientific and technological insights.

Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO’s views.
THE RIGHT TO HEALTH:
FROM THE SOLEMNITY OF DECLARATIONS
TO THE CHALLENGES OF PRACTICE

INTRODUCTION

Unless one wishes to rewrite the history of the second half of the 20th century, it can be taken as a generally accepted fact that, among the attainments of this period, the affirmation of basic human rights stands out as one of the best-acknowledged milestones, both in terms of the frequency of such affirmation and

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of the solemnity of the instruments that support it. It must, of course, be acknowledged that, in the manner of the vast majority of the subjects to which a universal value has been attributed, the national or regional moorings of basic rights are essentially dependent on the circumstances in which they gain a hold, such that they may be deflected from the purpose assigned to them as a matter of priority. However, it must always be remembered that, generally speaking, the affirmation of basic rights has been and remains at the confluence of all the development strategies of States, whatever their stage of economic or democratic development.

The vast majority of considerations underlying the affirmation of the principal fundamental rights of the individual are built on the cardinal nature of the right to life: this proposition requires no demonstration, given the pre-eminence position that it now occupies in discourses, irrespective of whether they are assertive or declaratory in nature. It is moreover this pre-eminence that explains the great variety of analyses and critiques, whether they are epistemological or ideological, whether they draw up paradigms, or whether they are strictly positivistic. Accordingly, the right to life participates in the same theoretical mobility as the right to development. In both cases, the theoretical pluralism and the often contradictory contributions of the disciplines that study it help to fashion images of a rare complexity that defy a synthesis that is coherent or at least intellectually satisfying. The approach that consists in observing how the right to life has served the affirmation of fundamental individual rights and how these rights have facilitated the emergence of new legal relationships between citizens and States is fairly classic, but it offers the advantage of observing the progression, in the traditional legal order, of values which, despite or because of the multiplicity of their meanings, have acquired a universal character and have been solemnly declared as such.

The pre-eminence of the right to life and the recognition of its sacred nature meant that it was not long before the strictly biological meaning of the concept of life was extended to incorporate the concept of quality understood from a dynamic viewpoint in order to take into account the legitimacy of the desire for well-being and also the means for promoting and attaining it. The right to health derives from the elementary need to ascribe to the right to life a much broader sense than the simple fact of existence. Health, insofar as it constitutes a basic value of human life, must be an element associated with every move to recognize and promote fundamental rights: on this ground alone, it should be the subject of a system of protection as explicit and effective as that accorded to other human values of the first rank. The solemnity of the affirmation of the right to health is an undeniable attainment of recent decades and may be clearly observed at all
levels — international, constitutional, and national — of legal order. On the other hand, despite the apparent magnanimity of declarations, it should be noted that the challenges imposed by the application of the right to health are considerable, being on a par with or even greater than those imposed by the right to life or by its corollaries, namely the right to physical integrity and the right to dignity. The first part of this paper describes where and how the right to health can be affirmed, while the second examines some of the challenges, whether actual or prospective, that the application of this right entails.

1. AFFIRMATION OF THE RIGHT TO HEALTH: A CONVERGENT BEAM

No one would be so bold as to maintain that health has become an object of legal concern only since the advent of the international legal texts of the last 50 years, but it is probably true to say that the modern concept of health, defined as the means of promoting a theory that recognizes intrinsic rights in this field — rights that have a quasi-absolute nature and which could be used against State decisions — is fairly recent. Apart from the observance of a few measures, the first of which originated in the 17th and 19th centuries, that consider health from the standpoint of the protection of populations and trade or from that of relations between belligerent nations, probably adopted with a view to safeguarding military manpower, the first indications of the emerging right to health are to be found, in the view of the vast majority of commentators, in the Universal Declaration of Human Rights of 1948. These are, however, only indications. Unlike other contemporary international instruments or those adopted after the Universal Declaration, the latter does not refer explicitly to a right to health. The formal recognition of the right to health, through a succession of declarations and through the accumulative effect that is often the case with propositions that have universal implications, was at the same time accompanied by a great many theoretical controversies that seized as much on the concept of health as that of right. The impossibility of reconciling all aims does not, however, prevent the identification of main themes that are sufficiently clear for the conclusion to be drawn that the idea of the right to health has served as a powerful means for the promotion of health and that it has been effective in throwing light on citizens' expectations vis-à-vis States.

1.1. Formal declarations of the right to health

Article 25 (1) of the Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate for the health and well-
being of himself and of his family. The objective here is to recognize that persons entitled to rights should have a sufficiency of the necessary means for the right to life, liberty, and security of person — explicitly recognized in Article 3 of the Declaration — to be fully exercised and for the person entitled to the right to have control over the destiny of his person and that of his family. However, the Declaration does not make the holder of rights alone responsible for the quality of his life, since it explicitly recognizes in Article 22 the right to social security, thereby constituting a debt vis-à-vis the society of which the holder of rights is a member. To the extent that social security, according to the meaning generally ascribed to it, includes an extensive range of health protection measures and that it encompasses health care and health service programmes, it is certainly not forcing the meaning of the Declaration to read in it the intention of protecting health and deduce from it the will to recognize a right to health.

That it should be otherwise would be all the more surprising given that the Preamble to the Constitution of the World Health Organization, by all accounts drafted at the same time as the Declaration (the WHO Constitution entered into force on 7 April 1948 and the Declaration was adopted on 10 December 1948), states that "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". While some have been able to read into this text a recognition of the right to health care, which is undoubtedly something that is included in the right to health, it is inappropriate to refute, at the outset, the more magnanimous nature of the words chosen for drafting the Preamble. At the time when the fundamental rights of the individual were being identified, health evidently constituted an object of primary importance and it is probably because of the difficulty of reaching sufficient consensus on the specific concept of the right to health that the Declaration tackled it in a more diffuse manner than, for example, the right to education, the boundaries of which are easier to define (see Article 26 of the Declaration).

The adoption on 16 December 1966 of the International Covenant on Economic, Social and Cultural Rights (which entered into force on 3 January 1976) rendered obsolete the debate on the causes and consequences of the absence of the formal inclusion of the right to health in the Universal Declaration. Taking up the text of the Preamble to the Constitution of the World Health Organization, Article 12 of the Covenant sets forth that States Parties are to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The second paragraph of the same Article gives a non-exhaustive list of the steps to be taken by the States Parties in order to achieve the full
realization of the right to health: from epidemiology to general health control measures and the promotion of public health, these measures include guarantees of access to medical services and medical attention. The multiform nature of the right to health forms a coherent whole in the text of the Covenant: a means of attaining the full development of the right to life and integrity of the human person, a means of recognizing the right of each individual to what the community owes him, and a means of creating duties under State responsibility to contribute to the satisfaction of the individual aspirations of citizens.

With all the nuances required by the inclusion of a right in international or regional legal documents, it must be recognized, from the strictly enunciative standpoint, that the essential consensus required for the adoption of such documents takes account, with varying legal implications and values, of adherence to the idea that certain values must be protected and that the right constitutes a way of crystallizing this imperative of protection while conferring upon the standard thus established an autonomy of development that must serve to reinforce the initial protection. Accordingly, the movement initiated by the international recognition of the right to health marks a decisive stage in the structuring of the various strategies of health promotion and protection. It has also given rise to the identification of a veritable corpus of rules that are nowadays quite naturally classified as “international health law”.

In this respect, what might appear to be a simple classification operation is rather a reflection of the reality of the convergence of the objectives pursued by the standards adopted. Thus, to cite just one example, it is sufficient to re-read Resolution 1989/11 on non-discrimination in the field of health, adopted on 2 March 1989 by the United Nations Commission on Human Rights, in order to appreciate how the links and connections with the principal declarations of the right to health have been established and reiterated. One finds in this Resolution the formal reaffirmation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the reminder that this right, described as a human right, must be exercised with full equality.

In the legal order however, the principal challenge to the affirmation of the right to health is that of its implementation. From the moment that it is established as a cardinal principle to guide the action of political decision-makers and is likely to create obligations under State responsibility, the characteristics of its normative status become the subject of analyses that give rise to a theoretical controversy that is not without effect on its impact.
I.2. Theoretical controversy

The expression “theoretical controversy” to describe the excitement that animated a number of legal circles following the affirmation of a right to health is perhaps exaggerated, but it cannot be denied that some fairly stern remarks were employed in order to stow this right into a sort of mythical universe the very membership of which serves to tone down the exercise of the right. By way of a counter-attack, it was soon demonstrated that the theory of the right could very well accommodate new forms of normative expression and that it proposed coherent models for the co-existence of rights whose objectives and implementation could vary appreciably. In short, it may be said that the debate was concerned with the very existence of fundamental rights, linked more with the development of the attributes of the human person than with the strict protection of the latter. It was, however, also concerned with the concept of health and with the appropriateness of providing a normative framework for a vague concept the definition of which had tactlessly been described as utopic, thus rendering practically illusory the right that claims to throw it into relief.13

A semantic detail must be supplied here, since it illustrates a shift that if far from fortuitous in the rhetoric of what must, in spite of everything, be described as theoretical controversy. The point at issue is the move away from the concept of the right to health to that of the right to health services. Recourse to the second is present, in particular, in scientific American literature or in international literature that is American-influenced, while certain French-language authors have peremptorily declared: “the right to health ... can only be a right to care and not an absolute right to perfect health”.14 The definition of health set out in the Constitution of the World Health Organization is, in part, the origin of the split between the two concepts, but this does not fully explain the phenomenon. This well-known definition states that health is “a state of complete physical, mental and social well-being ...”. The expression is all-embracing to say the least and it is hardly surprising that the specificity has been called into question of a fundamental right whose objective is so broad and elusive that it can encompass all those from which it has been derived. However, it would be very strange if the authors of the Preamble to the Constitution of the World Health Organization had intended to try and “assure for all absolute health [or] even an equal state of health for all”15 and if, had this been the case, we would have been right in saying that the right to health “only has a purely theoretical content and remains a dead letter for most people, if not for everyone”.16

Even a very cursory examination reveals that the right to health has its own
existence and that its wording is no different from that of several other modern fundamental rights. Nor does it show greater differences when compared with more conventional rights. In the case of the first, and in particular those that are classified as social rights such as the right to work, the right to social security, and yet others, their programmatic nature has long been recognized. They do not formally establish claims whose implementation a person may seek, but they constitute the normative expression of an undertaking of States to promote the realization of a right based on the premises of equality. In the case of the second, it should be recognized that their wording is often expressed in very general terms and refers to vague concepts. This is the case, for example, for the right to physical and psychological integrity and also the right to privacy. In all these cases, the methods employed in interpretation have revealed, in the manner of concentric circles, some areas that are definite and others that become increasingly ill-defined the further one moves from the interpretive data.

It must be added that the doctrine of fundamental rights has clearly outlined the fields that are proper to such rights and has separated the negative from the positive aspects. The right to health has something of the nature of both categories. It includes a negative aspect in that the beneficiaries have a right to expect the State to abstain from any act that might jeopardize their health. In this respect, it is similar to traditional fundamental rights. The right to health, interpreted as a social right, has a programmatic nature or a positive aspect in that it commits States to adopt the necessary measures for the prevention and treatment of diseases, as well as committing them to set up the appropriate structures and services for the protection or rehabilitation of the health of the persons entitled to the right. Without the contribution of mechanisms to incorporate international standards into national law, the right to health does not create, for each individual, a claim within the usual meaning of the term, but it nevertheless constitutes a social duty to which the State subscribes and for which it is responsible beyond the principles of political responsibility. The right to health services belongs to this meaning of the right to health, but it would be wrong to reduce the latter to the former.

A second element of the theoretical controversy that it is difficult for the right to health to escape concerns the concept of right and the legal relationships that it may underlie. In this connection, discussions are particularly lively and far from lacking in ideology. Most schools of legal theory have contributed to this debate, which brings together supporters of the natural right, libertarians, and egalitarians. More recent approaches, such as that of distributive justice, have also been adopted in the analysis of the right to health. The proliferation of
opinions has itself had to face fairly scathing criticism, such opinions being deemed to be abstract in nature or as having too little influence on the development of the right to health.\textsuperscript{23} One could of course close the debate with these sibylline criticisms and leave it at that, but there is no harm in taking a look at the principal characteristics.

In the first place, these debates are concerned with the right to health services and rarely tackle the question of the right to health directly. Secondly, they are not at all alien to the political controversy that has been raging in the USA for several decades concerning the planning and development of a health care system based on the principles of universality and accessibility that have guided the establishment of most national health systems over the last 40 years or so. These two characteristics are not unconnected; it is clear that the recognition of a right to health services, whether autonomous or derived from the right to health, could serve as a legal basis for the claims of those who demand a universal system of care. From the standpoint, in particular, of the case law of the Supreme Court of the USA which forced the introduction of State programmes intended to bring about the full realization of fundamental rights,\textsuperscript{24} the question of the existence of the right to health services is far from banal. However, the polemic is certainly fuelled by more than political considerations alone, whether they be explicit or implicit. It is also based on the concept of “right” and the attributes that derive from it. The classic definition of “right” evokes the dual idea of freedom and the capacity of controlling the actions of others.\textsuperscript{25} It is intimately bound up with the concept of “entitlement” which corresponds, somewhat imperfectly, to the subjective nature acknowledged in certain rights: it entails the right to claim the benefits of the object on which the right focuses. Conceived as a subjective right, the right to health services (it is always this one that is in question) should procure for the entitled person a claim that he is able to make against the debtor of the obligation which, in the case of social rights, is generally the State.

The idea has been mooted that the approach that distinguishes the negative aspect from the positive aspect of fundamental rights could reconcile the protagonists of the theoretical debate.\textsuperscript{26} It seems that such a reconciliation has not yet taken place, since it must be understood that the question of the legal implications of the right to health is not an issue exclusively within the international order — this would have the effect of limiting it to the interactions between the international order and the domestic legal order. However, it is today within the latter that the question is the most pressing. The ever-increasing number of States that have, according to one customary formula or another, incorporated the right to health into their domestic legal order is undoubtedly the
expression of the most remarkable consequence of the affirmation of the right to health in international texts. Challenges to the realization of this right have increased accordingly.

2. THE CHALLENGES TO THE REALIZATION OF THE RIGHT TO HEALTH

Following the development of the realization of the right to health in its widest sense is obviously way beyond the scope of this short text. The evaluation or simple description of the systems of protection established by States or by international organizations and also the study of the means implemented by individuals within the framework of the systems of recourse derived from international, regional, or constitutional instruments would demand an undertaking on a vast scale. It would, moreover, be thoroughly illusory in value, since relevant information is added on a daily basis to the existing compilations. There is, however, one clear and constant theme that runs through the studies that have already been completed: the recognition of the right to health among the fundamental rights of the individual has operated as a powerful fermenting agent for the emergence of a set of subjective rights pronounced by States of all regions and at all levels of development. The expression “health legislation” is often used to identify the corpus of standards that defines the legal framework of these rights. Health legislation is the reflection of prior political choices, but, once it is free of its origins, it provides evidence of a specific autonomy. Included in the logic of legal systems and the applications that such systems authorize, it provides a fairly faithful picture of the realization of the right to health and the challenges that qualify this right.

2.1. Health legislation and the realization of the right to health

In addition to measures intended for the general improvement of the level of health of populations, whether they are aimed at the eradication of certain diseases or the general protection of public health by preventive means and health safety actions, it is the programmes for access to health care that have been designated as the principal vehicle for the promotion of the right to health. As mentioned earlier in this article, the right to health care was rapidly perceived as equivalent to the right to health and, although it is important to re-emphasize that the second is much vaster than the first, there is good reason, particularly with respect to individual human rights, to maintain that the right to care is an essential element of the realization of the right to health. The World Health Organization
has moreover played an active role in the affirmation of the right to health care and it is apparent that its interventions with a view to the recognition of a new international health order, expressed notably through the objective of "Health for All by the Year 2000" and by the Declaration of Alma-Ata, have served as a frame of reference for enlisting States’ participation.

It is also evident that the commitments entered into by States in pursuance of their adherence to international normative texts have been reiterated in regional instruments and have thus contributed to reinforcing the scope of the international obligations that they had already agreed to assume. Drawn up in order to guarantee the equality of access of every citizen to measures enabling them to enjoy the highest standard of physical and mental health, the provisions of the European Social Charter and the African Charter on Human and Peoples’ Rights, adopted in 1961 and 1981 respectively, update the ground covered by international declarations and bring fundamental rights even closer to the contexts in which they are to be realized.

The right to health, conceived either in terms of protection or of access to care, receives formal recognition in a number of constitutional texts. At the end of the 1970s, more than 50 States of all regions of the world and all political systems had included in their constitutions guarantees as to the recognition of the right to health as a social right. More recently, the constitutions of most countries of the former Soviet bloc formally recognized the right to health, generally in order to assure its protection but sometimes in order to affirm the right of access to care and the obligation of the State to make such care available. States that have not had recourse to the technique of the constitutional declaration of the right to health can hardly be blamed for having adopted a restrictive approach, since their reserve can be perfectly well explained by the complexity inherent in the allocation of resources among different social rights through constitutional means. In actual fact, it is not so much where the standard that generates the right to health is recorded that matters as the formulation of the right itself. In addition to the procedures that declare the existence of a right to the protection of health, the implementation of the right to health is generally by means of two complementary channels: that of the access to care and services and that of the full recognition of the autonomy of persons who require such care and services.

Whereas scarcely three decades ago the mention of a right to access to care was extremely rare in national legislation, it is becoming increasingly frequent for general laws on health care to explicitly state this right on behalf of individuals. What differentiates these laws is the extent to which the right of access may be enforced by the courts when it is not immediately recognized by those responsible
for its realization. Certain very magnanimous affirmations of the right to access may be based on such discretion on the part of those responsible that they have no more than an incantatory value, while others, apparently with a narrower scope, authorize court intervention in order to assure realization. Structuring the right to access to care requires that a delicate balance be established between the population's needs and the allocation of the resources necessary to satisfy these needs. Such is the challenge for the vast majority of States where services are, entirely or partially, made available by the State itself or by an insurance system whose principal operating conditions it controls.

Moreover, the reforms introduced in the last decade by States that have revised their health legislation are clearly constructed with the objective of serving the rights and interests of persons who require or receive care rather than as purely structural laws that focus more on the operation of the health system than on its aims and objectives. Thus, a number of laws now assign to the health system precise objectives and create explicit obligations vis-à-vis the administrators. While the declaration of objectives and guiding principles may seem to have more of a rhetorical than an effective impact — a proposition that is somewhat questionable since these objectives serve as the interpretive framework of the law that expresses them — it should be noted that an ever-increasing number of national legislations are establishing genuine legal duties vis-à-vis those who dispense care and services, notably with regard to emergency care and even with respect to the allocation of resources. This demonstrates the extent to which the question of patients' rights has become central to the evolution of health legislation.

A fundamental right of the individual, the right to health takes on its real meaning in its interactions with the other fundamental rights, whether these belong to the category of social rights, such as that of social security, or, to perhaps an even greater extent, the category of classic rights, such as that of equality or the autonomy of the individual. The influence of these last-mentioned rights on health legislation is thus not accidental; it corresponds to a strong tendency on the part of legislative authorities. From the strict recognition of the consent to care to the expression of the freedom of choice of health provider or health establishment, patients' rights are now expressed formally and incorporate correlated obligations based on a new standard of care that is accessible to all in full equality. It should also be recognized that the application of the principle of equality in the provision of health care may require special measures to be taken for categories of persons who are particularly vulnerable.

In recent years, it is HIV-infected persons and those suffering from mental
illness that have received special attention. With regard to the former, it is sufficient to mention the extent to which social stigma demands firm interventions to reduce the acceptable level of the discriminatory practices observed in a number of States. It should be added, however, that public health imperatives have made it necessary to take measures to control the spread of an epidemic disease. The imperative of protecting persons suffering from mental illness does not require demonstration with regard to observance of the right to autonomy by prohibiting the imposition of treatments, or the observance of the right to freedom by strictly limiting the confinement of persons to circumstances where they present a danger to themselves or to others. The provision of independent bodies with the means of appeal in order to ensure that rights are respected constitutes an accessory measure often deemed necessary in this context.

It may be said that, in general, States have incorporated the special dynamics of the fundamental rights of the individual into the remodelling of health legislation. The innovations and adaptations introduced, together with the nuances imposed by the respective stages of development of States, are evidently inspired by international strategies for the affirmation of fundamental rights, including the right to health. It seems that the high level of concern for the respect of fundamental rights that has become established during recent decades and the ethical dimension that has reorientated the proceedings of numerous legislative assemblies have resulted in the irreversible development of health legislation towards the attainment of the right to health. We are indeed a long way, unless we refuse to conceive of this right in its overall context and deny the necessary permeability of legal orders, from the declarations that confined the right to health to the realms of myth or illusion. This does not mean, however, that vigilance is out of place.

2.2. The right to health at the dawn of the year 2000

The statement that health care costs are too high has become a veritable leitmotif for many governments. Moreover, the will to control these costs better constitutes a policy followed doggedly by a number of States subjected to the neoliberal influence that characterizes the end of this century. It is not easy to answer the question of whether the resources — and particularly public resources — made available for health care are sufficient to satisfy the collective needs of a society, and the debates conducted by health economists do not point the way to an unequivocal conclusion. It is, however, clear that the subject of the allocation of resources, at both national and local levels, is the centre of attention.
The allocation of resources has always been an intrinsic element of health and medical care but, since guarantees of universal and equal access to care have been included in normative texts, everything takes place in a manner that suggests that the analysis of resource allocation methods is gaining pre-eminence. In States where care may still be refused on discretionary grounds that are not subject to legal control, the issue may seem less pressing but, as soon as this discretion no longer exists, generally in order to put an end to the risk that the exercise of this discretion might be abused, it seems essential that an attempt be made to find neutral resource allocation systems. Despite commendable efforts to achieve this end and arguments to justify it, neutrality has not been attained in a rationing and quota system. Thus, legislative texts or rules made for their implementation contain measures that restrict the exercise of the right to health services to the resources that are available at the time that the services are required. While it is true to say that these measures do not formally affect this right, they sometimes restrict its realization in a fairly serious manner and lead one to believe that the outcome is indirectly that which is otherwise prohibited. Other approaches have been attempted without apparent success, except that they have given rise to lively criticism: they consist in establishing priorities of access to health care according to a process that is probably deliberately complex in order to avoid any dispute concerning their discriminatory effects.

The rationing of health care is sometimes seen as inherent in universal systems of care. If this is the case, the process of resource allocation must be based on justifications that have been discussed by society, since the choices are, by definition, social choices. It is also noticeable that the individualistic and egalitarian approach that held sway over the affirmation of fundamental rights and their promotion seems to be giving way before more collective approaches. The tensions resulting from the confrontation of different interests cannot be simply cancelled out: they express a conflict of rationalities the determination of which is a decisive factor for the solutions proposed. While it may appear attractive to affirm that the collective rights of the community justify the suspension of the exercise of individual rights in the case of those who do not require care, it is probable that the same suggestion would be frankly unacceptable to those who are refused care on the grounds that their condition does not coincide with one or another of the priorities of access.

In short, we must ensure that the slogan “Health for All by the Year 2000” does not become “Health for All and Care for Some”. This is, no doubt, too strong a picture, but it underlines the absolute necessity of reinforcing strategies for the affirmation and realization of the right to health, even at the cost of being accused.
of a form of naivety or proselytism, behaviour which, curiously enough, we only criticize in others.

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5. The term “debt to the community” has also been used to describe the principal effect of the affirmation of social rights; see BURDEAU, G. Les Libertés Publiques. 4th Ed. Paris, Librairie Générale de Droit et de Jurisprudence (LGDJ), 1972, p. 20.


10. CAYLA, J.-S. L’organisation mondiale de la santé et la défense des droits de l’homme. Revue de Droit Sanitaire, 18(70): 236-248 (1982). See also TAYLOR, A. L., supra ref. 2; DAVID, É., supra ref. 9, at p. 11 (provides a list of legal instruments in support of health promotion and protection strategies).


15. CAYLA, J.-S., supra ref. 10, at p. 237.

16. EMMANUELLI, C., supra ref. 3, at p. 15.

17. See, for example, HUMAN RIGHTS PROGRAM, HARVARD LAW SCHOOL. *Economic and Social Rights and the Right to Health*. Cambridge, MA, Harvard University Press, 1995 (see, in particular, the summary of the second session: "Defining the right to adequate health").

18. Boethe, M., supra ref. 9, at p. 14. The author adds a third aspect, that of equality. Founded on the principle of the absence of discrimination in the enjoyment of the right to health, this aspect, which is relevant and cannot be circumvented, is innovative but does not seem to have been adopted by the doctrine. It is based rather on the necessary complementarity of fundamental rights among which the right to equality occupies one of the most prominent positions.


26. **Hayes, J.**, see *supra* ref. 19, at p. 408.


29. **Taylor, A. L., supra** ref. 2.

30. See point 11 of Part I of the European Social Charter which states that “everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable”. Article 11 of Part II of the Charter lists the measures that the Contracting Parties are to undertake in order to ensure the effective exercise of the right to protection of health. See also Article 16(1) of the African Charter on Human and Peoples’ Rights which states that “every individual shall have the right to enjoy the best attainable state of physical and mental health”. The second paragraph of this Article indicates the scope of the commitment of the States Parties with regard to medical attention.

31. **Boethé, M., supra** ref. 9, at p. 30 (list).


35. The principal difficulty lies in the justiciability of social rights and a number of States have chosen not to include rights that cannot be effectively enforced by court action. See **Boethé, M., supra** ref. 9, p. 17; **Lajoie A.** La macro-allocation des ressources et le droit aux services de santé. *Revue de Droit de l’Université de Sherbrooke*, 20(2): 231-248 (1990).
36. See *supra* ref. 27.


40. See, for example: SWITZERLAND (Berne) — Section 8 of the Decree of 14 February 1989 on the rights and duties of patients in public hospitals (Decree on patients) (*IDHL*, 41(1): 98-101 (1990)). See also (with regard to the allocation of resources): FRANCE — Article L. 711-4 of the Public Health Code, introduced by Law No. 91-748 of 31 July 1991 (*ibid.*, 42(4): 638-642 (1991)).

41. See, for example: CANADA (Quebec) — Act respecting health services and social services (*see supra* ref. 38); UNITED STATES OF AMERICA (Vermont) — Chapter 42 (Bill of Rights for Hospital Patients) of Part 3 (Hospitals, Health Centers, Nursing Homes) of Title 18 of the Vermont Statutes (*IDHL*, 42(3): 498-501 (1991)); SWITZERLAND (Zurich) — Ordinance of 28 August 1991 on the rights and obligations of patients in public hospitals and hospitals subsidized by the State (the Patients' Rights Ordinance) (*ibid.*, 43(2): 304-311 (1992)); SPAIN (Basque Autonomous Community) — Decree No. 175/1989 of 18 July 1989 approving the Charter of the Rights and Obligations of Patients and Users of the Basque Health Service (*ibid.*, 43(1): 84-92 (1992)). For the European Region, see the Declaration on the Promotion of Patients' Rights in Europe (*ibid.*, 45(3): 410-419 (1994)).


46. For an illustration of this phenomenon in Quebec law and Canadian law, see MOLINARI, P. L'accès aux soins de santé: réflexion sur les fondements juridiques de l'exclusion. In: Les Droits de la Personne et les Enjeux de la Médecine Moderne. Quebec, Presses de l'Université Laval, 1996, pp. 43 et seq.


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*Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.*
I. THE TRAINING IMPERATIVE

Training, that is to say the means employed in the context of a human being’s intellectual and moral education, and also the results obtained at the end of this process, is far from being a new concern of the international community. Historically, it has a significant application in the health field. Accordingly, it was included in 1948 on the list of priorities adopted by the First World Health Assembly. Various categories of training/education have thus been distinguished for a long time by international organizations. The Council of Europe, for

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example, distinguishes between basic, in-service, and further training. It is perhaps easier to distinguish between initial education (or basic education) and continuous (or continuing) education, to which may be added, if appropriate, a sandwich course education, which corresponds to an apprenticeship. In addition, categories of education may be considered that do not take into account the sequences of education, but the various orientations, thereby distinguishing professional education from interprofessional education and integrated education.

1.1. In the specific field of health law, the international effort with respect to education has no doubt not enjoyed the results that it deserved. WHO has, however, made sustained efforts to study and implement the best means for the dissemination of legislative information. Thus, WHO sponsored national training courses in health legislation, namely, courses on management of food safety held in 1982 in Beijing, and 1983 in Xian, China, as well as courses devoted to general legislation held at Hangzhou (1986), Shanghai (1988), and Kunming (1990). WHO's European Region was the first within the Organization to take a genuine interest in education in health legislation. An Advisory Committee on Health Legislation was established in 1981 within the WHO Regional Office for Europe with the task of assisting the Regional Office with the management of the Medium-term Health Legislation Programme, for the period 1980-1985, one of the five subprogrammes being in fact education in health legislation. In accordance with this programme, three successive international seminars in health legislation were organized by the WHO Regional Office for Europe, in July 1984 in Louvain, in August-September 1986 at Montpellier, and in November 1988 at Haifa, chaired by Professor A. Prims, Professor L. Rapp, and Judge A. Carmi, respectively, and co-chaired by G. Pinet. These seminars benefited from the participation of several of the authors who have contributed to this Special Issue, namely, Professor H. J. J. Leenen, Dr J. Martin, Professor R. Roemer, and Professor P. Vellas. This activity did not result in neglect with respect to the issue of education, as evidenced by the study that the WHO Regional Office for Europe assigned, at the beginning of the 1980s, to Professor J.-M. Auby. This issue of education in health legislation was also tackled by an Advisory Group that met in Jakarta in October 1991 at the initiative of the WHO Regional Office for South-East Asia, under the supervision of the Division of Development of Human Resources for Health at WHO Headquarters in Geneva. The WHO Regional Office for the Americas has, for its part, organized since 1994 a series of training seminars in health legislation and established, by means of an agreement signed on 13 January 1994 with the Government of Chile and the University of Santiago,
a Regional Bioethics Programme for Latin America and the Caribbean. Finally, it should be noted that there are two WHO Collaborating Centres for Health Legislation, one at Harvard University and the other at the University of Alcalá de Henares (Madrid).

One may wonder, however, whether education in health legislation corresponds exactly to education in health law. Article 63 of WHO's Constitution, which lays down that "each Member State shall communicate promptly to the Organization important laws, regulations, official reports and statistics pertaining to health which have been published in the State concerned", does of course make it possible to come up with an international definition of health legislation, but it is at once too broad (including reports and statistics) and incomplete. "Health legislation" refers, strictly speaking, to legislative texts, with which regulatory texts should be associated. Be that as it may, even if understood in the broad sense, which is desirable and even necessary, that is to say as encompassing all written legal rules, court decisions, and the unwritten customs and general principles of law, education in health legislation only provides an imperfect coverage of education in health law. Health law should be considered as a set of rules that have recourse to principles and that contain standards, whatever the basis for these rules. As J.-M. Auby wrote in 1984, "it would be inconceivable to exclude from teaching the elements supplied by case law. In doing so one would be forced to exclude from the programme essential aspects of health law". It should be added that, while they may also show a deontological aspect and/or an ethical nature, these rules remain principally legal in character. The concept of legal rule is thus extended with regard to its content. Moreover, it should not be forgotten that health law is not restricted to the study of texts, but is also concerned with their implementation.

Specific courses in health law have been introduced on a local basis, that is to say in certain universities. This has been the case in the University of Amsterdam since 1970 when a Chair of Social Medicine and Health Law was created in the Faculty of Medicine, followed in 1972 by the creation of a Chair of Health Law in the Faculty of Law, both of these being held by Professor H. J. J. Leenen. In France, the Faculty of Law of the University of Bordeaux-I was the first to establish education of this type when in 1975, at the initiative of Professor J.-M. Auby, it introduced a postgraduate course that included training not only in national law (French, in this case), but also in international health law. This training is still provided both for French citizens (students and professionals) and foreigners (notably persons from developing countries, and from Africa in particular). Similar training exists or is beginning to be introduced on other
continents. In May 1985, the University of Sherbrooke hosted the First World Colloquium on International Health Law. In May-June 1988, the University of São Paulo organized the First International Seminar on Health Law. In the USA, a Health Law Teachers’ Section was established in 1981 within the American Society of Law & Medicine.

Thus, it seems that education in health law has not so far been dealt with in sufficient depth on an international scale. A prerequisite for this is the development of research, expertise, and training in this discipline. Moreover, priority has until now been accorded to health information and health education in general at the expense, it seems, of reflection on what might be termed “legal education in public health”. In this connection, it may be noted that training in health law did not really appear until the end of the 1970s, and even in the northern countries, it is not yet widespread. Training may thus be envisaged both in general law and in national law, or again in international health law.

I.2. Today, more than ever before, it is imperative that education in health law be recognized and find expression at international level. The right to education must be asserted in all its dimensions, one essential dimension being education in health law. The legal approach, which undoubtedly forms the basis for operational health activities, is currently reinforced by the development of the allocation of liability with respect to health activities. However, law must not serve merely as a guarantee against hazards that are subject to civil, penal, or administrative sanctions incurred by health professionals, or as a theoretical protection for patients. The legal approach is fundamental for the establishment and implementation of health policies. Education in public health must, therefore, take into account health law. The legal approach is thus, before all else, a methodological approach. Legal methodology must serve as a basis for educational activities in the health field. The methodological approach must indeed precede a pedagogical approach, a point which to date does not seem to have been clearly perceived with regard to international health protection.

Such a realization must be the outcome of a dual methodological approach: first, the specificity method, which is applicable owing to a conceptual approach that emphasizes the need for such a method; and secondly, the globalization method, which may be used within the framework of a practical approach that demonstrates its desirable characteristics in terms of the available, notably financial, resources.
II. THE NECESSARY SPECIFICITY

It seems that the first thing to be considered should be the recognition of the specificity of education in health law. Such specificity is necessary if there is to be no confusion from a conceptual standpoint. Indeed, the question of the specificity of the concept of education itself must be dissociated from that of the specificity of the content of health law education.

II.1. The specificity of the concept of education in the health field is distinguished in relation to the concepts, now classic, of information-education-health communication. All these concepts are juxtaposed at international level. The 1981 Madrid Conference of European Ministers of Health considered that health education at school had become a major problem and tackled the question of the adequate training of teachers. The second recital of resolution WHA27.31, adopted by the World Health Assembly in May 1974, which was directly influenced by the Report of the WHO Expert Committee on Continuing Education for Physicians published in 1973, notes that “continuing education of health personnel must be an integral part of the total health and educational system and is of cardinal importance to the health authorities in assuring the quality and coverage of health services”. Article 5(i) of the Convention of 26 June 1985 concerning Occupational Health Services (Convention 161 of the International Labour Organisation) lays down that one of the functions of these services is “collaboration in providing information, training and education in the fields of occupational health and hygiene and ergonomics”.

This amalgam, which is basically a logical one, is still generally accepted today, and even reinforced by reference to the concept of promotion. This is the case, in particular, with Decision No. 645/96/EC of the European Parliament and of the Council of 29 March 1996 adopting a programme of Community action on health promotion, information, education and training within the framework for action in the field of public health (1996-2000).

The revival of interest currently shown for education in the health field favours the recognition of the specificity of this concept. The elements of this specificity are already known; they concern both the persons for whom education is intended and the objectives and content of this education. Society as a whole is targeted. This is emphasized in the fourth and fifth recitals of resolution WHA27.28 adopted by the World Health Assembly in May 1974, which read substantially as follows:
Taking into account the fact that WHO's activities should not be concerned solely with the prevention and control of physical and mental illness but that special attention should also be paid to the harmonious development and training of the rising generations with a view to the building of a healthy society;

Considering the important role of health education and of the multiplicity and complexity of educational factors, within the family, the school, and other institutions, in the training of children and young people ...

We now know that education should not be restricted to professional categories, even in the health sector. The specific education of health professionals nevertheless remains a determining factor, something that has been traditionally recognized by WHO since its creation. Point 1 of resolution WHA3.69, adopted by the World Health Assembly in May 1950, "emphasizes the importance of further development of international activities in the field of professional and technical education of medical and auxiliary personnel". WHO's Eighth General Programme of Work covering the period 1990-1995, for its part, emphasized the essential aspects of modern education in the health field, such as the training of trainers or primary health care personnel. Teachers now constitute a target group to whom educational efforts should be addressed. Recommendation No. R (88) 7 of 18 April 1988 of the Committee of Ministers of the Council of Europe states in this connection that primary teachers should receive training, preferably before taking up employment, and then during the course of employment. Secondary teachers should be initiated to health education during their basic training and have the possibility of increasing their knowledge during the course of employment.

The definition of objectives and methods also contributes to the specificity of training activities. Operative paragraph 1(2) of resolution WHA27.31 adopted by the World Health Assembly in May 1974 requests the Director-General to pursue measures to "develop, jointly by specialists in various disciplines, specific objectives and methods of continuing education for the health professions". Recommendation No. R (85) 5 of the Council of Ministers to Member States on a model curriculum for the training of specialists in blood transfusion includes an Appendix determining the aim of the training of blood transfusion specialists. This advocates a model training curriculum, but points out that this model is not intended as a rigid framework for training. Decision No. 645/96/EC of the European Parliament and of the Council of 29 March 1996 states that its objective, with regard to vocational training in public health and health
promotion, is "to help to familiarize the various categories of health staff, those who decide on and administer health policy or action and those in the front line of health promotion (e.g. teachers, educators, social workers) with knowledge, ideas and methods relating to public health, prevention, health promotion, information and health education".31

The concept of education in the health field is thus essential, since it appears not only as a unifier of the other concepts of information-education-communication-promotion, but also as the carrier of a general operational dimension. International texts have been too gradual in their perception of the various aspects of this concept, which will only acquire its specificity through this synthetic approach.

II.2. It is on the basis of this analysis of the concept of education applied to health that one may reflect on the necessary specificity of the content of education in health law. It is necessary, first of all, to emphasize the fundamental duality of health law, a duality that is at once both formal and material. It is formal with regard to the process of formulating international health law, a process in which the participants, as we know, are not only intergovernmental organizations but also nongovernmental organizations. This formal aspect is also expressed with regard to those to whom international health law is addressed, that is to say not only States but populations as well. Today, it is evident that this duality is also characterized by a material aspect, insofar as international health law borrows both from the technical field and from the ethical field. It is, therefore, not possible to restrict education in modern health law to technical education alone, that is to say legal education properly speaking (the knowledge of institutions, the study of legal rules); it must be supplemented by education in the field of health ethics. Education in health law thus reinforces education in public health, which is also based on a normative framework32 and now takes into account deontological and ethical issues. WHO also uses the concept of ethics in connection with medical education, for example in the case of nursing care.

Education must be "relevant".33 Many countries have introduced education programmes "for preparing health personnel with the necessary knowledge, skill and attitudes".34 Relevance in this context is concerned, in particular, with optimalization. The Eighth General Programme of Work covering the period 1990-1995 considers to this end that "the optimal use of the right kind of trained personnel is vital for the improvement of the entire health system and for cost-containment" (paragraph 248),35 and that "a priority approach of the Programme will be to improve the training of health workers to ensure the increased relevance
of such training to national health priorities” (paragraph 260). Such optimalization can certainly be envisaged with regard to health law education. International cooperation in the matter of legal expertise must then be envisaged on the basis of the idea of globalization.

III. CONCEIVABLE GLOBALIZATION

International reflection on education has led to a differentiation of the categories of personnel to whom educational activities should be addressed. Historically, the emphasis was on vocational training, which was aimed at “medical and public-health personnel”37. The Ninth General Programme of Work covering the period 1996-2001 considers that one of the priorities for WHO’s work in support of world action should be “to organize coordinated training programmes for health professionals, community health workers and traditional practitioners so as to foster complementary skills and integrated delivery of services”.38 More generally, the idea of horizontal categories was able to establish itself with the vocational training of women39 or of workers.40 Specific education in health law must, however, always be based on a distinction that makes use of the ideas of horizontal categories as well as that of vertical categories. Indeed, it must be established from the standpoint of health professionals as well as that of lawyers themselves. A general strategy for education must, therefore, be drawn up.

III.1. From now on, a special place should be reserved for the training of lawyers in health law. In the first place, this concerns teachers of law. Courses in health law, which were not developed until the end of the 1970s41 and which are still too few,42 are the origin of this education which, at the outset, is inevitably of the university type. Conceived within the framework of postgraduate studies, this course is incorporated within a system of continuing education (training of trainers) and is intended for academics whether they be lawyers or non-lawyers.

Other professionals in the law field (barristers, judges, administrators) must also be associated with this type of education, either as trainers or as students. The current trend towards extending liability in the field of health activities is, moreover, causing professionals in the field of law to take an ever keener interest in health law. Training in health law may prove useful, especially for future barristers. It would be desirable to contemplate the provision of such training not only in national schools training health administrators (in particular the directors of public hospital establishments), but also in national schools providing training for administration and the judiciary.
The education of health professionals in health law must be emphasized. It must be directed at all these professionals, that is to say physicians (civil and military physicians, general practitioners and specialist physicians, in particular expert physicians in the courts, occupational physicians, or school physicians), the other medical professions, and also the pharmaceutical and paramedical professions. Such training must be provided on the spot or given by specialized lawyers in faculties of medicine, pharmacy, or dentistry, in veterinary schools, and also in schools preparing managerial staff in the health field. Questions may arise as to the territorial level of such training. The international bodies that have already been set up should themselves accord a privileged place to the legal aspect of the education of health professionals.

III.2. The methodology of education in health law is also concerned to a large extent with the establishment of a global strategy for education. This education, at once initial, continuous, interprofessional, and integrated, must be appropriate. Its content must be adapted to the needs of countries in this field, although it should not be forgotten that international perspectives should be evolved on the basis of the principle of international cooperation. A certain number of actions may be envisaged, such as “support for cooperation between schools of public health, universities, and bodies providing training in this area”, or “the compilation of a European Directory”.

The programme may be exhaustive, that is to say it may be concerned with all activities, or carefully select its priorities. In reality, the programme must be adapted to the type of education, depending on the skills of the participants and the objectives of the education. The latter must, in any event, be subject to official recognition in the form of a “qualifying examination”, which may be organized on the basis of several tests, including the defending of a dissertation or a course report, in order to validate the candidate’s skills and know-how. A periodic evaluation of the training should also be carried out.

Finally, it should be noted that education may be considered as a condition of the free movement of professionals at international level. Thus, the European Community has, firstly on the basis of sectoral directives (between 1975 and 1986), and then through general directives applied a rule of “comparability”, that is to say the equivalence of the education of health professionals.

The movement to make education “worldwide” must be taken into account. In the case of education in health law, however, it is attenuated by the diversity of legal systems, a factor which reinforces the cultural aspect of each system of education. A “learning society” is in the process of being established, based on
the existence of “intangible assets”. Centred on health protection, and taking into account national and international legal rules, education in health law can only serve to reinforce “human development”.

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2. Recommendation No. R (88) 7 of the Committee of Ministers to Member States on school health education and the role and training of teachers (adopted by the Committee of Ministers on 18 April 1988).


13. See *supra* ref. 11, at pp. 8 et seq.

14. See *supra* ref. 11, at p. 9.

15. See *supra* ref. 11.


19. See, for example, resolution WHA31.42 of May 1978 (*supra* ref. 4, at p. 75), operative paragraph 2(1) of which invites the Director-General “to collaborate with Member States, and in particular with developing countries, in the development of appropriate educational technology for active participation of communities in health development, and in the training of all health workers in applying this technology”.

20. Strasser, T. & Gallagher J. *The ethics of health communication.* *World Health Forum,* 15(2): 175-177 (1994). According to the authors, “Health communication, a two-way process, takes place among biomedical scientists, between scientists and medical practitioners, between health professionals and the mass media, and between the mass media and the public”. There is, at WHO Headquarters in Geneva, a Division of Health Promotion, Education and Communication. In 1995, a WHO Expert Committee on Comprehensive School Health and Promotion was established. School-health networks have been introduced as from the beginning of the 1990s, particularly in the Region of the Americas (1993) and in the Western

21. See supra ref. 4, at p. 70.


25. See supra ref. 4, at pp. 74-75.

26. See supra ref. 1, at p. 43.


28. See supra ref. 2.

29. See supra ref. 4, at p. 70.


31. See supra ref. 24, at p. 304.


34. Resolution WHA31.42 adopted in May 1978 by the Thirty-first World Health Assembly, supra ref. 4, at p. 75.

35. See supra ref. 27, paragraph 248, at p. 85.

36. Ibid., paragraph 260, at p. 90.


39. See, for example, the implementation with respect to employment of the Conclusions of the Council of the European Communities of 26 May 1987. *Official Journal of the European Communities*, No. C 178, 7 July 1987, p. 3.

40. See, for example, Article 19(2) of the Community Charter of Fundamental Social Rights for Workers, adopted by the European Council in Strasbourg on 9 December 1989.


42. There is, however, a tendency to establish “networks” of specialists and institutions.


44. Within the context of the development of human resources for health, WHO supports the idea that “special emphasis will be laid on promoting the use of the district health system as a learning environment in the training of all categories of health workers”, *supra* ref. 27, paragraph 260, at p. 90.

45. These are international professional organizations. Mention should be made here of the advisory bodies established within the European Community, such as the Advisory Committee on Medical Training, the Advisory Committee on Veterinary Training, and the Advisory Committee on Training in Nursing, etc.

46. This orientation was already envisaged, at least in part, in resolution WHA27.31 (paragraph I(3)) adopted in May 1974 by the Twenty-seventh World Health Assembly, *supra* ref. 4, pp. 70-71.

47. Article 4 (International cooperation) of Decision No. 645/96/EC of the European Parliament and of the Council of 29 March 1996 resorts to this principle to implement it in its relations with WHO and nongovernmental organizations, *supra* ref. 24, at p. 301.

48. See *supra* ref. 24, at pp. 302-304. Annex entitled “Community Action Programme on Health Promotion (1996-2000)”. The Directory in question is a European one. According to the study by Auby, J.-M., *supra* ref. 9, it would be equally useful to compile, within the framework of WHO, a Directory of this nature on a world scale through enlisting the special participation of WHO’s regional agencies.

49. See *supra* ref. 2. The Explanatory Memorandum to Recommendation No. R (88) 7 thus distinguished between four steps: personal education, professional expertise, practical training, and training in the use of extra-curricular activities.
50. See supra ref. 2, point 6.2 of the Annex to Recommendation No. 4 (88) 7.

51. See supra ref. 30, point B (3) of the Appendix to Recommendation No. R (85) 5.


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Health law may be defined as the body of rules, whether statutory or otherwise, that regulates the promotion and protection of health, health services, the equitable distribution of the available facilities, and the status of all parties concerned, such as patients, providers, institutions, and financing bodies. Of course, other disciplines contribute to the structure and functioning of the health system, but the focus of this article is on law and legislation.

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1. Rules, legislation, and social processes

The nature of rules regulating a social system can vary. On the one hand, they may belong to civil, criminal, administrative, or international law and, on the other hand, they may originate from legislation passed by government and parliament, the case law of the courts, disciplinary law, self-regulation by private organizations, or generally accepted customs. Legislation, in other words, is only one way of regulating systems. Societal systems operate within the framework of all types of law.

However important the role of law in the regulation of social systems may be, these systems are also subject to social, cultural, and political processes. Through this interaction, these processes also influence the operation of the law. For the law to be effective, it is therefore necessary to take into account the social processes involved. If this relationship is disregarded, the result may be a non-functioning law, side-effects, or even adverse effects. This point should be emphasized with regard to legislation in particular, since politicians and governments sometimes suffer from what I like to call the “fiction of legislation”. They often suppose that the enactment of a statute means that the desired goal will be attained more or less automatically. In general, this will not be the case if social and other factors and the influence of other rules are not taken into account. These factors and influences have to be studied before drafting a law. If such matters are not taken into consideration, legislators will often be disappointed by the results of their efforts.

What is true of law and systems in general also holds for the health system. Different types of rules are involved and the social processes concerned have to be considered. When legislating with a view to promoting and protecting health and health services, it is essential that these factors and influences be assessed beforehand.

Let us take patients’ rights as an example. Different choices can be made with regard to the type of law used in regulating these rights. For instance, Finland, for instance, has enacted a statute on patients’ rights in administrative law, while the Netherlands have opted to incorporate these rights in the Civil Code. The administrative option emphasizes the role of the government as protector of the rights of the citizen, whereas the civil option focuses on the relationship and cooperation between the health care provider and the patient. However, the difference between the two options is smaller than it might appear. Opting in favour of the civil regulation of patients’ rights does not mean that administrative rule-making by the government is excluded. The government may, for instance,
help to give effect to patients’ rights through administrative rules. Again, administrative legislation is required when patients’ rights are infringed, as, for example, in the case of involuntary confinement on the ground of a severe psychiatric disorder. In the administrative option, patients are not prohibited from going to the civil court. Thus, in order to assess the patient’s legal position in either option, it is necessary to look at both types of law. Moreover, in both systems patients’ rights are affected by general rules of law and other statutes (for example, with regard to privacy). In addition, other forms of regulation may apply, such as professional codes and hospital rules. The entire body of rules involved and their effects need to be studied when drafting a law on patients’ rights.

Besides legal rules, many social processes influence the realization of patients’ rights. These must be studied during the preparatory phase of a statute on patients’ rights. Since these processes also play a role during the law’s implementation, a policy must be formulated as to how it is to be implemented once it has come into force. Implementation must be made a major issue in health policy and health professionals and patients’ organizations must be informed and educated as to how to deal with patients’ rights. Information on these rights must be disseminated to the population. It was for this reason that the Declaration on the Promotion of Patients’ Rights in Europe, issued in 1994 by a WHO European Consultation, drew attention to measures to promote patients’ rights and gain the support of all parties concerned.

2. Legislation, societal self-regulation, and legislated self-regulation

I have already made the point that there are many types of rules. Society functions for the most part without legislation. Recourse is made to legislation where specific needs are to be met: for example, the protection of common interests, the delineation of the powers of the State, the protection of the fundamental rights of citizens, the imposition of penal sanctions, the balancing of unbalanced power, and the establishment of procedures for resolving conflicts.

In many countries, legislation is also used for administrative purposes and this has led to an abundance of legal rules in the administrative sector. So much of this type of legislation has been enacted during past decades that it is often difficult to see the wood for the trees. In such a situation, the wish to deregulate and leave matters to societal self-regulation is understandable. The question then becomes whether and under what conditions societal self-regulation may provide an alternative to legislation. It should be noted in this context that the internal rules of a private organization that are only binding on its members do not
constitute societal self-regulation.

On the debit side, the deregulation movement carries with it the risk that necessary legislation is not enacted in fields where the legislator has his own responsibility. In such an event, the policy of deregulation results in under-regulation, or no regulation at all. In countries where patients' rights are not or insufficiently regulated, this would, for example, be a fate suffered by patients' rights. The result of deregulation could well be under-protection.

There are, however, other fields where there are arguments for leaving the regulatory process, in one form or another, to the parties concerned. A concomitant advantage is that citizens become involved and assume responsibility in affairs of public interest. Societal self-regulation may, in such cases, serve as an alternative to governmental regulation. For such self-regulation to be acceptable as an alternative to legislation, several requirements must be met:

- all parties concerned must be involved in rule-making and decision-making. Rules for oneself alone are not societal self-regulation. If some parties are left out, the regulation in question does not have an adequate basis for its rules to be recognized as socially acceptable;
- the parties concerned must be equal in terms of power. If power is not equally distributed, the government cannot assume that all interests will be reasonably balanced in the rules of self-regulation;
- the common interest must prevail over individual interests. This is essential if societal self-regulation is to provide an alternative to legislation;
- regulation must bind the rank and file of the parties involved. This is essential if individual members or individual member corporations are not to go their own way and if self-regulation is to fulfil its intended social function;
- regulation must function in the open and be controllable. Self-regulation behind closed doors cannot take the place of legislation; and
- appropriate means of enforcement must be established, such as mediating procedures and a procedure for lodging complaints.

Judged against these criteria, unilateral codes of manufacturers are not societal self-regulation. The same is true of a code of conduct established by an organization of health care providers. Such a code cannot serve as a substitute for legislation on, for example, patients' rights, however useful these codes may be for educating providers.

Self-regulation is not appropriate for every subject. As we have seen, legislation is required where the government has to assume responsibility. The formulation and protection of the fundamental rights of citizens and the safeguarding of access to indispensable social goods, for instance, are not matters
to be left to private rule-making.

Legislation and self-regulation can be combined. When this is done the advantages of both types of regulation are brought together and the disadvantages of both may be prevented. While government rule-making often leads to rigidity and bureaucracy, self-regulation may entail too much self-interest. In legislated self-regulation, the government draws up a framework law and further rule-making is left to the parties concerned. The aim is to prevent, on the one hand, the disadvantages of detailed government rules and, on the other, the disadvantages of self-regulation, such as the abuse of power and lack of consideration for the interests of others. Legislated self-regulation provides for an equilibrium between State responsibility and the responsibilities of the private parties concerned. In the framework law, fundamental norms, general rules, and procedural requirements are laid down. These norms, rules, and requirements aim at safeguarding public interests and the rights of individuals. Within this framework, it is up to the private parties to formulate more detailed rules and make regulation operational. Legislated self-regulation may cover an entire subject, or it may apply only to specific parts of a law. Legislated self-regulation unburdens the State without, however, taking away the responsibility of the government. It overcomes the antithesis between State and citizen and makes room for private forces and creativity, as well as for the government.

3. Regulating a health system

A health system can be divided into five subsystems:
1. Demand (citizens, patients);
2. Supply (e.g. personal providers, health institutions, prevention, health education);
3. Health protection (e.g. communicable diseases, environmental safety, the workplace, blood and medical devices);
4. Financing; and
5. Government.

Being part of one health system, subsystems interact with each other, whether or not there is a formal relationship between them. Subsystems that are not formally linked may influence each other in an informal way. Whatever kind of link may exist between subsystems, a measure taken in one will often have effects on one or more of the other subsystems and even on the functioning of the whole. These effects may or may not be desired. For example, the way in which physicians are remunerated (finance subsystem) may influence the relationship
between primary health care and hospital care (supply subsystem); if family physicians are paid fees for their services they will be less inclined to refer patients to a specialist than if they are paid a fixed sum per patient per year.

The same holds for rules. Rules in one part of the system may have consequences in other parts. There are links between, for example, rules on supply, the qualifications of providers, hospitals, the safety of drugs and blood (health protection), and financing. All these rules together influence how medical care and practice actually function. Legislation must, therefore, be drafted taking into consideration the interconnection between these various rules. If the effect of and on other relevant rules and legislation is not assessed, there is a serious risk that the law will not operate in keeping with its objectives, possibly giving rise to side effects and even contra-effects. If the legislator is blinkered, the result may be that walls are built between parts of the system, thus preventing the necessary interactions. Problems in health policy and health legislation often arise because these links are not established.

The same is true with regard to links with rules and legislation outside the field of health care. Many sectors of society (housing or the environment, for example) influence health. This calls for intersectoral cooperation and the links of health legislation with laws and rules in other relevant sectors of society must be taken into account.

Once the foreseeable effects of a proposed law have been assessed, a choice has to be made concerning its legal construction. As we have seen, there is more than one possible solution. How legislation and societal self-regulation, or their combination, will be applied in rule-making with regard to the promotion and protection of health and health services depends on a whole range of factors, such as a country's social, cultural, and political development, the organization of its government (whether central or decentralized), the national legal system and legislative style, and the organization of health care. A role is also played by the kind of interests involved. For instance, the more deeply private life is affected, the more it is up to the government to remain in charge of rule-making.

The legislative involvement of government in health protection and health services can be defended for a number of reasons. These include:
- the delineation of the public interest affairs to be administered by the government and associated authorities, such as the inspectorate of health;
- the guarantee of the quality of the provision of health care and health services. The responsibility for the improvement and protection of quality lies primarily with providers (professionals and health institutions) and manufacturers (of, for example, drugs, substances, and medical devices). The legislator too has a
duty to make rules with regard to quality, since the quality of services and products in the health sector is of public interest and patients are mostly not in a position to assess the standard of services and products in this field. Moreover, with services and products in the hands of the market, quality may be threatened owing to the role played by economic gain. Citizens may expect the government to make quality rules binding upon providers and manufacturers. These rules may be of a direct nature (regulating directly applicable norms and procedures) or of an indirect nature (establishing rules for self-regulation). Legislation of the direct type is often used in statutes concerning, *inter alia*, the qualifications of providers and the quality of drugs. The indirect type is often applied in legislation on quality supervision in hospitals and other institutions;

— the safeguarding of access to indispensable health care for all. Here the right to health care, which is recognized in many countries and at international level, is at stake. According to this right, governments have the duty to guarantee the access of all citizens to indispensable medical care and necessary preventive services (e.g. vaccination). This governmental responsibility may be realized by a national health service, compulsory or other insurance schemes or, when health services are left to the private sector, by establishing rules and taking measures with regard to, *inter alia*, financial access and the equitable distribution of services. Without government intervention, the poorer regions and poorer sections of the population will be badly off;

— the protection of patients and their rights. The patient is the weaker party in situations involving the provision of health services and is dependent on health care providers and institutions. The patient's position may be strengthened by statutes on patients' rights and the other measures discussed above. For the protection of the patient, there are, as we have seen, other instruments in addition to specific legislation on patients' rights. The patient may also be protected by, *inter alia*, laws on the computer storage of medical data and rules concerning the use of medical data for purposes other than treatment;

— the encroachment on the rights of individuals. In many countries, legislation is required in case of such encroachment. One example is the involuntary confinement in hospital of a dangerous psychiatric patient;

— the need to limit or balance the interests of third parties. Third-party interests are involved in, for example, the removal of organs for transplantation and medical experimentation. Another type of third-party problem arises from the wish of insurers and employers to get hold of medical data collected during medical examinations, pre-employment examinations, and those carried out on
insurance applicants. When third-party interests are at stake, the rights of the citizen come under pressure and it is then up to the legislator to protect the citizen. This may result in prohibitive regulation or rules to balance the interests concerned. An example of the latter concerns the rules on the use of medical data for indispensable medical research where consent cannot be requested because the patient is untraceable;

— the protection of the health of society. This is a classic reason for intervention by the legislator, one example being the control of contagious diseases; and

— the protection of the individual against the government itself. When David the individual is threatened by Goliath the government, legislation is generally the only effective instrument for restricting the power of the State. Examples are the force-feeding of hunger strikers and the access of public bodies to medical data collected during medical treatment.

In such matters and when fundamental norms are at stake, it is risky to leave the formulation and elaboration of rights and entitlements to the private sector. This does not exclude the use of the method of legislated self-regulation, in which the parties concerned are given room to elaborate in greater detail. In the case of third-party interests, for example, the legislator may use the method of legislated self-regulation whereby the fundamental principles are laid down in the law and it is left to the parties concerned to work out the details. Another example concerns the safety of blood and medical devices. Here, although legislation is appropriate, a role may also be given to the parties concerned. Sometimes it is left to the manufacturer to establish more detailed norms. This is not societal self-regulation, but a form of delegation to a single party. Because of the interests involved, there are arguments in favour of applying legislated self-regulation in this field, thereby drawing consumers and patients into the regulatory process. By transforming delegation into legislated self-regulation, the interests of consumers and patients are taken into consideration and unilateral power is restricted.

A special situation exists when health services are in the hands of commercial entrepreneurs. Although the rules of the law of commerce apply, this does not mean that health and quality requirements do not have to be observed. The type of regulation used in respect of these requirements depends on a great many (national) factors. Sometimes legislation is appropriate; sometimes the parties concerned may become involved in a form of self-regulation.

The issue of legislation and self-regulation is also a matter for debate with regard to ethics in health care. Since ethical norms play an increasing role in health, there is a corresponding increase in legislative initiatives in this field. When there is unanimity or near unanimity concerning an ethical norm, for
example the extracorporeal development of pre-embryos beyond two weeks, there is no problem with legislation. One may ask whether there is a need for legislation in such cases, since it may add little and have no more than a confirmatory function. However, a decision to formulate a statute will meet with no resistance. When, however, opinions differ and there are valid arguments in favour of each view, legislating in ethical matters becomes a problem. Legislating ethics under such circumstances will mostly result in opting for one ethical viewpoint, generally the majority view, people with other convictions then being forced to comply with a law that their conscience rejects. This may even give rise to conscientious objection. In the case of different ethical views, the legislator must show reserve. It is then often better to refrain from drafting a law. Everyone is then free to act in accordance with his own convictions and no one is forced to apply an ethical norm they reject.

4. Evaluation of legislation

It should now be clear that in a health system there is at work a cosmos made up of different types and mixtures of rules. As we have seen, this cosmos is also influenced by social processes. Consequently, using law to guide the protection of health and the health system is a very complex matter. Legislation, one of the instruments of law, has its own role to play. Only if it is carefully drafted, taking into account other relevant rules and social processes, will it attain its objectives. Experience is important if there is to be insight into the working of legislation. Equally important is the evaluation of legislation. It can explain what happened to a particular law, how it worked as a legal instrument, and what its effects were on the various actors whose role it was to work towards its objectives. Why did the law succeed or not, as the case may be, in reaching its goal? Was the preparatory phase lacking? Were the necessary examinations carried out during that phase? Were the links with other relevant rules assessed? Were there shortcomings in the system and drafting of the law? Have amendments by parliament introduced flaws or a lack of clarity? Finally, once it was adopted, was sufficient attention given to its introduction and implementation?

Problems of methodology need to be solved to answer these questions during evaluation. It is important to have a clear description of the point of departure and of the law's objectives. Without such a description, the impact of the law is difficult to assess. Another methodological aspect relates to the identification of cause and effect. Effects which may have been caused by other factors have to be eliminated. If, for example, since the introduction of a law, civil claims for
damages in the field concerned have increased, one may be inclined to see a relationship of cause and effect between this increase and the new law. The increase may, however, be caused by another law, such as one that introduces a complaint procedure, by a social process, or because rules governing general civil liability have been changed.

If an evaluation is carried out professionally, it will add to the knowledge of the possibilities and limits of health legislation and of health law in general.
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Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
HEALTH LEGISLATION AS A TOOL
FOR PUBLIC HEALTH AND HEALTH POLICY

Among the many tributes in honour of the 50th anniversary of the World Health Organization, this Special Issue of the International Digest of Health Legislation adds another laurel to WHO's crown. It celebrates a publication unique in the world, issued quarterly in English and French from 1948 to the present. The International Digest of Health Legislation is the only comprehensive source of health legislation available to health workers worldwide. Year in and year out, the Digest has published the original texts or accurate summaries of laws and regulations on the many subjects in the multidisciplinary field of public health. At

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first ranged by country and later by topic (with a chronological index by country), the legislation reported has provided invaluable comparative legal information and disseminated knowledge on health policy, enabling countries to profit from legislative experience in other places. In addition to national and subnational legislation, the Digest has also covered the texts of relevant international instruments produced by the United Nations system and other intergovernmental organizations, such as the Council of Europe and the European Union. The addition of book reviews by international scholars and a section entitled “News and Views”, with information on conferences, reports, and governmental documents in the field of health law and policy, has further enhanced the sweep of information available to an international audience. This article is dedicated to a long and robust future for the Digest.

In August 1995, the American Bar Association (ABA), as a contribution to the 50th anniversary of the United Nations and in fulfilment of its commitment to advance the rule of law in the world, issued reports and recommendations on several specialized agencies of the UN. Its report on WHO takes particular note of the latter’s role in providing comparative health legislative information and the need of countries in the process of development for more sophisticated regulatory schemes. The report draws attention to two resolutions of the World Health Assembly: a 1977 resolution calling for strengthening WHO’s programme in health legislation to assist Member States in developing appropriate legislation and a 1980 resolution recognizing appropriate health legislation as an essential component of health care services and environmental health systems. The ABA report notes WHO’s own evaluation of its programme of “Health for All”, which it acknowledged cannot be achieved in the absence of an up-to-date, enlightened, and realistic framework of laws, regulations, and other instruments that establish the responsibilities of government, other authorities, health professionals, and other elements of society concerned with health development. In accord with WHO’s position on health legislation, the ABA recommended that

... the Government of the United States should support WHO in exploring means of more effective implementation of public health improvements through increased standard setting and development of elements of model legislation, regulations and enforcement measures.

In pursuance of this objective, we discuss here the importance of legislation for public health and health policy, the functions of law and regulations in a health system, and the challenges in enacting and implementing legislation. Only a few
recent examples of legislation are cited because the volumes of the Digest are replete with legislation from countries throughout the world.

**Importance of legislation for public health and health policy**

Health legislation, public health, and health policy are all intertwined and interact. On the one hand, the health policy adopted by governments determines the character and content of laws and regulations. On the other hand, health legislation, consisting of statutes and regulations that fill in the details of statutes, shapes the way that health policy is translated into health programmes and services. The concern of public health with populations, as distinct from clinical medicine, which is concerned with individuals, is crucial to the creation of both health policy and health legislation.

To take the example of tobacco control, once a government adopts a policy to protect its people against the ravages of tobacco use, then it may enact legislation of various kinds, such as restricting tobacco advertising, banning tobacco sales to minors, assuring smoke-free public places and workplaces, and increasing taxes on tobacco. The legislation, in turn, provides the basis, authority, and funding for programmes and services to achieve tobacco control. Underlying this process, the epidemiological and clinical evidence provided by public health creates the science base for both the policy developed and the legislation enacted.

Legislation is the essential basis of authority for all public health activities. It expresses the political will of government and thus forms the legal framework for health policy. Without legislation a public health officer would have little power to clean up the environment, to stop the spread of disease, or to allocate funding for maternal and child health programmes. Of course, voluntary organizations and the private sector participate in developing and promoting health policy in various ways, but the legal basis for health policy depends on the enactment and implementation of legislation by government.

In federated countries with subnational levels of government, legislation is important to define the jurisdiction of each level of government and to specify the authority, standards, and interrelationships of the national and subnational entities.

Technological and social change have heightened the importance of legislation to keep health policy abreast of scientific advances and changed social norms. The role of the private sector in the provision of health care requires regulatory measures to assure access to services, to promote quality of care, and to contain costs. As health policy and health legislation respond to new developments in
science and society, many forces exert their influence on the process of modifying the health system — parliamentarians, other policy-makers, government officials, established and emerging health professions, public and private institutional providers of health care, managed care organizations, community health centres and other new organizational providers of health care, employers who finance health care, manufacturers of drugs and equipment, insurance companies, voluntary organizations, and consumers. Each of these forces brings its own values and perspectives to the formation of health policy and the development of legislation.

**Functions of legislation in public health and health policy**

The role of legislation in public health and health policy may be expressed in the various functions that the law performs in protecting the health of individuals and communities. These functions, approximately as they developed historically, may be described as follows:

1. Health legislation prohibiting conduct injurious to health;
2. Health legislation authorizing programmes and services to protect or promote health;
3. Health legislation regulating the production of resources for health care;
4. Health legislation providing for social financing of health care;
5. Health legislation establishing surveillance over the quality of care; and

**Health legislation prohibiting conduct injurious to health**

A classical function of health legislation is to prohibit conduct injurious to health. Basic legislation in all countries is designed to prevent the spread of disease by providing for environmental sanitation and waste disposal, regulating air and water quality, controlling the purity and safety of food and drugs (and the effectiveness of drugs), requiring immunizations, and assuring sound working conditions.

With the growth of industrialization and urbanization, environmental legislation has expanded to meet the threats of toxic chemicals and other environmental pollutants. But the need for economic growth may inhibit effective controls of hazards in the workplace and environmental pollution. In this sphere, recommendations and legislation by regional bodies offer guidelines and goals to assist policy formation and the design of legislative instruments at the national level.
Scientific and technological advances have required ever more sophisticated food and drug control laws. The enormous toll of accidents on the highways has led to laws requiring car seats for small children, seat belts, air bags, and motorcycle and bicycle helmets. Occupational health legislation has been directed at reducing or eliminating the risks of occupational diseases and accidents in the workplace. As the value of health promotion and disease prevention has been increasingly recognized, legislation has become an essential component of programmes to control the tobacco pandemic, to combat the use of addictive drugs, and to promote moderate use of alcohol.

Legislation to prevent conduct injurious to health is of broad scope and reaches into every place where people live, work, and play. It is therefore no surprise that it has drawn attention to the conflict between individual rights and social responsibility. Each country resolves this issue in the light of its own constitution and legal system. In the USA, for example, the police power of the States is an inherent and broad power that permits the States to enact legislation to protect the public health, welfare, and safety, but if the legislation conflicts with a fundamental right of individuals, then the State must have a compelling State interest to overcome that right. Other countries have similar ways of balancing the rights of individuals and the needs of society.

(2) Health legislation authorizing programmes and services to protect or promote health

The multidisciplinary nature of public health and its role in serving various populations and responding to many diseases and conditions affecting health inevitably result in numerous health programmes and services. These multiple and diverse programmes may be classified as services for specific persons (mothers and children, the military, veterans, industrial workers, rural people, etc.), for specific diseases (for example, communicable diseases, sexually transmitted diseases, mental disorders, chronic noncommunicable diseases, and dental diseases), and for specific services (such as environmental sanitation and emergency medical services).

The Subject Categories and Scope Notes in each volume of the Digest show the breadth and variety of laws throughout the world establishing specific programmes and services. For example, legislation in the field of mental health includes: care of mental patients; child psychiatry; commitment procedures; mental health programmes; psychological testing and counselling services; psychosurgery and behaviour modification; regulation of therapy; and the right to treatment. Even this broad range of laws does not include regulation of mental
health personnel, mental hospitals, or other mental health institutions — subjects covered elsewhere.

For each of the many health programmes, legislation generally establishes its structure and administration, the specific services to be provided, the personnel authorized to provide services, the eligibility standards for services, and, most importantly, the financing to support the programme.

Legislation authorizing programmes and services to protect and promote health must necessarily be dynamic to take account of changes in health needs and strategies. The emergence of new infectious diseases, such as HIV/AIDS, has called for new approaches and new laws to prevent the spread of the epidemic, to authorize innovative services (needle exchange, condom distribution, accelerated approval of promising drugs), and to protect the privacy and rights of HIV-infected persons. WHO recognized early the importance of the many new laws being enacted all over the world to combat the HIV/AIDS epidemic and undertook to disseminate information on this legislation by periodically publishing tabular information on the statutes and regulations enacted.  

(3) Health legislation regulating the production of resources for health care

Legislation regulating the production of resources for health care takes several forms. It may authorize and specify the training and practice of the many kinds of health workers. It may provide funding for the training of physicians, nurses, and other types of health personnel. It may authorize, regulate, and finance hospitals and other health facilities. Funding for the training of personnel and the construction of facilities is generally made dependent on meeting certain standards or conditions. Legislation may establish requirements for the production of drugs and equipment and create a system of oversight for their manufacture, testing, and quality control. Since knowledge is also a resource for health, legislation that provides financing for biomedical and behavioural research and requires institutional review committees to assure safeguards for human subjects contributes to an important resource for health care. Similarly, legislation providing funding for research on access to care and on quality and costs of care assists policy decisions to improve health systems. Perhaps the most important function of the vast array of legislation in this sphere is to create institutions to manage the production of resources for health care. Involved in the all-important resource of health personnel, for example, are educational institutions, accrediting agencies, licensing bodies, planning organizations, peer review agencies, and financing systems for health services, which all affect the
kinds, numbers, and quality of health personnel produced. Legislation regulates each of the entities concerned with the many resources needed for health care.

(4) Health legislation providing for social financing of health care

Fundamental to all health systems of the world is the economic support provided by government and the private sector. Legislation to authorize social financing of health care may take the form of establishing a system of national health insurance or a national health service, as exists in all industrialized countries of the world, except the USA and South Africa (where such legislation is anticipated shortly). Even in the absence of a national system of financing, legislation may exert a powerful influence on financing and organization of health services by the private sector.¹³

Social financing may also be expressed in government grants for specific health services, as for maternal and child health, mental health, or environmental controls. In specifying requirements for programmes funded by such grants, the financing has the effect of setting standards and providing incentives for achieving specified health objectives.

Legislation imposing taxes for specific health purposes has proved to be an effective mechanism of social financing. Two examples may be cited: earmarking increased tobacco taxes for public education to combat the tobacco epidemic¹⁴ and imposing an assessment on hospitals to create a Statewide pool to finance losses from bad debts and the costs of charity care.¹⁵ In fact, we have only begun to explore the potentialities of legislation to strengthen financing of health care. For example, a statute in the State of California affecting non-profit health maintenance organizations that change to for-profit status has resulted in the transfer of substantial assets to charitable foundations to be used for the benefit of the health of Californians.¹⁶ The rationale for requiring dedication to charity of the assets of non-profit health maintenance organizations that convert to for-profit status is that their wealth was enhanced by their tax-exempt status as non-profit organizations.

Not all legislation on health care financing is directed at expanding economic support. Legislation may also be designed for cost containment. Thus, legislation may limit expenditures for certain types of care, may restrict eligibility, or may place caps on funding for physicians and hospitals.

Legislation on social financing of health care is of prime importance in the struggle to achieve equity in health care. Braveman et al. define equity in health care as meaning—

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... that health care resources are allocated equitably, health services are received equitably, and payment for health services is equitable.17

While various educational, geographic, and social strategies can be adopted to close gaps in health care, the economic support available for health services and the conditions attached to it are crucial to making progress towards achieving equity in a health system.

(5) Health legislation establishing surveillance over the quality of care

The unequal positions of physicians and patients make surveillance over the quality of health care a necessity everywhere. Physicians have the scientific knowledge of health and disease that patients need. Patients, while increasingly informed about their health, must rely on physicians and other health care providers for their professional expertise. Legislation is essential to ensure that physicians are qualified, that medical practice protects patients, that patients' rights are safeguarded, that hospitals and nursing homes meet acceptable standards, and that drugs and equipment are safe and effective.

Legislation establishing surveillance over the quality of care includes accreditation of educational institutions for the health professions and occupations, licensing laws governing health personnel and health care facilities, standards for other forms of credentialling personnel and accrediting facilities, peer review systems overseeing medical practice, and regulation of medical malpractice through the financing mechanism.

This function of legislation is important not only because of the inevitable reliance of the patient on medical expertise but also because it is a form of public regulation of private providers — physicians and other health workers, hospitals and other health institutions, drug and equipment manufacturers and distributors. Advances in medical technology and expanded knowledge of health outcomes of various procedures increase the importance of legislation providing surveillance of the health system.

(6) Health legislation concerning ethical issues in health care

The development of the health law field over the past half-century has led to concern with regard to justice, fairness, equity, individual rights, allocation of resources, and societal costs. In fact, all the legislative functions discussed above raise issues of beneficence, non-maleficence, justice, and autonomy — the
cardinal principles governing ethics in health care.

In the past, medical ethics was concerned largely with personal behaviour and individual rights, but in recent years ethical issues affecting the health and rights of populations have become prominent — entitlement to care, inequities in allocation of resources, rationing of services, individual rights, and social responsibility. In response to this expanded consideration of ethical issues in health care, legislation has been concerned with life and death issues — the "right to die", physician-assisted suicide, clinical decision-making for severely defective neonates; with allocation of scarce resources, such as kidney dialysis and organ transplants; and with issues related to human reproduction, such as in vitro fertilization and surrogate motherhood. The enactment of legislation on these matters has provided physicians with guidelines and narrowed their sphere of decision-making.

Legislation on ethical issues thus addresses substantive matters, such as boundaries for clinical decision-making and rights of individuals. Another important function of legislation on ethical issues is adjectival, that is, to set up procedures and mechanisms for resolving ethical issues. Such mechanisms include ethics committees of hospitals, ombudsmen to settle disputes, appeals procedures, review tribunals to monitor involuntary admissions to mental hospitals, and protocols governing care of the terminally ill.

The next generation of ethical issues amenable to legislation will undoubtedly be associated with advances in technology and science. A high priority will be how to assure confidentiality of computerized medical records. Certainly, legislation will be called on to deal with issues of privacy and discrimination raised by the mapping of the human genome and developments in genetic knowledge of disease and drugs.

**Challenges in enacting and implementing legislation**

Essential to the enactment of effective health legislation is a sound science base. With knowledge of the biological, epidemiological, behavioural, and socioeconomic aspects of health problems, legislation can be enacted, implemented, and win social acceptance. For example, scientific evidence of the dangers of environmental tobacco smoke has led to legislative restrictions by national and subnational governments on smoking in public places and workplaces, including hotels, restaurants, and even outdoor public places such as beaches and parks.¹⁵

One cannot overestimate the crucial importance of documenting the facts
necessitating proposed legislation and its specific provisions. If public health professionals and public health lawyers do this job well, the various constituencies concerned with the legislation can be rallied to support it. Administrators of the law will then have guidance in drafting regulations under it. Public information explaining the reasons for or benefits of legislation can lead to effective implementation.

Effective implementation is all-important. A law on the statute books that is not enforced is almost useless. A major challenge is to close the gap between the black letter of the law and the way that it operates in real life.

Finally, legislation has the capacity to respond to new health and social needs. In the past, the law has sometimes constituted a barrier to needed health services; as a result such laws have been amended, repealed, or replaced. In the future, innovations and expansions in legislation will be impelled by scientific and technological advances and changed social norms. The policies enunciated by the UN-sponsored global conferences on the environment, population, social development, women, and human rights will surely have an impact on national and international health legislation of the future. The dynamism of the law is one of its great strengths. Legislation is a powerful resource for public health professionals in their efforts to develop sound health policy and protect and promote the health of the people.

ACKNOWLEDGEMENT

The author wishes to express appreciation to Mr S. S. Fluss, former Chief, Health Legislation Unit, WHO, Geneva, for his review of my papers and for his wise counsel and creative suggestions on matters relating to health legislation over the years. Recognizing the importance of health legislation as an essential foundation for public health programmes and services, Mr Fluss devoted his expert work in WHO's Health Legislation Unit for 30 years, from 1965 to 1995, to strengthening WHO's role in technical assistance and diffusion of knowledge concerning health law and policy.
REFERENCES


3. See WHA33.28. Ibid., at p. 63.


5. AMERICAN BAR ASSOCIATION, supra ref. 1, at p. 695.


8. See GOSTIN, L. O. The future of public health law. American Journal of Law & Medicine, 12(3-4): 461-490 (1986), recommending revision of US public health laws to provide clearly stated criteria for defining “public health necessity” to guide public health officials in exercise of their powers, to ensure protection of confidentiality in the collection and storage of public health information, and to authorize a graded series of less restrictive measures than currently exists, such as a community health order that can be adjusted to the particular risk to the public health presented by each case.


13. See, for example, legislation of Pakistan (Punjab): the Punjab Health Foundation Act, 1992 established the Punjab Health Foundation, which is responsible for taking measures for the promotion, development, and financing of health services in the private sector. *IDHL*, 46(2): 161 (1995).


18. ROEMER, R., *supra* ref. 14, Chapters 9 and 10.

Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO’s views.
Introduction

Historically, the primary focus of international health law was on the health consequences of increased international mobility and traffic. The roots of international cooperation for the improvement of health conditions lie in Europe, where the first international meetings on health matters took place (notably, the

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first International Sanitary Conference in Paris in 1851, devoted to quarantine requirements, and the Conference in Brussels in 1853, the topic of which was the uniform classification of the causes of death).

Contrary to what might be expected, concerted government action in the field of health cannot be traced back to humanitarian considerations for the protection of the health of individuals. Its origin was the growing concern to remove hindrances to trade and export and to defend Europe against "exotic pestilences". The eradication of communicable diseases was a primary concern and the first international health legislation was limited to infectious disease control. The Conventions drawn up during the first part of the 20th century under the responsibility of the Office International d'Hygiène Publique (OIHP), established in 1907, were all concerned with sanitary regulations (1912, 1926, and 1933). Despite the OIHP's predominantly European orientation, these Conventions were observed by a great many non-European States. Moreover, the OIHP initiated a valuable activity in publishing summaries of public health laws and regulations in force in various countries, an activity that is still alive today in the form of WHO's *International Digest of Health Legislation*.

The first International Sanitary Convention of 1851 never came into force. It still may be regarded as the root of the present International Health Regulations. One of the reasons for the Convention's lack of success was the fact that it dealt with matters of strictly national concern and therefore with national sovereignty. This argument is still frequently used when the possibility of international ruling on health-related measures is envisaged. Another reason was that the knowledge of the nature and mode of propagation of the diseases concerned was not yet well advanced.

Since then, the scope and impact of international activities have expanded considerably, as has the role of health law. Developments within health care systems, the increasing complexity of such systems, and the progress made in the medical and health sciences and technology have resulted in greater concern for the position of patients receiving health care, their possibilities for access to health care services (as a social human right), and the adequate protection of their individual rights. Moreover, increased international cooperation brings with it a greater need for a common, concerted policy in the field of health care, such care being a social human right that is linked with closely related individual human rights. It is a logical outcome of these developments that international health law has gradually more impact on national health law, and vice versa. International organizations contribute significantly to the development of health law from the standpoint of its human rights connection. This is largely a 20th century
development and operates at both national and international levels.¹ Health law at the national level often has to be supplemented by the setting of norms and standards at the international (regional) level. This challenge is increasingly being taken up by the international organizations, not only worldwide through specialized UN agencies, such as WHO, UNESCO,² and the World Bank,³ but also in the European region. The various interconnections between national and international health law may be characterized as the “internationalization of health law” — a development that offers valuable perspectives for both national and international public health policies. In this article, I propose to focus on the European region with a view to indicating the underlying concepts of this field, its achievements, and prospects.

Scope of health law from an international perspective

Health law is a legal discipline, which can be described as the entire set of rules of law related to the care of human health and the application of other civil, administrative, penal, and international law in that connection. Legislation, self-regulation, and case law, whether national or international, are important sources of law for health law. Health law is not, as is sometimes suggested, the same thing as health legislation. Health law is concerned with the right to health care (a social human right) in its broadest sense. The right to health care covers a great many aspects, which is probably why none of the international human rights instruments properly reflects its overall nature. Nevertheless, the international enshrinement of certain aspects of the right to health care has contributed a great deal to the promotion of the right to health care at national and international levels. Intrinsic to the proper realization of the right to health care — and thus part of health law — is the respect for individual human rights. As is the case with the right to health care, these rights are included in international human rights texts. Associated primarily with the rights to physical and mental integrity, including the right to privacy, they are based on the principle of individual self-determination.

Health law as a legal discipline thus addresses both social human rights and individual human rights.⁴ These rights are laid down in various international texts on human rights of a general nature.³ The Convention on Human Rights and Biomedicine of the Council of Europe (opened for signature in 1997), which is also open to non-Member States of the Council of Europe, is a sectoral instrument, encompassing both the individual and social dimensions of health law. The same holds for the 1994 Declaration on the Promotion of Patients'
Rights in Europe, issued by WHO's Regional Office for Europe. The rationale for formulating international principles and rights addressing the individual and social dimension of health is clearly reflected in this Declaration:

National situations vary in respect of legal frameworks, health care systems, economic conditions, and social, cultural and ethical values, but there are certain common approaches which can be appropriately adapted to the circumstances of each country.

The right to health care in international human rights law

The social right to health care implies, first of all, a right to health protection. Article 11 of the European Social Charter of the Council of Europe (1961, revised in 1996) bears the title: “The right to protection of health”. It requires the Contracting Parties to take appropriate measures designed inter alia: to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; and to prevent as far as possible epidemic, endemic, and other diseases, as well as accidents. Secondly, the right to health care implies that governments, within the limits of existing possibilities, should assure sufficient availability of necessary facilities and services for diagnosis, treatment, care, and prevention. The facilities and services should be of good quality and accessible to everyone without undue financial burden to the individual. This latter aspect is covered in part by Article 13 (The right to social and medical assistance) of the European Social Charter. Recently, it was expressed in much clearer terms than ever before in the Council of Europe Convention on Human Rights and Biomedicine. Article 3 (Equitable access to health care) of that Convention reads as follows:

Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.

Both aspects of the right to health care (the “protective” part and the “facilitating” part) are included in the International Covenant on Economic, Social and Cultural Rights (1966). Article 12 clearly states that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken to achieve the realization of this right are to include
both "protective" elements (reduction of the stillbirth-rate and the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases), as well as "facilitative" elements (the creation of conditions which would assure to all medical service and medical attention in the event of sickness). Both aspects taken in conjunction could be termed a "right to care for human health".\textsuperscript{6} In short, its rationale is that health is a basic human value, that the good health of the population is a requisite for a country's economic health, and that governments therefore have a positive responsibility to assure equitable access to necessary medical services and to protect individuals against unhealthy circumstances that could jeopardize their physical and mental integrity and affect their private lives and well-being.

The right to (bodily and mental) integrity in international human rights law

For the right to health care to be realized, it is of primordial importance that individual human rights be respected. Such rights include the right to life, the prohibition of torture, maltreatment and medical experimentation without free consent, the right to privacy in relation to the right to information, and the requirement of informed consent in relation to physical integrity. All these aspects are covered by international human rights instruments. Particularly applicable here are Articles 6 and 7 of the International Covenant on Civil and Political Rights (1966) and Articles 2, 3, and 8 of the European Convention on Human Rights (1950). More recently, these rights were defined in the Convention on Human Rights and Biomedicine of the Council of Europe (1997). These rights are commonly addressed as "patients' rights". Apart from the basic principles (human self-determination and individual freedom) underlying individual human rights in general, their specific rationale in the field of health care is firstly that, as has been shown by research, patients who are involved in their treatment and whose rights are respected in medical practice, recover more quickly. Secondly, if the relevant individual human rights are not sufficiently respected, patients will show a lack of trust and will not be fully in a position to exert control of themselves. This may create a barrier to access to medical services. For example, insufficient protection of an individual's right to privacy with regard to the access of third parties to personal medical information might create an obstacle to the consultation of a physician, causing an adverse effect on human health. This explains, in the international context as well, the attention paid to appropriate legal protection of medical data. Inevitably, however, not all relevant individual human rights aspects of advances in medicine and medical

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technology can be covered by international agreements. National, cultural, philosophical, and religious differences, the multiformality of values, and differences in legislative styles and political approaches may stand in the way of appropriately addressing certain problems.9

Implementation and enhancement of the conceptual foundations of health law

Clearly, the human rights relating to physical and mental integrity and to health care by virtue of international human rights instruments have to be further qualified and made operational at the national as well as the international level. As social human rights are gradually accorded more legal precision, the possibilities for their enforcement in court will increase. Similarly, the principle of non-discrimination is gradually gaining status with regard to the right to equal access to health care facilities. Moreover, there is a clear tendency to strengthen the reporting procedures within the framework of international social human rights instruments. As to compliance with individual human rights, both nationally and internationally, the right to complaint procedures provides an appropriate instrument for the promotion of respect for these rights in health care. In fact, the international case law of individual human rights — of relevance for the attainment of the highest attainable level of mental and physical health (health and health care) — has had much influence on the development of national health law. This applies, in particular, to the reports issued by the United Nations Commission on Human Rights and the case law of the European Court of Human Rights under the European Convention on Human Rights of the Council of Europe.

Additional activities based on international human rights texts are also necessary in order to further enhance the relevant human rights in the context of new medical, scientific, and technological developments. Strategies for the implementation of shared principles are supported by international health law within the framework of international organizations active in the field of human rights, such as WHO and, in Europe, the Council of Europe. Since the 1970s, binding agreements have been drawn up in the European region, as well as numerous valuable recommendations touching upon fundamental human rights in health care. These address specific subjects of a topical nature, such as respect for human rights in the fight against AIDS, the health care of psychiatric patients in prison, genetics, and quality systems in health care.

In addition to these issues, health law is clearly very much concerned with the consequences of internationalization and the globalization of trade and commerce.
It must be constantly on its guard in order to prevent economic considerations from taking precedence over health interests. This applies in particular in Europe, where the European Community (EC), operating as a supranational organization, has created an internal market based essentially on economic interests. The area of public health as such is a non-harmonized area and Member States may invoke the protection of public health only exceptionally as a reason to depart from Community rules. However, since measures taken in other areas covered by the EC Treaty thoroughly affect the health sector, the EC has a major impact on health law. The EC internal market implies the free movement of persons (including, for example, patients and medical professionals), services (including medical services), goods (including pharmaceuticals, blood products, and human tissues), and capital (fiscal and taxation policies may have repercussions on, inter alia, the level of health protection and the marketing of new pharmaceutical products). It follows from the EC objective of abolishing restrictions — including discriminatory restrictions — on the freedom of movement, that some rules need to be drawn up on individual human rights that are relevant to health and health care, as in the case of the protection of personal (medical) data. The EC norms and standards affecting health protection and health care and related human rights must be respected by Member States in the context of other international organizations to which they belong. Thus, the EC Common Market evidently influences the possibilities intergovernmental organizations have for action in the field of health law. They may not go below the level prescribed by the EC; whether or not they are permitted to set higher norms and standards depends on the issue involved.

The role of health law: high level of consumer protection

The right to health protection dictates that a range of activities be carried out in various areas. Included here are measures to combat contagious diseases, hygienic measures, measures to assure the safety of blood, organs, and tissues, as well as of industrial products used in health care (medicaments and medical devices), and measures to promote occupational health and the health of workers in general. Though the background to such activities is an economic one, their purpose is primarily to prevent ill health resulting from unsafe products and unsafe living conditions. The perspective of international trade generates requirements, norms, and standards of importance for both international and national health law. In the context of trade, mutual recognition agreements on a worldwide basis can be achieved only when there is agreement on minimum
safety requirements and their control. Commerce and trade are, as we have seen, major arguments for formulating health protection measures at international level. Only by setting common rules and standards, be they minimum requirements, can barriers to trade resulting from differences between national rules be overcome. Given the generally accepted principle that economic considerations should not take precedence over those relating to the health of individuals or the public, it is hardly surprising that a high level of health protection is predominant in international rules. A high level of consumer protection in such fields as medicaments, cosmetics, foodstuffs, medical devices, and human organs and tissues represents a logical progression from the need to protect public health. Appropriate standards are formulated by WHO and, in Europe, by the Council of Europe and the EC.

In addition to its role of assuring compliance with the highest possible standards of quality and safety, health law is also called upon to intervene at an international level in order to protect the individual human rights of the patient or consumer in relation to international trade and commerce. One example is the conduct of multi-centre multi-State trials in the field of pharmaceuticals. The development of new medicaments through such trials is only possible if there is agreement on the principles to be observed with regard to respect for the individual human rights (such as informed consent and privacy) of the persons involved in experimentation. Another example concerns the potential misuse outside the health care sector of advances in medical technology; for instance, increased knowledge concerning the health status of an individual can have adverse effects on his position in society, if there are not sufficient safeguards to render such information inaccessible to others. This may deter people from seeking necessary medical advice. Similarly, the application of, for example, genetic testing for purposes other than an individual's health can have serious effects on his privacy, including his right not to know, especially in cases where there is no possibility of treatment. To date, the issue of the adverse effects on society of advances in medicine and medical technology has only been covered in part, notably by Articles 11 (Non-discrimination) and 12 (Predictive genetic tests) of the Council of Europe Convention on Human Rights and Biomedicine.

The role of health law: access to health care

Over the years, there has been an expansion of international activities devoted to the right to health care. Since the principle of subsidiarity applies, the content (to a certain extent), organization, and financing of a health care system remains a
national affair. The right to equal access to health care is formulated in international legal instruments, but its implementation is left to the judgement of Member States. Yet, here again, countries are not entirely free in their policies. Increased international movement of persons and goods and international social policies must go hand in hand. In particular, the International Labour Organisation and, at European level, the Council of Europe have formulated norms and standards with regard to health care coverage. The relevant treaties set a minimum level, thus providing a certain guarantee against social dumping. At the same time, the international treaties in the field of social insurance have contributed much to the enforcement of the right to health care and hence to the highest attainable standard of physical and mental health at national level.

Health law should again be on the alert when it comes to international standards and rules designed primarily for purposes outside the health sector, but which, nonetheless, affect the functioning of the health system and, indirectly, access to health care. Examples include EC rules on such matters as competition, working hours, and public supply contracts.

**Health law on the move**

Health law is of great importance in achieving WHO’s goal of the highest possible level of health for all. The internationalization of health law will gain in importance, qualitatively as well as quantitatively, as geographical barriers dissolve. Health legislation is increasingly applied nationally, as well as by international organizations, as an instrument for the protection and promotion of individual human rights in health care, for the protection of the individual against social discrimination on the grounds of health status, and in order to implement national health policies, to support the development of health systems, and to provide equal access to health care facilities of good quality. Health law has contributed much to the growing awareness that health and human rights are closely interlinked — an interrelationship demonstrated by various international human rights instruments. Both nationally and internationally, there is consensus that the health status of a population is one of the determining factors for social and economic well-being, and that “good health” can be stimulated by respect for the individual and for his right to self-determination. There has been progress in both the individual and social dimensions of patients’ rights since the Universal Declaration of Human Rights of the United Nations (1948). The individual human rights instruments and socioeconomic human rights instruments that have been developed worldwide and at regional level address many important issues
from a health law perspective. Their current meaning will have to be further substantiated in the light of future developments. The emergence of new ethical and legal issues as a direct consequence of progress in medical science and technology, as well as the changes in the social, political, and economic environment, clearly influence the role of health law at both national and international levels.

There will be further internationalization of health law through a number of simultaneous developments. One of these is that medical and health information concerning individuals is increasingly revealed as a result of scientific progress in medicine. If the matter is not dealt with diligently, it may have profound consequences for the individual and his ability to function in society. This applies to the field of genetics in particular. Another important focal point for health law is the fact that the resources available for health care are limited. This is at a time when demographic changes contribute to an increased need for health care facilities, when there is often a high price tag attached to new technological possibilities in health care, and when the mere availability of facilities and technology influence demand with regard to the delivery of curative care. Health law has, therefore, a major task in contributing to the just and fair distribution of scarce resources and in setting priorities in health care so that equitable access to health care of good quality is assured for all.

The policy trends and normative initiatives, at least in countries of a specific region such as Europe, show important similarities, despite the range of legislative approaches adopted by those countries. At the same time, a substantial increase in cross-border activities of all sorts and increased international trade and commerce (and hence competition) affect many aspects of health care and associated human rights. Thus, the increased importance of international health law can be explained by the common interests of different countries, and also by the absolute necessity for international rules and guidelines as the result of cross-border movements. This applies both to the support provided by international organizations to health policy development in many countries, as well as to the drawing up of binding international and supranational rules and standards.

The world environment is changing rapidly. This means that the internationalization of health law still needs to be reinforced, both nationally and internationally. Health lawyers should formalize their international contacts, formulate common research programmes, organize specialized conferences at international level, and increase the number of international publications in the field of health law. The internationalization of health law also requires the active involvement of patients and health care professionals. The Council of Europe has
already initiated an activity concerning the development of structures for patient/citizen participation in the decision-making process affecting health care, while WHO's European Region is looking into the possibilities of further developing patients' rights in Europe by setting up a network for the promotion of these rights. Concerted action by both organizations in the field of patients' rights in particular, and health law in general, could be extremely beneficial. Given the important role of informal rules (codes of conduct, guidelines, and the like) of representative organizations in the context of health law, health care workers — and physicians in particular through international professional organizations — should also address relevant issues in consultation with patients and health lawyers. WHO should take full advantage of its regional structure to assist health law to further promote and strengthen fundamental human rights. In the European region, this should be done in close cooperation with the Council of Europe and the European Union.

The internationalization of health law should be a focal point of attention at the threshold of a new century. As such, it calls for a strengthened, combined, and concerted effort on the part of health lawyers and international organizations.
REFERENCES


2. On 11 November 1997, the General Conference of UNESCO adopted the Universal Declaration on the Human Genome and Human Rights, drawn up by UNESCO’s International Bioethics Committee which has been active since 1993.

3. Since 1993, when its report *Investing in Health* was published, the World Bank has oriented its efforts towards accessible and affordable health care services in developing countries.


6. This expression was used by Professor Leenen, when presenting a preliminary report on the subject to the Dutch Society of Health Law at its annual meeting in 1997.


Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
This article is dedicated to the memory of the late Dr Jean de Moerloose, Chief of WHO's Health Legislation Unit from its inception in 1948 until the end of 1976. A distinguished physician and public health specialist with a profound commitment to medical and health law, Dr de Moerloose was born in Ghent, Belgium, in 1914, and received his doctorate in medicine, with high distinction, at its University in 1939. He subsequently undertook medical research under Professor Cornelius Heymanns, an eminent Belgian pharmacologist who was awarded the Nobel Prize in Medicine and Physiology in 1938. After specializing in urology during the period 1941-1945, he became Director of the Public Health Services of East Flanders before joining WHO. The continued existence of this journal is a testimony to his competence and commitment.

* Mr S. S. Fluss is Special Adviser to the Secretary-General of the Council for International Organizations of Medical Sciences (CIOMS), having formerly been Chief, Health Legislation Unit, and subsequently Programme Manager for Human Rights, Office of Health Policy in Development, WHO, Geneva. Except where clearly indicated, any views expressed are not necessarily those of WHO. The author alone is responsible for any errors of fact or interpretation.

INTERNATIONAL DIGEST OF HEALTH LEGISLATION, 1998, 49 (1)
I. ORIGINS AND CONSTITUTIONAL BASIS

On 30 January 1909, the Director of the Paris-based International Office of Public Hygiene (a body established by the Rome Arrangement of 9 December 1907), addressed a Circular to the administrations of the participating States in that Arrangement, requesting them to transmit to the Office copies of “general and local laws and regulations published in the different countries concerning communicable diseases”. Thereafter, the Bulletin of the Office (which was published in French only between 1909 and 1946) carried a regular rubric devoted to significant international and national legislative instruments related to diverse aspects of health (and not merely communicable disease control). One of the decisions taken by the Interim Commission of the World Health Organization in 1947 was that the new global health organization, WHO, would report on health legislation in an entirely new journal, the International Digest of Health Legislation. The first issue appeared in 1948 (when the Health Legislation Unit was also established); it will be recalled that WHO’s Constitution came into force on 7 April 1948. Included in the Constitution is Article 63, under which each Member State is required to “communicate promptly to the Organization important laws, regulations... pertaining to health which have been published in the State concerned”. It is essentially under the terms of that Article that WHO has, during the last 50 years, operated a vigorous and dynamic programme in the health legislation area, with primary emphasis placed on information transfer although with due attention to technical cooperation and, in certain areas, normative activities. The orientations of the programme have been deliberated upon and determined by the World Health Assembly and the Executive Board in a series of specific resolutions adopted between 1950 and 1980 (see Table 1). In addition, there have been a large number of resolutions that have addressed legal, legislative, or regulatory issues, on such matters as food safety, the use of breast-milk substitutes, substance abuse, blood safety, pharmaceuticals and biologicals, reproductive health, the protection of the human environment, occupational health, organ transplantation, cloning, etc. Whenever such resolutions are adopted, the programme consults with the technical staff concerned to determine how best to respond to the particular provisions that address the legislative area.
TABLE 1. PRINCIPAL RESOLUTIONS OF WHO's GOVERNING BODIES ON THE HEALTH LEGISLATION PROGRAMME

<table>
<thead>
<tr>
<th>WHO ORGAN</th>
<th>RESOLUTION NO.</th>
<th>DATE</th>
<th>SUBJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Assembly</td>
<td>WHA3.63</td>
<td>May 1950</td>
<td>Criteria for selection of material for IDHL</td>
</tr>
<tr>
<td>Executive Board</td>
<td>EB6.R19</td>
<td>June 1950</td>
<td>Criteria for selection of material for IDHL</td>
</tr>
<tr>
<td>Executive Board</td>
<td>EB9.R70</td>
<td>January 1952</td>
<td>Reaffirmation of criteria for selection of material for publication in IDHL; reaffirmation of obligation of Member States to provide legislative materials</td>
</tr>
<tr>
<td>Executive Board</td>
<td>EB47.R37</td>
<td>January 1971</td>
<td>Expression of satisfaction with WHO's activities in the field of health legislation</td>
</tr>
<tr>
<td>World Health Assembly</td>
<td>WHA30.44</td>
<td>May 1977</td>
<td>Strengthening of WHO's programme in the field of health legislation; strengthening of collaboration with other specialized agencies; request for a study of optimum means for dissemination of legislative information</td>
</tr>
<tr>
<td>Executive Board</td>
<td>EB65.R13</td>
<td>January 1980</td>
<td>Reaffirmation of criteria governing selection of material for publication in IDHL, with emphasis on priority to legislation in support of Health for All</td>
</tr>
<tr>
<td>World Health Assembly</td>
<td>WHA33.28</td>
<td>May 1980</td>
<td>Endorsement of reorientation of Health Legislation Programme; request to the Director-General to formulate detailed programme of technical cooperation and information transfer in health legislation</td>
</tr>
</tbody>
</table>

II. INFORMATION TRANSFER AND CLEARINGHOUSE FUNCTIONS

The international system for the dissemination of legislative information

In the same way as WHO has an implied constitutional responsibility to disseminate legislative documentation in the health field, and does so as rapidly and comprehensively as possible subject only to the constraints of available resources, other international agencies inside and outside the United Nations system engage in the compilation and dissemination of legislation in other areas, some closely related to health. Among the agencies that have been and continue to be active in this field are FAO (Rome), the ILO (Geneva), the United Nations Population Fund (UNFPA) (New York), the United Nations International Drug Control Programme (Vienna), and the Nuclear Energy Agency of the OECD.
Active work in the dissemination of information on environmental legislation is undertaken by the United Nations Environment Programme (Nairobi and Mexico City). Every effort is made by the WHO staff concerned to share and exchange relevant information and documentation with other agencies, notably to avoid, as far as possible, any duplication of effort. It should be mentioned in this context that efforts were made during the period 1991-1992 to lay the groundwork for the creation of what had been tentatively designated as the “International Legislative Information Network” (ILIN). Unfortunately, it appears that this initiative is no longer being actively pursued.

The International Digest of Health Legislation

Now in its 49th volume, the journal appears quarterly, in separate English and French editions. The total circulation of the Digest is approximately 2600, while that of its French-language counterpart, the Recueil International de Législation Sanitaire, is nearly 1000. The policy of the Health Legislation Programme since the first issue has been uncompromising: reliance solely on primary sources, i.e. the legal instrument as published in the particular country or jurisdiction’s official gazette or the equivalent. Only in exceptional cases does the multilingual team responsible for the Digest resort to translations prepared in the country. Just under one-third of WHO’s 191 Member States comply with their constitutional obligation under Article 63. For the others, recourse is had to the excellent legislative collections of the ILO and the United Nations in Geneva, the Swiss Institute of Comparative Law in Lausanne, and the Library of Harvard Law School in Cambridge, Massachusetts, USA.

During its first 28 years, the Digest remained essentially unchanged. Following the adoption of World Health Assembly resolution WHA30.44 in 1977, and extensive consultations involving all Member States, the format and content were significantly restructured as from 1980. The LEGISLATION section of each issue is, as users will be aware, subdivided into 22 rubrics (some of which are further subdivided). This scheme, developed by two specialists in the classification of legal materials, was introduced in 1981 and has stood the test of time.

International as well as national health legislation has been covered systematically since 1977. Major events in the health/medical law world, and, increasingly, in the field of bioethics, are reported in the NEWS AND VIEWS section; and up to 400 books and other significant publications — in a wide range of languages — are reported in the BOOK REVIEWS and IN THE LITERATURE sections. Contributors and reviewers are selected on one basis
only, viz. their expertise and professional competence. They are selected from a vast, if informal, worldwide network of health/medical/environmental law specialists. The Digest thus offers a vehicle whereby books in the less widely known languages are drawn to the attention of the estimated 10,000 or so regular readers and users of the journal.

The development of computerized databases

Although the Digest is still produced by essentially conventional systems, modern methods of handling legislative information have resulted in a commercially produced CD-ROM version, covering Volumes 31-48, published between 1980 and 1997. It has proved to be a very useful working tool for searching for documentation on specific topics in a rapid and efficient manner. Reference should also be made to the LEYES database (Documentation System for Basic Legislation in the Health Sector for Latin America and the Caribbean), developed by the WHO Regional Office for the Americas/Pan American Health Organization, in Washington, DC. This database has been developed with the active involvement of the Hispanic Law Division of the Library of Congress in Washington, DC, and the Faculty of Law Library at the University of the West Indies in Barbados. A collaborating centre for LEYES, located at the Center for Studies and Research in Health Law, School of Public Health, University of São Paulo, Brazil, has now been established.

The creation of a multilingual library

The growing interest in health, medical, population, and environmental law in many industrialized and certain developing countries has been accompanied by a veritable explosion in the number of books and journals devoted to these fields. No less remarkable has been the enormous increase in publications on bioethical issues. WHO is sensitive to these developments and over the last few years every effort has been made to build up a library containing as many such publications as possible. This collection now forms a cornerstone of the clearinghouse function of the Unit. The vast majority of these publications have been provided to WHO at no cost. Such a library can never be complete and the staff often have recourse to the network referred to above to deal with inquiries from Member States.
Information transfer

The 80,000 or so legal texts available in the Unit's collections, and the other publications we have described, are drawn upon in dealing with a constant flow of requests for information. These emanate from governments, other international organizations (governmental or nongovernmental), WHO technical programmes, public health administrators and specialists, practising physicians, nurses, and other health care workers, academic and practising lawyers, commercial companies in the food, pharmaceutical, chemical and other industries, etc.

It is important to emphasize at this juncture that while the Digest is a valuable, and indeed essential source of information for academic and professional workers, it has been found extremely useful by national authorities.

In 1978, a thorough analysis was made of the responses by health ministries throughout the world to a questionnaire. No fewer than 55 Governments stated at the time that the Digest was used for ready reference within the health ministry, while 43 countries indicated that it was used by legal draftsmen in the preparation of new health laws and regulations.

It is noteworthy that the Digest is indexed regularly in Biological Abstracts, International Pharmaceutical Abstracts, Adolescent Mental Health Abstracts, Current Advances in Ecological Sciences, Dairy Science Abstracts, Cadscan, Food Science and Technology Abstracts, Leadscan, Nutrition Research Newsletter, and Zincscan. Most of these abstracting services are available on-line through a number of international database hosts.

Non-serial publications and legislative reviews

From the very inception of WHO's activities in health legislation it was considered that Member States could gain much from comparative surveys of legislation in particular sectors. Such surveys, whether prepared by WHO staff or (as is most frequently the case at the present time) by outside experts, have been well received and generally regarded as an important component of the programme. Table 2 lists the surveys and reviews published from 1952.

Regional publications

In 1986, the WHO Regional Office for Europe had published on its behalf a book entitled Trends in Health Legislation in Europe. This was followed up by such publications as: Is the Law Fair to the Disabled? A European Survey.

In 1989, the Pan American Health Organization (which serves as the WHO Regional Office for the Americas) published (in English and Spanish editions) *The Right to Health in the Americas: A Comparative Constitutional Study*. It proved invaluable to those interested in the concept of the right to health, and the right to health care, in countries having different legal systems (the editors make a distinction in this book between common law countries, civil law countries, and socialist law countries). In 1990, a special issue of what was then the Bulletin of the Pan American Health Organization was devoted to bioethics. 

### TABLE 2. SURVEYS AND REVIEWS OF SPECIFIC ASPECTS OF HEALTH LEGISLATION, AND OTHER REPORTS (1952-1991)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1952</td>
<td>Tuberculosis; Communicable diseases in schools</td>
</tr>
<tr>
<td>1953</td>
<td>Nursing</td>
</tr>
<tr>
<td>1954</td>
<td>Leprosy; Smallpox vaccination; Midwives</td>
</tr>
<tr>
<td>1955</td>
<td>The hospitalization of mental patients; Control of insect vectors in international air traffic</td>
</tr>
<tr>
<td>1956</td>
<td>Venereal diseases; Malaria</td>
</tr>
<tr>
<td>1957</td>
<td>Diphtheria immunization; Medical specialization</td>
</tr>
<tr>
<td>1958</td>
<td>Notification of communicable diseases</td>
</tr>
<tr>
<td>1959</td>
<td>Communicable diseases in schools</td>
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<tr>
<td>1960</td>
<td>Classification of pharmaceutical preparations; Endemic goitre: legislation on iodine prophylaxis</td>
</tr>
<tr>
<td>1961</td>
<td>Pharmaceutical advertising</td>
</tr>
<tr>
<td>1962</td>
<td>Treatment of drug addicts; Distribution of and trade in pharmaceutical preparations</td>
</tr>
<tr>
<td>1963</td>
<td>Air pollution; The control of tuberculosis</td>
</tr>
<tr>
<td>1964</td>
<td>Protection against ionizing radiations</td>
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<tr>
<td>1965</td>
<td>Legislation on vaccination in the Member States of the European Economic Community</td>
</tr>
<tr>
<td>1966</td>
<td>Auxiliary personnel in nursing; Control of water pollution</td>
</tr>
<tr>
<td>1967</td>
<td>Equivalence of medical qualifications and the practice of medicine</td>
</tr>
<tr>
<td>1968</td>
<td>Medical, dental and pharmaceutical auxiliaries; Pharmaceutical advertising</td>
</tr>
</tbody>
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### TABLE 2 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TITLE</th>
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<tbody>
<tr>
<td>1969</td>
<td>Use of human tissues and organs for therapeutic purposes; Control of pesticides</td>
</tr>
<tr>
<td>1970</td>
<td>Abortion laws</td>
</tr>
<tr>
<td>1971</td>
<td>Protection against ionizing radiations</td>
</tr>
<tr>
<td>1975</td>
<td>Venereal disease control</td>
</tr>
<tr>
<td>1976</td>
<td>Legislative action to combat smoking around the world</td>
</tr>
<tr>
<td>1977</td>
<td>The law and mental health: harmonizing objectives</td>
</tr>
<tr>
<td>1979</td>
<td>Abortion laws in Commonwealth countries</td>
</tr>
<tr>
<td>1980</td>
<td>Some factors influencing the regulation of pharmaceuticals in developing countries, with particular reference to Africa</td>
</tr>
<tr>
<td>1981</td>
<td>Self-care and the law: a symposium</td>
</tr>
<tr>
<td>1982</td>
<td>Problems in the harmonization of health legislation at the regional level with reference to the Commonwealth Caribbean</td>
</tr>
<tr>
<td>1983</td>
<td>Legislation on fluorides and dental health; Laws and policies affecting the training and practice of traditional birth attendants</td>
</tr>
<tr>
<td>1984</td>
<td>Mental health legislation in ten Asian developing countries: the perceived need for change; Assessment and reduction of psychiatric disability</td>
</tr>
<tr>
<td>1986</td>
<td>Legislation to control smoking: a round table</td>
</tr>
<tr>
<td>1987</td>
<td>Regulation of the advertising of alcoholic beverages: a survey of national legislation</td>
</tr>
<tr>
<td>1989</td>
<td>The future of international health law: a round table</td>
</tr>
<tr>
<td>1991</td>
<td>Human organ transplantation</td>
</tr>
</tbody>
</table>

### III. STRENGTHENING NATIONAL CAPACITIES IN THE FIELD OF HEALTH LEGISLATION

Certain major countries have sought and obtained WHO's cooperation in various forms in this area. WHO has, for example, hosted consultations with senior officials from the Russian Federation and provided support and input to a series of National Workshops on Health Legislation in China over a 10-year period. The Pan American Health Organization has been particularly active in this field and numerous instances could be quoted of various forms of formal and informal support to countries in Latin America and the Caribbean, as well as to intergovernmental bodies, in the formulation of new health legislation that is fully
in line with new orientations in health care, not least the increasing role of the private sector in health care delivery in many of the countries concerned.

IV. ACTIVITIES IN SPECIFIC AREAS OF HEALTH POLICY

Legislation relating to the prevention and control of HIV/AIDS

Less than two years after the first cases of AIDS were reported in Los Angeles in the summer of 1981, the first of what was to prove an unprecedented outpouring of legislative instruments were received by WHO's Health Legislation Programme. The first items were enacted in the Canadian Province of British Columbia in January 1983, and in Sweden in March of the same year. Very soon thereafter, the first requests from Member States and others for information on legislative responses to the HIV/AIDS pandemic began to reach WHO and what was initially an ad hoc response rapidly gave way to a more systematic approach. This received strong support from the then Division of Communicable Diseases from 1985, and thereafter from what became WHO's Global Programme on AIDS. Following the setting up of the Joint United Nations Programme on HIV/AIDS, on 1 January 1996, this support was continued, as exemplified by, inter alia, the regular production of what was initially known as "Tabular Information on Legal Instruments Dealing with HIV Infection and AIDS", and is now known as the "Directory of Legal Instruments Dealing with HIV Infection and AIDS". The latest version runs to no fewer than 206 pages and contains information on international, national, and particularly significant subnational legal instruments on the subject, including the important texts developed under the auspices of the European Union and the Council of Europe. Essentially, all countries/jurisdictions are included and the only major exclusion is in respect of State legislation in the United States of America. The decision to exclude such legislation was taken at an early stage, in the light of other significant, and indeed in many ways parallel, efforts to monitor and systematically list such legislation.

Efforts have likewise been made to prepare occasional reviews and surveys of emerging issues in the field of HIV/AIDS legislation, and papers have been published in various journals on the subject. Furthermore, a commercial publication containing selected instruments originally reported in the Digest appeared in 1989. It is hoped that, in due course, a new edition will be produced, since the amount of legislation that has appeared both internationally and nationally over the intervening eight years has reached major dimensions. The Programme has likewise endeavoured to monitor some of the major WHO
(and, subsequently, UNAIDS) declarations, policy statements, etc. on the subject, and has cooperated with others concerned in the dissemination of these texts, not least because of the undoubted impact that many of them have exerted on the current configuration of HIV/AIDS legislation. Indeed, it is no exaggeration to affirm that this configuration has been substantially influenced by the policy statements and the equivalent formulated by WHO and other intergovernmental organizations (notably the Council of Europe), as well as by nongovernmental organizations, such as the London-based Rights and Humanity.

Activities in the field of organ transplantation

In 1987, 1989, and 1991, the World Health Assembly adopted a series of important resolutions on organ transplantation, representing the Organization’s response to a field of medical technology where rapid advances have been accompanied by a number of significant legal and ethical issues. The Assembly’s 1991 resolution (WHA44.25, adopted on 13 May 1991) is reproduced below:

The Forty-fourth World Health Assembly,

Having considered the report of the Director-General on human organ transplantation,

1. THANKS the Director-General for his report;
2. ENDORSES the Guiding Principles on Human Organ Transplantation contained therein;
3. RECOMMENDS that Member States take account of the Guiding Principles in the formulation of their own policies on human organ transplantation and that by appropriate means they disseminate the idea of multi-organ donation for human transplantation from deceased persons;
4. REQUESTS the Director-General:
   (1) to review the Guiding Principles from time to time in the light of national experience in their implementation and of developments in the field of human organ transplantation;
   (2) to disseminate the Guiding Principles as widely as possible to all interested parties.

The Guiding Principles themselves, and the commentaries thereon, have been widely disseminated, and have been influential in the development of national legislation in this area. WHO is aware of a number of countries that have used the Guiding Principles as fundamental elements in the formulation, or updating,
of their own legislation on the subject. However, in the light of recent developments, consideration is being given to the possibility of re-examining the original formulation. Preliminary work has begun, a multidisciplinary WHO Task Force on Organ Transplantation (set up following a recommendation of WHO’s Advisory Committee on Health Research) having met in October 1996 and October 1997.

It should also be mentioned that WHO has cooperated closely in matters relating to organ transplantation with relevant entities within the United Nations human rights system in matters relating to allegations of children sold with a view to the use of their organs for transplantation purposes. In this connection, it is noteworthy that the Vienna Declaration and Programme of Action, adopted on 25 June 1993 by the World Conference on Human Rights, included, in a rubric devoted to “The rights of the child”, a statement confirming that “[effective] measures are required against ... sale of children and organs”. In a sense, this was a response to successive reports of the then United Nations Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography, Professor Vitit Muntarbhorn. This issue has been on the agenda of successive sessions of the Commission on Human Rights, and its subsidiary body, the Sub-Commission on Prevention of Discrimination and Protection of Minorities, as well as the latter’s Working Group on Contemporary Forms of Slavery. It is noteworthy that on 11 April 1997, the Commission on Human Rights adopted a resolution (1997/20), in which it requested the Secretary-General of the United Nations to continue to examine the reliability of allegations regarding the removal of organs and tissues from children and adults for commercial purposes and to analyse this issue in a report to be submitted to the Commission on Human Rights. It is clear that WHO may be called upon to play a role in the preparation of this report, although it should be emphasized that the second meeting of the Task Force stressed the need for United Nations bodies to make a “clear distinction ... between suspected abuse of children for organ recovery and voluntary organ donation by competent adults” (the citation is from the summary of the Task Force’s recommendations addressed to the Advisory Committee on Health Research).

Activities relating to the medical ethics/bioethics/human rights nexus

WHO’s Health Legislation Programme has played an active role in the rapidly emerging areas that lie at the interface between classical medical ethics, the emerging field of bioethics, human rights as they relate to the health sector, and health policy. For example, the then Chief of the Health Legislation Unit served as the first Secretary of WHO’s internal Secretariat Committee for Research
Involving Human Subjects, established in 1973. WHO provided input to the 1975 revision (adopted in Tokyo) of the original 1964 version of the World Medical Association’s Declaration of Helsinki, which sets forth guiding principles for physicians engaged in biomedical research. WHO’s Health Legislation Programme also contributed to the drafting of the 1982 Proposed International Guidelines for Biomedical Research Involving Human Subjects and the two sets of Guidelines developed subsequently under the auspices of the Council for International Organizations of Medical Sciences (CIOMS) with strong WHO support, namely the International Guidelines for Ethical Review of Epidemiological Studies (1991) and the International Ethical Guidelines for Biomedical Research Involving Human Subjects (1993). The Programme has likewise paid close attention to the ethical and human rights dimensions of advances in biomedicine and health technology. Thus, input was provided to the 1976 WHO publication, Health Aspects of Human Rights with Special Reference to Developments in Biology and Medicine. Just three years previously, in November 1973, the Programme contributed to the CIOMS Conference on Protection of Human Subjects in the Light of Scientific and Technological Progress in Biology and Medicine. It has collaborated closely with the relevant United Nations human rights bodies in the implementation of a March 1995 resolution (1995/82) aimed at ensuring, *inter alia*, that “the life sciences develop in a manner fully respectful of human rights”, and in the implementation of two subsequent decisions by the Sub-Commission on Prevention of Discrimination and Protection of Minorities (adopted in August 1996 and August 1997) on “human rights and scientific and technological developments”. It is noteworthy that the WHO Delegation to the World Conference on Human Rights, held in Vienna in June 1993, contributed to the drafting of a paragraph of the Vienna Declaration and Programme of Action (VDPA) in which the Conference noted that “certain advances, notably in the biomedical and life sciences as well as in information technology, may have potentially adverse consequences for the integrity, dignity and human rights of the individual” and called for “international cooperation to ensure that human rights and dignity are fully respected in this area of international concern”. The VDPA also includes a paragraph urging that special attention be given to ensure universal respect for, and effective implementation of, the 1982 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment adopted by the General Assembly of the United Nations. WHO and CIOMS contributed to the formulation of these Principles.
WHO’s Health Legislation Programme has been privileged to benefit from the invaluable contributions of a series of interns, many of them with a particular interest in the field of bioethics and its legal and legislative implementation. Thus, a 1990 intern, Sharon Perley, contributed, in cooperation with WHO and CIOMS staff, an important chapter in a book devoted to one of the seminal events in the history of bioethics, the Nuremberg Code of 1947. Another intern, Mr Sujit Choudhry, prepared a survey of the provisions addressing biomedical research on children, contained in existing international guidelines and other texts. This was subsequently published in the *Cambridge Quarterly of Healthcare Ethics*. A United States physician, Dr Han Choi, prepared a study of international and national legal instruments governing gene therapy, which was subsequently delivered to a Conference held in Germany in March 1996, and published in the Proceedings thereof.

In a sense, this activity has indirectly led to a strengthening of the international links which the Health Legislation Programme has established with governmental and nongovernmental entities, including academic institutions, in fields of common interest.

**Activities in the field of environmental protection legislation**

The Health Legislation Programme has consistently contributed a chapter describing WHO’s activities relevant to the legal dimensions of the protection of the human environment to the annual *Yearbook of International Environmental Law*. More substantively, it contributed to an important WHO publication prepared for and presented to the United Nations Conference on the Human Environment (Stockholm, June 1972), as well as the various stages in the drafting of the 1976 Barcelona Convention for the Protection of the Mediterranean Sea against Pollution and the 1980 Athens Protocol (including the preparation of a major survey of relevant national legislation which assisted States in the drafting of the technical Annexes to the Protocol).

**Activities relating to tobacco consumption**

This has been an area of strong focus by the Programme since the late 1960s, and has contributed substantively to the preparation of a series of global surveys of legislation designed to combat the world smoking pandemic. The most recent of these surveys, by Professor Ruth Roemer (a contribution by whom appears elsewhere in this Special Issue), was published in 1993.
products of the Programme have proved extremely useful to WHO expert committees and other groups that have addressed this global health problem, and will no doubt be useful in the process of initiating the development of a framework convention in accordance with Article 19 of the WHO Constitution.

V. CONCLUSIONS

WHO operates in a world where serious inequities in health at the individual, family, community, district, and other levels, and major differences in national development, remain very much on the global health agenda. The Health Legislation Programme seeks to remain sensitive to these differences, on the one hand continuing to report on what might be described as "classical" legislation to deal with the age-old scourges of society, such as microbiological pollution, communicable diseases, etc., the development of health services to address these issues, while at the same time covering the latest legislation governing, for example, biotechnology and medically assisted reproduction. In other words, every effort is made to reconcile within the pages of each issue of the Digest the preoccupations and concerns of developed and developing countries alike. There is, for example, considerable interest in the regulation of relatively new technologies such as food irradiation, but no less in the control of the traditional aspects of food safety. Legislation on the control of smoking is not new (it may be recalled that an anti-smoking Decree was adopted by Cambridge University in 1606!), but that on the control of smokeless tobacco products is today acquiring ever-increasing importance. One of the leading United States experts in health law, Professor Frank Grad of Columbia University in the State of New York (whose contribution appears elsewhere in this Special Issue), has noted that: "The reach of public health law is as broad as the reach of public health itself. Public health and public health law expand to meet the needs of our society". WHO must, and is endeavouring to, adjust to this expansion, for example, in the recognition of traffic and domestic accidents, and many forms of violence (notably child abuse and intrafamily violence) as public health problems. It is doing so in regard to the relevant resolutions of WHO's governing bodies. One illustration of the importance of this activity can be cited. In 1978, the following comment was made in an editorial in one of the most respected medical journals: "Public health legislation and related measures have probably done more than all the advances of scientific medicine to promote the well-being of the community in Britain and in most other countries".

This affirmation, possibly more than any other recent contribution to the
literature on the role of health legislation in public health, indicates the importance of a strong, pro-active, and responsive Health Legislation Programme in WHO, as foreseen by the Founding Fathers and as reflected in the Constitution and in the resolutions on the subject adopted to date by the governing bodies. That such a Programme is needed was amply illustrated by the results of a questionnaire-type survey undertaken in 1980. This clearly indicated the great importance attached by WHO’s Member States to the delivery of an integrated programme comprising both information transfer and technical cooperation components, designed to meet the needs of Member States at all stages of economic and social development irrespective of their political and legal systems.
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12. Legislative Responses to AIDS. Dordrecht, the Netherlands, Martinus Nijhoff, 1989.


Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
1. DETERMINANTS OF HEALTH

The 1978 Declaration of Alma-Ata opened up a new era in public health thinking and practice. The Health-for-All Strategy, rooted in a progressive implementation of primary health care, has led to the achievement of major health gains worldwide. This primary health care concept has been interpreted and applied in many varied ways and was in fact conceived as a flexible concept.

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applicable to all nations and adaptable to local cultural conditions. To developed and developing nations alike it has brought notable health benefits: a number of deadly diseases have been gradually conquered, overall mortality has decreased, infant and child mortality rates have declined significantly, access to health care has improved and, during the last decades of the 20th century, life expectancy has increased considerably worldwide. Many infectious diseases, humanity's foremost curse before the discovery of antimicrobial drugs, have been subdued or even eliminated (the eradication of smallpox is the classic example) and several other major diseases are steadily being defeated, such as poliomyelitis and leprosy.

On the socioeconomic scene, due to the profound political and economic changes which occurred in the early 1990s, clear signs of improvement and recovery are visible in many countries. New international agreements are expected to facilitate trade and its expansion, provide to all parties greater access to markets, accelerate exchanges, increase access to world economic resources, and boost prosperity. The continuing process of globalization of the economy is expected to have a favourable effect on technological innovation, further expansion of the service sector and communication patterns, and promote the wide diffusion of values and ideas embracing a universal culture in fields as crucial as the protection of the environment and the defence of human rights and individual freedom. These new forms of global transaction and interaction will be beneficial to the future of the world's health. From the political viewpoint, this end of the 20th century has witnessed major historical changes: new borders are being drawn, growing emphasis is being placed upon democracy, and increasing efforts are being made to achieve social justice and respect for human rights, all indispensable in striving to ensure peace and security and greater opportunity for better health.

Despite these encouraging facts and unquestionable achievements, a host of adverse factors darken the horizon. Although the wealth of nations has increased, poverty persists, and at the same time the gap in health standards between the rich and the poor has widened; huge, unacceptable disparities in health remain between and within countries, age groups, and sexes. Local wars and armed border conflicts have resulted in a growing number of refugees and displaced persons with the cortege of suffering, ill-health, and mass movement-related diseases. In some countries, ethnic confrontations, political instability, and social unrest will persist and directly influence health. Major contributors to the burden of ill-health in the future will be environmental hazards, generalized pollution threats and potentially disturbing effects of climatic changes, possible global
HEALTH DETERMINANTS

warming, and the spread of infectious diseases to new geographical areas. In this context, it is worth mentioning what health researchers often refer to as “the epidemiological transition”, a changing pattern of health in which poor countries with economies in transition inherit the problems of the rich industrialized ones, including not merely illness but also the harmful effects associated with changes in lifestyles, the so-called “diseases of affluence” — a phenomenon sometimes known as the “double burden”.

Thus, in the decades to come, most countries will be confronted with an array of challenges to health. Challenges inherited from the present, in particular those from noncommunicable diseases, are likely to become even more important in spite of expected improvements in their treatment. There will also be challenges created by re-emerging infectious diseases, which present new problems of drug resistance; and by potentially newly emerging pathogens, where there is an incomplete understanding of the factors responsible for them. While the AIDS pandemic remains the major public health concern, it is quite clear that old and new infectious diseases will still be an important threat to global health in the decades ahead.

The object of this paper is to reflect upon the legislative approach to health challenges of the 21st century. To guide our reflection we have linked these challenges to health with underlying influential factors, referred to as “the determinants of health”. In 1974, Lalonde introduced a concept which became widely accepted in public health, defining health as a result of four major factors: human biology, behaviour, medical care, and the environment, interpreting the latter in the broadest sense of the term. Since then, other professionals in the public health field (e.g. Berthee and Martin) have reflected further upon these general categories. We will, therefore, analyse first Lalonde’s major factors, limiting however his broad concept of “environment” to its physical aspect. We will then consider in turn — though they are very closely interrelated — the “socioeconomic” factors which are nowadays viewed as a dominant determinant of health, emphasizing the destructive influence of poverty on human life. Continuing with our consideration of the social sector, we shall go on to discuss “sociocultural” factors, of considerable importance in view of their impact on lifestyle and behaviour. Broadening our approach to the determinants of health, we shall next examine situations outside the scope of the conventional health sector over which the individual has little control. These situations concern changes virtually unprecedented in the evolution of our societies, namely: “the demographic revolution”, particularly the aging of the population, the “advances in science and technology”, and the “information and communication
revolutions”. Finally, further extending the traditional list of determinants, we shall give due consideration to the three fundamental health-related issues expected to figure prominently in determining future health care (currently matters of lively public interest and the subject of many authoritative publications): “the gender concept”, “social justice and equity”, and “human rights”.

In considering the vast domain of health determinants, our intention is to be neither exhaustive nor discriminatory in reviewing and grouping them in a particular way. Figure 1 in the Annex is an attempt to illustrate under eight main areas the numerous and various factors that reduce or increase the burden of disease, being potentially either positive or negative determinants of health status. The diagram below presents the 12 main determinants of health, which will be addressed in the second part of this article.
2. A LEGISLATIVE APPROACH TO HEALTH DETERMINANTS

2.1 Biological determinants of health

Biological determinants, also referred to as “inborn” factors influencing health, are largely genetic. Human genetics is becoming a predominant health matter in our society, and an individual’s genetic composition a progressively more important determinant of his health. This is explained by the remarkable advances in molecular biology and genetics of the past 20 years, which have revolutionized our knowledge of the role of inheritance in health and disease; their implications concern many aspects of medical practice and also the development of public health approaches to the prevention of some disorders with a genetic component.

Nowadays, medical genetics offers hope for prevention and treatment of a wide spectrum of diseases, thus the prospect of better medicine and longer, healthier life. A vast field of knowledge has yet to be exploited. It plays a particularly important role in genetic screening and gene therapy. This knowledge will help people achieve better health; the individual has the opportunity to assert greater control over his life and long-lasting suffering can be reduced and sometimes avoided. The benefits and disadvantages of screening programmes for individuals, families, and societies will need to be carefully assessed. These advances will only be acceptable if applied in an ethical manner.

It will be necessary to manage and control this knowledge by setting safeguards against the potential dangers and malpractices which may affect every member of society and rightly raise public concern. Patterns of safeguard currently envisaged are as follows: participation in screening on a voluntary basis; safeguard of the freedom of choice of the individual and his right to self-determination based on informed consent — in this respect, essential information goes beyond medical considerations to include social aspects; strengthening the right to privacy and fostering respect for genetic privacy; legislating to adopt policies to regulate private sector intrusion into genetic privacy both in the area of medical testing for employment and for insurance; the right of the person to be informed of the results of screening but also the right not to know as a form of protection of personal privacy; addressing the complexity of ethical and legal aspects of confidentiality because of the implications for the family (a matter addressed in depth by Professor B. M. Knoppers in this Special Issue); and exploring the need for government approval, central coordination, and monitoring of genetic screening programmes.
The threat of eugenic abuse of genetic screening requires special safeguards, and it is essential that the public have a better understanding and be better educated with regard to genetics. In order to make individual choices possible, society must display solidarity with those who are confronted with such choices. Solidarity with children and adults with disorders must constantly be stimulated. The welfare of people with disabilities is highly dependent on the opportunities for development which society offers them. The choices which parents make with regard to their offspring can be directed by the opportunities offered by society to cope with disabilities.

The way public opinion perceives human genetics is varied and gives rise to polemics. One understands the difficulty of the community to grasp the real significance of genetic problems, and its concern about the achievements of the Human Genome Project, "which in reality does not raise any new problems but contains, and magnifies the complexity of many basic ethical, legal, and social issues".

The European Convention on Human Rights and Biomedicine, signed by 22 Member States out of a total of 40 of the Council of Europe, on 4 April 1997, is the first international legal instrument that specifically prohibits any discrimination against a person on the basis of his genetic heritage and only authorizes predictive testing for genetic disease with a medical objective. The Universal Declaration on the Human Genome and Human Rights, adopted unanimously by the General Conference of UNESCO on 11 November 1997, strikes a balance between safeguarding respect for human dignity, freedom, and human rights and the need to ensure freedom of research, while emphasizing the prohibition of all forms of discrimination based on genetic characteristics.

The announcement of the successful cloning of an adult sheep by a team of scientists in Scotland in March 1997, although offering interesting opportunities to advance biomedical research on diagnosis and treatment of diseases affecting human beings, raised great concern the world over, because of the potential implications of cloning procedures in human reproduction. WHO's Director-General, Dr H. Nakajima, reacted immediately with an official statement, in which he explained WHO’s position in the following terms: "WHO considers the use of cloning for the replication of human individuals to be ethically unacceptable as it would violate some of the basic principles which govern medically assisted procreation. These include respect for the dignity of the human being and protection of the security of human genetic material".

That same year, the World Health Assembly adopted by consensus resolution WHA50.37 affirming that: “the use of cloning for the replication of human
individuals is ethically unacceptable and contrary to human integrity and morality”. However, it underlined “the need to respect the freedom of ethically acceptable scientific activity and to ensure access to the benefits of its applications”.

In October 1997, the Scientific and Ethical Review Group of WHO’s Special Programme of Research, Development and Research Training in Human Reproduction was convened with representatives of UNESCO, IARC, and the Council of Europe as there was felt a need to develop international guidelines covering the technical and ethical issues of cloning in human health. In January 1998, 17 Council of Europe Member States signed an additional protocol to the Convention on Human Rights and Biomedicine banning cloning of human beings.

At its 102nd session in 1998, WHO’s Executive Board recognized that developments in cloning and other genetic procedures have unprecedented ethical implications and raise serious matters of concern in terms of safety of the individual and subsequent generations of human beings, reaffirmed that cloning for the replication of human individuals is ethically unacceptable and contrary to human dignity and integrity, and recommended to the World Health Assembly to urge Member States to take appropriate steps, including legal and juridical measures, to prohibit cloning for the purposes of replicating human individuals.

Today’s remarkable developments in the biological disciplines and future progress will together ensure that the “inborn” determinants of health continue to increase in importance. In particular, molecular genetics may — through the investigation of the determinants of chronic diseases which will be increasingly prevalent in the years to come — make it possible to identify persons at risk and devote special attention to them.

### 2.2 Behavioural determinants of health

A better knowledge of the determinants of health and disease would offer a dual advantage: firstly, that of understanding the nature and impact of their influence so as to plan where and how targeted interventions should be directed; and secondly, that of permitting more judicious decisions in the choice of priorities for action. Accordingly, it would be of interest to estimate quantitatively the respective contributions of the major determinants of the health of a community. With this objective in mind, studies were carried out in the 1970s in North America by several researchers (McKeown and Lowe, 1974). Considering the complexity of the problem and the variety of the populations
studied, different results could be expected as to the distribution of the responsibilities attributed to one determinant or the other. The group of factors catalogued as "behavioural" appeared consistently ahead of others. WHO's *World Health Report, 1995* corroborates these findings, stating that lifestyle-related diseases and conditions are responsible for 70-80% of deaths in developed countries and about 40% in the developing world. Even in developing countries the situation is expected to worsen in the future with a growing number of lifestyle-related diseases, attributed to the rapid emergence in the middle classes of unhealthy dietary and behavioural changes. The development process brings about changes in lifestyle which increase the risk of developing those so-called "diseases of modern civilization" common in industrialized countries, such as cardiovascular diseases, certain types of cancer, and obesity. Many of these diseases have multifactorial causes; the behavioural factors shown in Figure 1 can be favourable or harmful to health, depending on personal choice.

Behaviour is of importance to health, either directly through learned lifestyles or indirectly in the environmental and socioeconomic context. Influencing people's behaviour requires initiatives by the individual, the family, and the community. In this respect, WHO promotes healthy lifestyles by mobilizing public opinion and the media, and by strengthening health education, health information, and advocacy for health. As a result of improved public information, for instance, a fall in mortality from coronary heart diseases has been observed in many developed countries over the past few decades.

Because lifestyle is recognized as one of the most important determinants of health, one wonders whether a more proactive use of legislation could be successful in influencing changes in people's behaviour, ultimately bringing about a major societal shift? However, delicate ethical questions are raised as to the limits of the role of legislation in health promotion. The need to reach a balance between the use of legislative measures and respect for individual freedom is an argument fully developed in Professor J. Martin's article in this Special Issue. The principle of the free determination of each individual must be preserved. However, irresponsible individual conduct may lead the individual to become a social burden at public expense (heavy smoking and drinking leading to chronic diseases) or even to endanger other persons (passive smoking, driving under the influence of alcohol). The reality is that each and every one of us changes our behaviour patterns frequently due to all kinds of outside pressures, whether from society, families, friends or from commercial advertising promoting specific products. The issue is therefore not whether to influence individual behaviour, but rather to achieve a fair balance in that influence. Health issues must achieve a
degree of penetration in the midst of the various subjects vying for the public’s attention.

Legislation on health promotion, by expressing government policy, emphasizes government’s commitment to health promotion and prevention. It can launch governmental and voluntary health promotion programmes/actions, encourage healthy behaviour, dissuade harmful lifestyles, and contribute to form a climate of opinion favourable to healthy behaviour. The combination of educative, compulsory, and incentive measures constitutes an original legislative strategy, incorporating, for instance: legislation that prohibits certain types of behaviour because they are considered a risk to health, such as not wearing a seat-belt when driving; legislation that provides incentives for healthy behaviour, for example through tax benefits or by influencing the way in which insurance rates are structured; and legislation that supports the governmental policy of health education of the population and community participation, thereby imparting knowledge and motivation for healthy behaviour. The government can also undertake to facilitate activities of interest to public health which are run by like-minded independent private forces and nongovernmental bodies. In the field of health promotion, there is a great deal to be said for allowing the population time to grasp the value of particular measures before they are introduced. Greater reliance by governments on public opinion may considerably favour greater acceptance and implementation of eventual legislation. The role of public opinion in reaching public health goals points to the importance of information, education, and participation of the population in health legislation.

Further considerable benefit to lifestyles could be gained through the rational use, in the information and communications technology field, of innovations focused on the young, and adolescents in particular; this would also involve the participation of teachers and those responsible for recreational and sports establishments. In other words, it would be a concerted and coordinated community-based incentive programme. This exercise of solidarity could result in real benefits for the promotion of healthy lifestyles, if local governments do their share through enabling measures, in terms of personnel, material, and financial contributions.

WHO’s World Health Report, 1997 indicates six priority areas for international action, including: a major intensified but sustained global campaign to encourage healthy lifestyles, with emphasis on the healthy development of children and adolescents in relation to risk factors, such as diet, exercise, and smoking; and the adoption of healthy public policies, and their legislative support.
2.3. The environmental determinants of health

The environment is usually defined as the aggregate of all the external conditions and influences affecting the life and the development of an organism. Thus, the environmental factors in disease causation may be related not only to the physical aspects of the environment but also to its biological, social, and economical aspects, which impinge upon man's physical and mental health.

Since the physical aspects and their inherent characteristics are so important and play such a prominent role in health promotion and disease causation, they have been considered herein as a category apart from the general environment, although they are inseparable from it. Thus the determinant of health we are considering here is the physical environment, an approach which is shared by Professor Kiss in his article in this Special Issue where he comments upon the relationship between health and the environment, their happy marriage, albeit rather belated, its potential, and the respective contributions of their legal instruments amongst the wedding gifts.

Studies carried out in North America in the 1980s, aimed at calculating the respective influences on health of each main group of factors, show that right after the "lifestyle" group of factors, the "environment" ranks second, far ahead of the other determinants of health. Thus, their cumulative influence on health is clearly dominant, to the point that, in industrialized countries, the diseases of this last quarter of a century have been labelled as being predominantly behavioural and environmental. Another interesting aspect is the close relationship between these two determinants; the way that people live has a continuous effect on the physical environment. As lifestyles change, some health hazards are controlled or eliminated, while new ones are generated. The relationship between environment and health must be seen in this dynamic context.\(^9\)

In the poor and least developed countries, the domestic environment remains a major factor of ill-health, linked with lack of access to safe water supplies and adequate basic sanitation, upon which the control of many infectious diseases largely depends. In a report issued in 1997, UNICEF states that nearly three billion people — more than half the world's population — still lack even basic sanitation; this situation contributes significantly to deaths from diarrhoea or related illnesses of 2.2 million children annually.\(^10\) In fact, the percentage of people with access to sanitation has actually fallen in the developing world since 1990, as funding has declined and population has increased. Hence the importance of political will, its legislative support, and an understanding of the implications of failing to act.
In the industrialized countries in particular, but also on a global scale, there is considerable concern about the adverse health effects of continuing environmental degradation: notably, pollution, the uncontrolled dumping of chemical wastes, and the transport and storage of potentially dangerous substances, especially nuclear wastes. Another environmental threat is the depletion of the ozone layer, predicted to result in global climate changes. Changes in climatic conditions may have an impact on public health, increasing the potential for transmission of infectious diseases through the extension of breeding areas for mosquitoes and other insect vectors of disease. Together with the WMO and UNEP, WHO is studying the impact on health of the depletion of the ozone layer and analysing the potential impact on health of global climate change.

In the 21st century, developing countries will still be coping, possibly even more intensively, with the environmental health consequences of the lack of basic sanitation and unsafe water; worldwide, there will still be the problems of the noxious side-effects of energy production, uncontrolled industrial developments, harmful agricultural practices, large-scale destruction of tropical forests, and haphazard urbanization.

The Earth Summit, held in Rio de Janeiro, Brazil, in June 1992, heralded a new approach to development and environmental planning. By adopting the principles of the Rio Declaration and Agenda 21 (United Nations, 1993) as the route to sustainable development in the 21st century, the world's leaders stressed that development is about meeting the needs of people, their health, their well-being, their lives, and the environment upon which they depend. Sustainable development was defined by the Brundtland Commission as “development that meets the needs of the present without compromising the ability of future generations to meet their own needs”. This Declaration is an incentive for the legislator to act in this field. The reduction or elimination of environmental hazards to human health depends largely on legislation and regulations to be adopted both by national or regional authorities and at international level. Whilst the intent is improved health and safety standards, the financial constraints affecting the implementation of legislation sometimes dilute the extent of that legislation.

In practice, it must be recognized that numerous obstacles of an economic, historical, social, and psychological nature hinder or delay the adoption of measures for preventing hazards and safeguarding health. Many bodies of legislation on the environment derive from laws which are often very old and which have administrative traditions not amenable to change and are slow to
adapt to progress. The health standards that are aimed at limiting pollution are often compromises between the requirements of health protection and economic and political interests. They are too few in relation to the existing or potential sources of pollution and are often inadequate from the public health point of view. The economic cost of anti-pollution measures leads to serious reservations on the part of those responsible for environmental pollution and places in jeopardy the organization of the monitoring of pollution sources and the reduction of their harmful impact on man and his environment. In environmental policies, the protection of health occupies an important place but is not necessarily a predominant concern. It is essential that the issues of health are promoted and that public health authorities do not lose sight of this objective.

International cooperation occupies an increasingly important place in the whole legislative system for protecting man and his environment. Environmental policies must be based on a global approach associating protection of the environment with social progress and a sustainable development of the economy of the countries concerned, whilst ensuring the safeguard of living natural resources and the stability of ecosystems. Environmental law that makes it possible to carry out this global policy is relatively new; its development has been put on a firm basis, particularly since the Stockholm Conference of 1972. The considerable expansion of international cooperation over the last 20 years has been supported by several cooperative legal initiatives. A number of organizations have drawn up conventions, guidelines, and texts of a legal nature directly concerning the protection of the environment and bilateral and multilateral agreements have been signed.

An international consensus must be reached in order to establish more stringent environmental standards. These are essential because of the persistent and ever-increasing degradation of the environment and reflect the consistent demands of public opinion for improved standards.

There is at present a remarkable convergence of views on the need to reinforce existing legislative and regulatory provisions and to formulate new legal principles and rules to support environmental protection strategies. There is particular emphasis on three elements of these strategies: implementation of global environmental protection policies; priority for risk-preventing activities and the evaluation of risks before any potentially dangerous activity is undertaken; and development of international cooperation by promoting regional health cooperation agreements and improving information and knowledge of health legislation in the various regions of the world.

There are regional strategies on the scientific, technical, and legislative fronts.
that are genuinely capable of gearing policies towards common health goals. They focus on the importance of an overall strategy, the importance of prevention, environmental impact assessment, the need for a common terminology, development of community participation, and the importance of evaluating the results of the policies. Several WHO Regional Offices have drawn up corresponding strategies and action plans. For example, in Europe, a Second European Conference on Environment and Health, held in 1994, drew up the "Helsinki Declaration" — a mechanism for long-term cooperation between the major players in this field.16

2.4. Health system as a determinant of health

Health care systems in the 21st century will continue to be confronted with a wide variety of challenges, such as demographic evolution, new patterns of diseases, escalating environmental degradation, changing economic and social structures and status, further developments in health technology, and growing expectations of health care consumers. These conditions will continue to generate service changes and systems reforms, ranging from incremental approaches to more radical reform, requiring the intervention of the legislator to implement alternative strategies to finance and deliver services more efficiently and equitably.

In any reform process a wide range of options exists and guidance is needed in selecting the right approach. Since the concept of primary health care was defined and given international recognition at the International Conference on Primary Health Care, held in Alma-Ata in 1978, primary health care has marked the dawn of a new strategy to improve the health of peoples of the world. Twenty years after this historic turning point, the experience in countries with widely varying national circumstances has brought further development of the concept, differences in interpretation, and raised new questions and challenges. The Alma-Ata Conference defined primary health care both as a "level of care" and as an "approach" to health services development, which has major implications for the entire health system and for its interactions with the broader economic and social development structures.

On the positive side, most countries, many nongovernmental organizations, and health institutions have made formal commitments to Health for All. This global movement has had considerable influence in promoting a more equitable distribution of health resources, in reorienting health services (for instance, in integrating into primary health care certain preventive and health promotion
functions formerly carried out by vertical public health programmes), and in training new types of health workers in many countries. The coverage of several primary health care elements has been considerably expanded. Health status has improved, as indicated by lower mortality rates in all countries, although significant epidemiological variations and inequities are found both between and within nations.

However, less effort has been made to define clear primary health care objectives and targets. Little progress has been made in introducing necessary changes in resource allocation based on primary health care principles. The coordination of activities and resources has been a weak point; too little attention has been paid to management issues such as the setting of priorities, quality assurance, and operational research. Undoubtedly, the most serious finding is that inequalities in health and health care between different social, ethnic, gender, and occupational groups show little decrease and sometimes even an increase. Many of the health reforms that have been introduced have been concerned with improving efficiency, with inadequate attention to equity issues. Special efforts are needed to reach the underprivileged in the pursuit of equity. There must be renewed attempts to raise the quality and effectiveness of health services, both public and private, and a rethinking of current approaches to the setting of priorities, involving balancing trade-offs between health care objectives.

One important tool for the successful implementation of comprehensive primary health care in countries is legislation to support the various strategies already used or advocated. At present, the primary health care movement is essentially driven by the good will of individual countries and the global community. If it were rooted in legislation it would acquire the necessary sustainability. There is a need for a legal framework to support primary health care. The starting point of such a legal framework is the recognition by individual countries and the global community that access to essential health care is a human right. Debates must be encouraged in all countries leading to the identification of suitable national and international regulatory and supervisory mechanisms. Legislation can support primary health care both as an approach to health development and through the implementation of the content of primary health care programmes according to the eight essential elements of comprehensive care: health education; food and nutrition; water and sanitation; maternal and child care and family planning; immunization; prevention, and control of locally endemic diseases; treatment of diseases and injuries; and the provision of essential drugs.

The ability to achieve the objectives of health systems rests with the capacity
of policy-makers to respond flexibly and creatively to the policy environment they confront; how reform is introduced is nearly as important as what reforms are adopted.\textsuperscript{18}

Improving health care in today's world calls not only for new medical techniques but also for new human relations. Modern health care systems can only function when physicians and patients behave as partners. Indeed, experience and research have shown that patients who are informed and involved, and whose rights are respected, recover more quickly and have shorter stays in hospital.\textsuperscript{19} Awareness of patients' rights is evolving rapidly. WHO has encouraged the emerging movement in favour of patients' rights since the 1970s, on the basis of two comparative studies carried out in the European Region.\textsuperscript{20, 21} The Declaration on the Promotion of Patients' Rights in Europe was adopted as a common framework in 1994 at the Amsterdam Consultation.\textsuperscript{22, 23} Its purpose is to define a set of principles and strategies to support the development of country policies on patients' rights, particularly in the context of the health care reform process currently under way in most countries. The Declaration focuses on such individual rights of patients as information, consent, confidentiality and privacy, as well as on the social dimension of patients' rights, such as the right to treatment and care, to adequate social cover, and to proper information about health services. This Declaration is the symbol of a new relationship between physicians and patients that is developing within the broad perspective of health promotion and patient education. The formulation of patients' rights is just one part, but an important one, of the regulation of the health care system.

Health systems in many countries are nowadays in considerable disarray, trying to cope with increasing demands in an environment of poverty, growing inequity, and budget constraints and with the implications of a market economy and globalization.\textsuperscript{24}

The rising cost of health care has been a thorny problem for governments in practically every country. Health economists have tried to identify and understand the causal factors of this trend, those commonly accepted being: the emergence of expensive new high technologies; the availability of costly new treatments and expensive new drug therapies for severe diseases; the aging of the population, associated with a high level of chronic conditions; the growing expectations of the public for health care; and the attitude of the physician.

The major issue to be examined from the standpoint of its legal, ethical, and practical implications is that of the choices to be made at a time when material resources are limited, the possibilities of diagnosis and treatment are undergoing continuous expansion, and it is felt that the best possible use should be made of
the funds available. In this context, in some countries the government may be reducing its role in financing and increasing its role in regulating the health-related activities of its various partners. These institutional arrangements are changing. However, one should ensure that these arrangements move towards the goal of Health for All. We should promote the economical use of resources, but this does not necessarily mean spending less. Well-tried cost-saving methods are available and the need to use them cannot be over-emphasized and health authorities must insist that they be used. For instance, generic essential drugs instead of brand-name drugs, low-cost but effective therapies, and disease prevention activities all help to reduce the cost of curative care. One imperative is clear: to achieve better health through better use of resources. This can be done through making explicit the basic value framework for the health system and proposing openly principles on which priorities should be based, such as: dignity, need and solidarity, and cost-effectiveness.

2.5. The socioeconomic determinants of health

The socioeconomic situation of a country, closely dependent on its sustainable development, has a definite influence on the health of its population. A large body of evidence supports the view that the lower the socioeconomic status the higher the prevalence of disease; at the lowest level stands poverty. More people live in poverty today, and many in extreme poverty, than 20 years ago, despite the fact that this period has seen an unprecedented creation of wealth worldwide. The number of poor people has increased substantially, both in the developing world and within developed countries as well, among people with low social status, the underprivileged population groups, particularly in the slums of big cities. These pockets of poverty will continue to be a major obstacle to health development on an egalitarian basis. Poverty is increasing in absolute terms; the number of people living in absolute poverty was estimated to be 1.3 billion in 1993, or more than one-fifth of the world’s population. There are more and more poor people in the world and, between 1981 and 1989, the number of countries officially recognized as least developed countries had increased from 28 to 41. In one African country the incidence of poverty rose from 30% of the population in 1985 to around 60% in 1992. The level of government expenditure on health (less than $5 per capita in the two dozen poorest countries) declined in the 1980s for many of them. The Human Development Index improved globally between 1960 and 1992, but with increasing disparities between countries. Patterns for the provision of aid are changing; for instance, in 1993, aid to all
Low Income Countries fell below 50% of total DAC (Development Aid Committee) aid, compared with an average of more than 55% for the previous decade. The share of aid to the health sector has fallen under 5%. Poverty is perhaps the major single determinant of individual, family, and community health, and is, therefore, a major challenge of our times. UNICEF has repeatedly pointed out that many risks faced by children are rooted in poverty. Figure 2, entitled “The negative circle of poverty and ill-health”, serves to illustrate the interrelationship, pushed to its extreme, between poverty and ill health and its consequences on a person’s ability to work, to earn a living, to support a family, and often merely to survive. In his message presenting the 1995 World Health Report, the Director-General of WHO, Dr H. Nakajima, cited poverty as the world’s deadliest disease, stressing its role in contributing to the suffering and burden of illness, disability, and death affecting many people worldwide. In fact, extreme poverty — the world’s most ruthless killer — is listed in WHO’s *International Classification of Diseases*. Reduction of poverty is one of the four key priorities identified for future international health action in achieving the goals and targets defined in WHO’s Ninth General Programme of Work (1996-2001). In renewing its Health-for-All policy for the 21st century, WHO has chosen the combat against poverty as its first strategic line of action.

Since health status depends increasingly upon social and economic circumstances, the conventional health sector has little influence upon the “three-dimensional” context of poverty, namely: political, economic, and social. It is primarily the role of the political decision-maker to search for a proper balance between economic realities and social needs. The responsibility falls on the government to legislate so that national resources and wealth are equitably shared between the different sectors of the country’s activities, a reasonable percentage of the national budget is allocated to the health sector, and health is given a higher ranking in the order of national priorities established by the government for public expenditure; only then, will health occupy its rightful place in general development.

Economic policies conducive to sustained growth are thus among the most important measures governments can take to improve the health of their citizens. Of these economic policies, increasing the income of those living in poverty is the most efficacious for improving health. The reason is that the poor are most likely to spend additional income in ways that enhance their health: improving their diet, obtaining safe water, and upgrading sanitation and housing. And the poor have the greatest remaining health needs. Government policies that promote equity and growth together will therefore be better for health than those that
Among such poverty reduction instruments are: policies that help to improve inadequate initial distribution of factors of production; enhancing human capital with a meaningful food policy; public investment in education; improving human capital by channelling adequate public funds for health; establishing cost-sharing methods that safeguard the interests of the poor; and further improving access to health care.

Experience has shown that intensified WHO cooperation makes most progress in those countries where commitment to action for health is part of an overall policy response to problems of economic and social development, further supported by a will to link all resources to an implementation process with well-defined priorities. Public authorities should be guided by the principle that the good health of a country’s work force is a fundamental component of economic productivity and that to improve it represents an investment in the campaign against poverty. Such a strategy should convert the negative circle presented earlier into a positive circle of poverty reduction, and lead to better health, economic growth, adequate income, and improved welfare and quality of life.

2.6. Sociocultural determinants of health

Health is a variable reality perceived differently by various social groups, but depending to a large extent upon the very close interrelationship between life patterns, education, and culture. In the section entitled “Behavioural determinants” we commented upon the influence of lifestyles on health. We will focus here first on education as a factor in determining the level of health of a community and then on the relationship between culture and health.

Education is a decisive factor in health improvement, and the first of the eight essential elements of primary health care; moreover, basic education is the foundation of health education, a major component of health promotion. Education is decisive in improving health and reducing mortality, particularly infant mortality; several studies have indicated that educating the male parent alone does not have a significant positive impact on infant and child mortality if the mother is illiterate. Other studies confirm that wide differentials in child survival are closely related to differences in the educational level of the mothers. The evidence available also points to a close relationship between educational levels and a readier acceptance of family planning, spacing of births, improved health of mothers, and better care and health for children.

In societies where people do not proceed beyond the primary educational stage, primary school takes on a greater role in health promotion. Thus, other
programmes which should also be given priority for allocation of resources are those specifically targeted at strengthening a close collaboration between health and education in the school, where it can best take place. Many countries have recognized the productive role of the school in health improvement. Three creative aspects of this role are usually noted: the school provides health care for the young; it educates them in healthy living, a lifelong benefit; and it permits effective community participation on essential health concerns. Higher learning institutions, secondary schools, and universities are also in a position to promote health in their own ways, but to a lesser extent; one should remember that the students of today are the decision-makers and the community health leaders of tomorrow.

Educational personnel should be fully aware that their efforts to expand access to education, particularly for women, will have a lasting benefit on the health of the community. Equally, efforts of health personnel to improve community health will increase educational efficiency. The health sector therefore has a vital interest in promoting equity-oriented policies giving priority to resources for primary education and paying special attention to health-related problems of women. It should especially support educational programmes where female literacy rates are low. Universal primary education should be recognized as essential for the achievement of Health for All goals; health and educational goals have to be achieved concurrently and are both equity-oriented.

The relationship between culture and health also plays an important role as a health determinant. In developing countries, emphasis on the sociology of health and ill health is increasing, but the health sector has yet to develop a systematic approach to the cultural dimensions of health. Such an approach should draw on the positive health protecting and promoting elements of traditional culture, while examining ways of removing cultural practices, attitudes, and values having damaging consequences for health. A most sad testimony of such damaging cultural practices is female genital mutilation, an aspect of violence against women which is also a violation of human rights. It is estimated that there are at present up to 110 million girls and women who have undergone some form of genital mutilation.

In any society, social norms and mores are in a state of flux; they bring fundamental changes in the structure and value system of the society and consequently create problems of maladjustment of individuals and groups and ensuing health risks. Family breakdowns and the abandonment of parental roles, separation of the elderly from family and society, uncontrolled sexuality amongst young people, unwanted pregnancies amongst teenage girls, accident-prone
younger males, violence and unlawful behaviour of adolescents in the slums of big cities, the growing number of marginalized people, mainly due to unemployment, the homeless, culturally displaced or isolated groups, such as migrants, refugees, ethnic minorities, all these sociocultural aspects, particularly when compounded, impinge on the health of a society. Major progress could be made in raising the health status of the population by enhancing the quality of the social environment and developing social support networks. The disruption of traditional rural cultures has, in many circumstances, been accompanied by the erosion of social support systems. Urbanization, which resulted in an improvement in the quality of life and health in many countries, affects the social environment in a negative way when it outstrips the capacity of health and social infrastructures to meet people's basic needs, as the urbanization process has often been too rapid and ungovernable. The burden of violence, which has dramatically increased worldwide in recent decades, is borne mostly by women and the young. Women are beaten and sexually abused; lonely, elderly women are victims of aggression. There is violence at home, in schools, in sports stadiums. These are some of the most glaring features of social disintegration, with its negative impact on health.

What can be done to address the sociocultural determinants of these acute problems of today and tomorrow? What range of policies, when combined with appropriate legislation and education programmes, can delay and even reverse these trends?

The aim of a legislative strategy in this area should be to strengthen man's ability to adapt through changes in educational systems, but also to adapt society so that it is better suited to man by avoiding the progressive dehumanization of societies resulting from the needs and constraints of production technology and failure to take into account the costs of social maladjustment and social distress. The legislator must therefore try to impart to society a more human and better adapted structure, to enhance natural links of solidarity in line with the pledge made at the World Summit for Social Development (Copenhagen, 1995). The legislator should foster social self-protection so that the individual benefits from the group to which he belongs, be it the family, the neighbourhood, the village, or his profession. It will also be necessary to adapt and supplement the legal regulations intended to ensure the physical security of persons and to establish suitable systems of protection, especially by a proper integration of violence and crime prevention services into social life. Social support networks in the community can assist greatly as partners in the development of health programmes, since they are highly motivated human resources based on natural social units. They can increase substantially the effectiveness of health systems.
and extend their scope of action in the community, such action being all the more important as budgetary resources become scarcer. Greater emphasis should be placed on constructive legislation in favour of the family as well as societies and associations for health and social purposes. The family needs to be strengthened and protected against the trend towards disintegration and, moreover, given the means to develop, in particular through: financial measures (family allowances and those for the care of the disabled, children, and the elderly), tax concessions to help keep the family together, and measures to ensure the availability of accommodation suited to the needs of the family. The family as a protective social structure generates a feeling of physical, mental, and social well-being and helps to neutralize health-risk factors.

2.7. The aging of the population as a determinant of health

A regular increase in life expectancy, ensuring an increasingly larger population of elderly people of 65 years and over, has created in industrialized countries a new and most important societal phenomenon in the second half of the 20th century: the aging of the population. Since the longevity revolution is also expanding to developing countries, the increase in the number of elderly persons in the world will have profound consequences for humanity and will represent a strong force affecting health and social services far into the next millennium.

Today there are an estimated 540 million people in the world aged 60 and over, 330 million of whom live in developing countries. By the year 2020, the world will have more than one billion people aged 60 and over and more than two-thirds of them will be living in developing countries, since many of those countries will then be far advanced in the demographic transition to an aging society.

To help promote a global response to this major societal concern, in 1995 WHO reoriented its programme of health of the elderly towards healthy aging, and it is now called “Ageing and Health”. It incorporates the following perspectives: life course, healthy aging, cultural settings, gender, intergenerational, and ethical. To make people more aware of the opportunities it will offer, the theme of World Health Day 1999 will be “Healthy aging”. A much wider campaign on active and healthy living for older people will also culminate in 1999, which is the United Nations International Year of Older Persons.

Professor Pierre Vellas, in his article for this Special Issue, first draws attention to the relatively new concept of “successful aging” and then makes proposals for
innovative programmes and the legislative measures to back them up.

Although the elderly in many countries enjoy better health than hitherto, a major concern of rapid population aging is the increased prevalence of chronic diseases and disabilities, both being conditions that tend to accompany the aging process, in particular in the older part of the population where there exists a definite concentration of chronic health care problems. The long-term consequences of chronic diseases are said to affect 7-10% of the world’s population.\textsuperscript{37} In 1996, these diseases caused more than 24 million deaths a year,\textsuperscript{33} equal to almost half of all deaths worldwide. Indeed, chronic illness is a condition that is a much broader problem in the world than is often realized. WHO’s World Health Report, 1997 was devoted to the theme of chronic conditions, disability, and ill health caused by noncommunicable diseases. Chronic diseases have often been regarded mainly as problems of the industrialized world but they are emerging at an alarming rate in developing countries for several reasons. Firstly, all populations are aging, but the rate of increase in the number of people over the age of 65 is occurring faster in middle- and low-income countries than in industrialized ones.\textsuperscript{39} Secondly, life expectancy is also increasing in developing countries, thus making people increasingly prone to diseases that are more common amongst older age groups. Thirdly, behavioural patterns of living are changing and poor countries inherit the prevailing health problems of the rich — chronic ailments.

On the world scene, two other facts are to be considered: firstly, chronic ailments are more prevalent with age, and the oldest age group, 80 and over, is increasing faster, thus raising the number of very old people; secondly, the aged woman suffers more chronic ailments than the aged man and because of her important longevity, one speaks of “feminization of old age”:\textsuperscript{40} This explains in part an increase of chronic diseases and disabilities as the senior population grows.

People live longer. Later death is of course a benefit, but it is essential to reduce the suffering from chronic diseases and disability that longer life often brings. “In celebrating our extra years, we must recognize that increased longevity without quality of life is an empty prize, i.e. health expectancy is more important than life expectancy.”\textsuperscript{44} These are the very words of the Director-General in his message presenting the World Health Report, 1997. The Report’s concluding remarks indicate priority areas for international action in health intended to control chronic diseases, including legislation in support of prevention programmes and health development initiatives.\textsuperscript{42} How could legislation contribute to fulfilling the needs of the chronically ill person in an aging society?
A good many chronic patients are free of impairments, their health and social welfare being provided for, in part, by legislation on the care of the elderly and patients' rights. Legislation for the elderly is considerably influenced by moral principles rooted in religious or laic precepts, which should remain vivid enough to help us in properly integrating the reality of sickness, suffering, and death into our common social concerns. The opportunity for the elderly to continue to contribute to the common goal can reinforce social development across generations and raise the level of health of the elderly. As for protection afforded by patients' rights, the vulnerability of the sick and the frailty of the aged put chronic elderly patients at a disadvantage, subjecting them more easily to violations of their rights and the shortcomings of social and health administration. Thus, there is a need to advocate the recognition and advancement of patients' rights in the context of an aging society.

Persons with chronic diseases entailing disabilities deserve special attention. However, the interests of the disabled are not easily acknowledged in the policy process that leads towards laws and administrative practices, though important progress was accomplished during the United Nations Decade for Disabled Persons (1981-1992). Policies for persons with disabilities have suffered from inefficiencies. In particular, it has proved difficult to reach a coordinated policy because responsibility is divided among too many varied authorities, leading to a multiplicity of regulatory and legal arrangements resulting in poor quality, uncertain validity, gaps, and increased weight of administration with its burden upon persons with disabilities. Moreover, laws and regulations are usually compiled in a way that suits bureaucratic purposes rather than with a view to access by and information to the general public and persons with disabilities. Problems of a social ethics nature are particularly difficult to overcome: persons with disabilities are often denied the right to self-determination in their own life and the chance to take part in the social life of their community. This socially inflicted deprivation is especially acute for the mentally disabled.

Problems raised by chronic diseases with dependence are the most compelling ones and a priority issue in the health and social policy for the elderly. The vulnerability of dependent persons makes it essential to reinforce already existing social protection and to encourage the recognition in law of provisions specific to dependence. Social justice implies a true national solidarity which should recognize and appreciate the risk of dependence in a way similar to other major risks individuals face in their life. Social rights should contribute to building up a guarantee that covers the citizen with loss of autonomy so that the individual regains some control over the essential acts of daily living. The fundamental
interrogation bears on the cost of dependence of elderly citizens and its evolution. Are our societies prepared to concede the necessary sacrifices to ensure the delivery and financing of medicosocial services due to dependent persons in order to enable them to enjoy equal rights and protection as other citizens? All human beings are worthy of respect, care and dignity, regardless of age or social contribution.

In response to our original question on how legislation could contribute to improving the health and well-being of the aging chronic patient, it would seem that before addressing the political decision-maker and the legislator, we need to find the answer within society itself. It is a matter of creating collective awareness of the necessity for a profound ethical reflection on this new challenge facing our society. The principles of equity and justice in a democratic society demand that we arrive at difficult decisions openly and by so doing confront citizens and governments with assumptions about the quality of life of the aging chronic patient.

2.8. Advances in science and technology as a determinant of health

Advances in science and technology, medical sciences, engineering, and communications of the last decades of this century offer untold opportunities to influence health. We focus here on such advances pertaining to the medical and biological fields, while the next section is dedicated to information/communications technology. This progress has brought substantial dividends to health in the past and is likely to yield even greater benefits for all in the 21st century. However, there is a need to consider the benefits as well as the potential risks of these new technologies in terms of health, integrity, and dignity of the individual. Advances in fields such as genetic screening, assisted reproduction, organ transplantation, and intensive care units have reaped considerable advantages. They also produce potentially adverse consequences for the health of the individual and for human rights, thus raising difficult ethical problems. For instance, intensive care units are using technologies which make it possible to maintain life almost indefinitely by artificial means but may also prolong the dying process at the expense of human dignity. The application of the benefits of a technical innovation in medicine, necessarily restricted to a few, or following its widespread use, resulting in expensive medical care (renal dialysis, organ transplantation, medically assisted procreation), may involve the strict selection of beneficiaries for purely restrictive economic reasons, while there are heightened expectations of a changing society eager to share the advantages of
progress in the health field.

These examples highlight the difficulties which will continue to emerge and even acquire greater importance as the availability of new techniques increases. Because of their rapid pace of development, medicine finds itself in possession of outstanding and efficient, yet more and more threatening, tools. These refined instruments give man more and more power to manipulate life and come to question our values. This inevitable technological evolution necessitates ongoing ethical reflection in order to prevent deviations or excesses and ensure the respect of the identity, dignity, and autonomy of the human being.

The essential ethical markers have already been expressed in codes of medical ethics. Wise recommendations have been and continue to be issued by a dense network of ethical committees in various national settings, as well as at the international level in nongovernmental and intergovernmental organizations. Biomedical laws and other national legislation, international universal declarations, and regional conventions make up a body of knowledge which provides an ethical frame of reference.

There remains a large margin of uncertainty in the reality of daily practice, as the use of complex new techniques can create situations where limits are difficult to determine. It is not easy to draw the line between acceptable and unacceptable, between right and wrong. Health professionals may be confronted with new ethical interrogation on the spot; are they left with too heavy a moral responsibility to bear? Should one, in that case, turn towards a legislative response to an essentially ethical problem? Should one ask the legislator to prepare texts adapted not only to situations which are at present poorly regulated, but also to new necessities and thus protect society from potential abuses? But is it up to the legislator to define an ethical frame of reference for the use of new technologies? Should the law provide ethical rules when confronted with problems of life? Ethics and law complement each other. The passage from an ethical principle to a legal right is a function of a perceived social need, conditioned by the cohesion of society and its ability to reach a consensus. Justice requires impartial judgement based on common ethical values, which are difficult to establish given the wide differences of opinion in society. Moving from ethics into law also depends on the capacity of the legislator to respond to a felt social need. This requires precise identification of the need to be satisfied, the determination of feasible and desirable solutions, and the choice of the most relevant legal tool.

The development of technology is testing the boundaries of ethical norms and challenging the very notion of what makes us human. The current status of
research and technology development in the area of xenotransplantation (the transplantation of animal organs, cells, and tissues to humans) is an example of a technology that offers potential to improve human health but must be carefully monitored. The development and implementation of this technology is not solely a biomedical issue; it is also a philosophical issue. People's ethical, social, and religious perceptions and attitudes, and legal norms, need to be examined when considering the development of national policies on this technology. Public acceptance should not be assumed. Concerns need to be addressed through frank public debate, and the dissemination of accurate information and education. In order to foster such debate and provide the necessary guidance on the issues raised by the potential use of this technology, WHO convened an international consultation on xenotransplantation in October 1997.45

The role of governments is to ensure that essential public health functions are maintained, inter alia, fostering the use of science and technology. The role of WHO in the 21st century will be not only to support the effective use of essential existing technologies and the development of new technologies for health, but also, in close collaboration with the international and scientific and academic community, to encourage innovations in science that serve the values and needs of all.46

Firm ethical principles are therefore needed to anticipate and guide developments in science and technology and their application, and to guide decisions about matters that influence health. The renewal of WHO’s Health-for-All Policy in the face of the rapid advances in science and technology will seek to: monitor and update, as necessary, ethical norms for research; anticipate ethical implications of advances in science and technology for health, for instance with regard to cloning and genetic engineering; apply internationally accepted codes of ethics; and ensure that agreed ethical standards guide future work on the human genome.

2.9. The information and communication revolutions as health determinants

We are witnessing the transition from a post-industrial age to an information age and experiencing the early days of two interconnected revolutions, in information and in communications, which are transforming the way we live, the way we work, the way we learn, and the way we relate. What are the tools of these revolutions? Briefly, the use of computers, a worldwide interactive network (Internet) allowing high-speed access to information databases and communications, i.e. E-mail.
The Internet, also called "the information highway", originally North American, is growing fast and is already widespread throughout the world, where it is serving a broad range of applications. The development of the new technologies in information and communications offers tremendous opportunities in providing an easy and instant access to medical information once difficult to retrieve. It contributes to its dissemination worldwide, serving the needs of many physicians, health professionals, biomedical scientists and researchers, the mass media, and the public.

In this context, WHO has taken advantage of these technologies through the use of services available via Internet, E-mail and CD-ROM. WHO facilitates access to a number of databases through WHO Gopher, Worldwide Web, and Telnet. The WHO home page on the Internet w.w.w. makes it easy for Internet users to retrieve up-to-date health-related data on a wide range of topics. The scientific community can now also have access to a special bulletin board through Internet. Telehealth, which includes telemedicine, uses telecommunication technology and services for surveillance, control of infectious diseases, emergency preparedness, and education. Global electronic networks maintained by WHO monitor such critical developments as the spread of antibiotic resistance, levels of air and water pollution, toxic reactions to chemicals, and adverse reactions to medical drugs.

The role of WHO in the 21st century in providing leadership to the multiple partners involved in and committed to achieve Health for All will be sustained by the use of communications technology. "Global surveillance" and "alert systems" will be the first beneficiaries in rapidly and widely-spreading timely information about current and pending transnational threats to health. They will continue to help detect, prevent, and mitigate the impact of disease outbreaks and environmental hazards. Existing "early warning systems" for emerging infections and for impending famine will be expanded to other threats to health, such as illegal trade in products that harm health. Advances in information and communications techniques will make possible enhanced linkages between local and regional settings at national or global levels, relevant organizations, and WHO, and thus perfect active surveillance. These improvements will allow voices from local settings, warning not only about threats to health but also to human rights, to be rapidly and globally amplified, enabling concerted action. WHO will also use communication technologies to connect researchers who, because of inadequate resources, have been isolated from global initiatives. The development of truly global networks of excellence will allow local researchers to contribute to, and in return benefit from, globally distributed knowledge.
Through the improvement of local and national information systems, the new technologies and their expected advances will become important means for an efficient management of health care systems, evaluating policies, and contributing to decision-making. Their use will also be beneficial to training and education. As for health information and education, communications technology, including interactive methods, can allow every community, and the most remote families as well, to benefit from current medical knowledge and from interventions in behavioural areas. This can help raise the public perception of health and improve the quality of life.

However, new technologies have no moral dilemma; their integration is not necessarily a force working for good; it all depends on the use made of them. The field of health communication might be abused. There is a dark side to every technology which makes people look at some of the unwanted applications with apprehension and create legitimate concerns about: individual privacy, confidentiality, security, and personal freedom; potential misuse or misunderstanding of available information on diseases and treatments, particularly on drugs; excessive health information which may undermine the capacity of the public to absorb essential advice and to make rational decisions; not mentioning the risks of aggressive commercial marketing; and the authenticity of the information and reliability of its source. Equity issues will have to be addressed too, because the “information society” should serve all its citizens, not just the economically privileged, the technically sophisticated, or the elite.

As Internet has grown in popularity around the world, the freedom it confers on anyone to distribute without control any kind of information almost anywhere has alarmed some countries, governments, specialist groups, and individuals. The question that comes to most people’s minds immediately is whether or how information on the Internet should be controlled, restricted, or rated. Well-meaning policy-makers advocate establishing ethical safeguards and regulating the flow of information. Those at the other end consider Internet now perhaps the most democratic and global form of human communication and that the world cannot afford policies that impede its development, diminish its utility, and limit its social reach. They therefore want the network to be wide open, free of constraints and barriers. Even if it makes sense to come up with specific detailed recommendations and regulations, not only are the policies of many nations in conflict but also policies within nations. The USA is an example where these problems are being addressed. In 1996, the United States Congress passed the Communication Decency Act, “which was so restrictive that it could have made it
a felony to use the Internet to communicate detailed information about birth control, AIDS prevention, or how to get an abortion. However, a U.S. District Court in Philadelphia ruled the Act as unconstitutional abridgement of free speech; the affair was referred to the Supreme Court.47

Many governments will wish to make decisions about the Internet. However, the high-tech nature of the communication network will make it difficult for any single country to address the problem. Taking into account the versatility of digital technology, the rapid renewal of material, compounded with the absence of generally accepted guiding principles, and an approach of considerable scope, measures can be considered as valid and efficacious, only if an international consensus is reached at the planetary level, the network being worldwide.

Without any doubt, the rights of individuals to the protection of their health and privacy have to be protected from misuses of the emerging information and communication technologies. Certain ethical principles should be applied. Since health professionals must observe ethical obligations in communicating medical information, servers of this new means of information transfer should be similarly compelled to do likewise.

Such mobilization of health professionals has already taken place, as shown by the World Health Assembly (1997) and the Executive Board (1998), concern being expressed with regard to the cross-border advertising, promotion, and sale of medical products through Internet. When used by the general public for gathering information and shopping for medical products, the Internet may present a risk for the individual patient and a hazard for public health. The product may be inappropriate or even dangerous, while the medical prescription is bypassed as well as the control and professional counselling of the pharmacist. WHO is urging Member States to review the adequacy of the legislation and to take regulatory action when appropriate to address such issues raised by the use of Internet and encourages collaboration between Member States in this respect.

To conclude, the boundaries in the field of public health are expanding and are becoming more intertwined with communication technology. Handled diligently through medical ethics and supported by appropriate national and international health legislation, the true advantages and benefits to be derived from this dual revolution in information and communication will make it rank in the future as one of the main determinants of health.

2.10. Gender as a determinant of health

The gender concept was first used in the 1970s to describe those characteristics
of men and women which are socially constructed, in contrast to those which are biologically determined. A gender perspective leads to a better understanding of the factors that influence the health of women and men. It is not only concerned with biological differences between women and men, or with women's reproductive role, but acknowledges the effects of the socially, culturally, and behaviourally determined relationships, roles, and responsibilities of men and women, especially on individual, family, and community health.

The 1990s have witnessed an increased concentration on women's issues, the role of women in development, and women's health; however, in many countries of the world, women's health is still not a priority for policy-makers and when on their agenda this is usually in the context of maternal and child health. There are only a few programmes that have addressed women's health in a lifespan approach. The most significant aspect of this gender approach is the realization that women's health must be viewed in a holistic way, within a lifespan perspective and within the socioeconomic, cultural, and political context of their lives.

With regard to the health of women and children, the benefits of family planning services are well established. Their availability is still mainly limited to women living in urban areas and women having the material resources. It is estimated that worldwide 300 million couples who express a need for family planning assistance are not provided with this service; consequently, abortion remains a frequently used method of fertility regulation. WHO has estimated that in different countries unsafe abortion can cause from 25 to 50% of maternal deaths, simply because women do not have access to family planning services they want and need, or have no access to safe procedures or to humane treatment for the complications of abortion and because of costly contraceptive methods, lack of information, and restrictive legislation.

With regard to the quality of basic obstetric services, many countries suffer from lack of funds and consequently lack of safe, modern equipment and essential drugs to treat obstetric complications. The differences in maternal mortality between countries are unacceptable. From a recent study, jointly carried out by WHO and UNICEF, about 99% of pregnancy-related deaths occur in developing countries (55% in Asia and 40% in Africa) and, by contrast, less than 1% in developed countries. Many of these complications can be addressed through cost-effective technologies at the community or health centre, advocated as part of the WHO Safe Motherhood and Maternal Health Programme.

The rise of the AIDS epidemic has brought to our attention the risk of sexually transmitted diseases and the vulnerability of women to HIV infection and AIDS,
in all parts of the world, related to their status in society, including social and cultural expectations about their sexuality. By the year 2000, WHO estimates that over 13 million women will have died. This stark truth demands a realistic response. Specific targeted interventions with proper legislative support must be devised to enable women to protect themselves and receive appropriate care and support.

Aging is another major issue. It is estimated that the number of women over the age of 65 will increase from 330 million in 1990 to 600 million in 2015, the majority of whom will live in developing countries. In most regions of the world, the elderly woman does not receive particular attention from the health services and since she has less access to economic resources than men, many elderly women, especially when living alone, are subject to conditions of extreme poverty.

Malnutrition, an increasing problem among elderly women, is also a problem for women during pregnancy and lactation and for infant and adolescent girls. Paradoxically, although women produce more than half of the food in the developing world, discrimination exists in food allocation to girls and women. Available data shows that, in some countries, a sex bias in favour of males determines nutritional intake. Considering this, the Plan of Action emanating from the International Conference on Nutrition (Rome, December 1992) underlines an essential policy orientation that: “women are inherently entitled to adequate nutrition in their own right as individuals”. The Plan indicates a series of measures which would contribute to better nutritional status of women.

Education has been emphasized as a principal means of improving a woman's health status and that of her children and family; lack of education acts as a major contributory factor to the feminization of poverty. Nearly two-thirds of the world's illiterate adults are still women (565 million); most of them live in developing regions of Africa, Asia, and Latin America. A quarter of the world's girls are estimated to be out-of-school, compared to around one-sixth of the world's boys.

Lack of education has also been a major factor in limiting the work options available to women working outside the domestic sphere. In fact, many women in the world constitute the bulk of the labour force and often fill the ranks of poorly paid manual workers in unqualified occupations, working in the fields and factories, in hazardous conditions presenting high health risks. In addition, they are submitted to excessive working hours at a relatively low pay compared to men. Women in employment outside the home frequently bear a double work burden in that, after earning a hard day's pay, they are responsible for all the
domestic tasks in their homes. This aggravates the ailments that affect them and limits the time available for self-care and recuperation and increases social strains within the family. Legislative measures to protect and promote women’s physical and mental health in the workplace is an area where study and advocacy efforts are needed.

The discrimination against women that manifests itself throughout their lives begins almost from birth, but it becomes acute during the years of adolescence. The adolescent girl is especially vulnerable to oppression and violence of all kinds because of her relative lack of power physically, sexually, and economically. She will often have lower status in the household and the workplace and fewer opportunities as regards education, training, employment, and inheritance rights, all of which make for greater vulnerability.

The issue of violence and the problems of youth, which gained in importance in the 1990s, are linked in part to the breakdown of the family. Violence against women, both inside and outside the family, is reaching alarming proportions in developed and developing countries alike; although such violence is widespread, epidemiological knowledge is scarce. Physical and psychological injuries caused by violence against women are being inadequately recognized, diagnosed, and treated in part because of the social stigma attached to the causes of such injuries, and consequently intervention strategies are not fully developed. Domestic violence and rape have only recently been viewed as a public health problem, and yet they are a significant cause of female morbidity and mortality. Thus women experience, both inside and outside their homes, assaults on their integrity and bodies that deny them the sense of well-being, security, and esteem that contributes to health.

Shaping the development of policies aimed at investing in and improving women’s health is a priority for WHO. In order to respond more effectively to country needs, WHO has formulated a comprehensive Reproductive Health Programme, creating functional links between programmes focused on special health needs of families, children, adolescents, and women. A major step was taken in the area of women, health, and development when, in 1993, the Global Commission on Women’s Health was established as an advisory body to WHO. The Commission drew up an agenda for action on women’s health covering nutrition, reproductive health, the health consequences of violence, aging, lifestyle-related conditions, and the occupational environment. It has brought about an increased awareness among policy-makers of women’s health issues and encourages their inclusion in all development plans as a priority. At the 1994 International Conference on Population and Development in Cairo, WHO played
a key role in helping to reach a consensus and transcend political and religious
differences, thanks to its priority concern for health for all. The Fourth World
Conference on Women in Beijing in September 1995 was the culmination of a
series of major international conferences dealing with women’s health and
development, including the 1993 United Nations Conference on Human Rights,
for which WHO prepared a study on Human Rights and Women’s Health. As a
follow-up to the Platform for Action set up at Beijing, the Global Commission
geared its activities to the endorsement and promotion of women’s rights,
particularly the right to health, and the enjoyment by women of health security
throughout their life span.

Consensus is developing on the need to advance women’s health because of
the stark testimony of health risks associated with women’s poor status. The
overall goal is: the elimination of those factors within society that put women at
health disadvantage. Health legislation has contributed substantially to promoting
public health and could be used more vigorously to promote women’s health.
Laws that give women the right to control their fertility and provide access to
such services tend to reduce mortality and morbidity related to pregnancy.
Women themselves should be encouraged and supported to take advantage of the
basic human rights and freedoms that empower them to realize their own health
goals, not only as regards the right to health care, the right to benefit from
scientific progress, and patients’ rights with their important aspect of
confidentiality and privacy, but also as regards a broader span of rights — for
instance, the right to be free from discrimination, rights regarding survival and
security, family and private life, information, and education. As Professor Cook
concludes in her paper on “State accountability for women’s health”: “Fifty years
of documenting health legislation show that law is seldom used as a positive force
to respect, protect, and fulfil rights relating to women’s health”. She has provided
us with a valuable approach to address the application of human rights to protect
and promote women’s health.

2.11. Equity in health and social justice as determinants of health

Equity in health and social justice are amongst the major determinants of
health and will remain the foundation of WHO’s Health for All policy in the 21st
century: “the renewal of the Health for All vision will be based on equity and
social justice, values that never change. What will change is how to adjust, how
to react and how to sustain the global health values based on equity in different
socioeconomic and political environments”. These are the very words
pronounced by the Director-General of WHO, Dr Hiroshi Nakajima, at the close of the CIOMS Conference on Ethics, Equity and the Renewal of WHO’s Health for All Strategy in Geneva in March 1997.55

WHO was the first to recognize the right to health as one of the fundamental rights of every human being, as stated in its Constitution. The concept of equity is crucial to achieve both equal rights and equal opportunities for health.55 “Equity in health status implies that everybody has an equal right to reach the highest attainable level of health status, and that access to health services should be equally accessible to everybody to achieve good health status.”57

WHO’s action in this field is inspired by an egalitarian philosophy and by the idea that law should intervene as a force in support of humanity, justice, and equity. The concept of equity was given pre-eminence over that of equality to stress that differences in health status within and among countries are in essence ethical issues and as such require political attention.

Since this subject is multifaceted there is a diversity of views as to its meaning. One view of equity focuses on the health of the most vulnerable; another view is inclusion: no one should be left out; a third view is that equity is concerned with narrowing or eliminating large gaps in health status between the most favoured and the most disadvantaged. This is WHO’s rather pragmatic concept of equity and because of the very large differences in health status among groups, equity is thus well enough defined to establish WHO’s programmes and targets for the renewal of the Health for All Strategy.

“Equity means that people’s needs, rather than their social privileges, guide the distribution of opportunities for well-being. In virtually every society in the world, social privilege is reflected by differences in socioeconomic status, gender, geographical location, ethnic/religious differences and age; other dimensions also can be very important. Pursuing equity in health and health care means trying to reduce avoidable gaps in health status and health services between groups with different levels of social privilege.”58

It was intentional that the first of WHO’s World Health Reports was dedicated to the theme “Bridging the gaps”59. The Report bears witness of wide and widening gaps in health and health care between different social groups throughout the world. The “health gap” widens not only between rich and poor but also between the poor and the poorest of all, between those who have access to health care and those who are denied it, between countries and within countries, between age groups, sexes, and occupations. The gradual improvement in health worldwide conceals growing inequities everywhere, in rich, transitional, and poor countries.
As the 1995 World Health Report points out, growing inequity is literally a matter of life and death for many millions of people, since the poor pay the price of social inequality with their health, that is the price of social injustice. Precise statistics are simply appalling: as we approach the 21st century there are “still almost six million deaths each year from undernutrition and a further 2.7 million deaths caused by poor water supply, sanitation and lack of hygiene”\(^6\) In South-East Asia, 40% of the population of the Region do not yet have effective access to health care, contributing to the unacceptably high maternal mortality rates which are amongst the highest in the world.\(^6\) In Africa, one of the greatest sources of inequity is the unequal distribution of health facilities for large areas of underserved populations and if these people were to have access to health services an investment would have to be made in the entire infrastructure.

Equity is now seen as the major WHO policy and ethical requirement. In order to face new challenges to equity since the Alma-Ata Conference, WHO has embarked upon a global initiative whose goal is to promote and support practical policies and action to reduce avoidable social gaps in health and health care. This includes: improving knowledge of health inequalities in different socioeconomic situations; formulating national multisectoral policies and strategies adapted to the needs and situations of disadvantaged groups; and stimulating international action by making policy-makers in health and other sectors, health professionals, and the public at large aware of the burden of being socially disadvantaged.\(^6\)

A society that aims at equity and social justice has to demand that legislators set up measures that will enable the “minorities” fully to use their rights and fulfil their duties. These endeavours will be influenced by the economic and the human development of society. Within individual countries this requires above all a willingness to recognize the problem, an active search for information on its real extent, and the political will to design social policies that go to the roots of social deprivation. To find the proper legislative support to such social policies is a challenge to governments. It is an important endeavour as legislation is part of our life in society and also a mirror of the leading values in a society.\(^6\)

National legislation can make an essential contribution to reducing health inequalities with measures aimed at a more satisfactory distribution of facilities and services between different regions in a country or different areas of a town; better adaptation of health facilities and services to the needs of the most disadvantaged populations and particularly groups at risk; and training community health workers to increase the use made by the population of available services, implement health education programmes, and reactivate the development of social support networks where natural solidarities already exist.
(family, neighbours, self-help groups, etc.) to create a climate facilitating
community participation.

Equity between countries presupposes major transfers of scientific, technical,
financial, and human resources. This may be by means of, for instance, regional
cooperative health programmes specially designed to correct disparities in the
health development between countries, or bilateral health cooperation agreements
concluded between States with the same aim.

Legislation has a role to play in ensuring that the quality of health care is the
same for everyone, independently of their socioeconomic status. Differences in
quality can also result from differences in the attitude of health care providers
towards groups of patients. The legislator should make provision in the legal
structure for quality control, for instance by setting standards and establishing
control mechanisms.

Equity in the distribution of health care is realized through financial access.
Here socioeconomic differences can cause injustice and create obstacles for
obtaining health care according to needs. The legislator has to establish a legal
system for financial access to health services, to create solidarity between social
groups and prevent inequality in obtaining curative and preventive care. Special
measures are needed to support financial access to prevention because the lower
social classes and some minority groups (such as immigrants) are especially
difficult to reach by preventive activities. In many countries there is a trend
towards a change from a centrally planned to a market economy; during the
transition period, the role of governments is crucial in ensuring equity by
financing services that benefit the poorest and most vulnerable segments of
society who are the hardest hit. For this reason, it is more important than ever to
come to a better understanding of what can be achieved by complementary
actions on the part of governments and the private sector.

The geographical distribution of health care facilities should not be left to the
market forces. The legislator has to ensure that the planning of health care
facilities allows for correction by legal intervention, when social processes fail to
provide a reasonable amount of the requisite health services in all parts of the
country. Fair distribution should be ensured not only of primary health care but
also of secondary and tertiary care.

The successful implementation of a policy of equity in health and social justice
requires cooperation and support from several government sectors working in
health-related fields. This emphasizes the importance of securing adequate
intersectoral action for health.

In conclusion, the challenge for the future is to obtain a wide acceptance of the
unfairness in the present distribution of health and in services utilization. Beyond that acceptance, the important task is to help politicians and policy-makers never to forget the target of equity in health. Today, as a new generation approaches a new century, it is time for the appalling silence over health inequities in the world to be broken — and for the cries for help of hundreds of millions of people to be heard.  

2.12. Human rights as health determinants

The recognition of the interdependence between human rights and health is a precondition for advancing human well-being and dignity.

Those who prepared the WHO Constitution had the foresight to envision health within the context of human rights, peace, and security. The Constitution asserts that: “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 HFA movement launched in 1977 was based on the recognition of the close linkage between health, human rights, and social development. Resolution WHA30.43 on “Health for All in the Year 2000” set a more precise standard than the Preamble to the WHO Constitution. It reaffirmed that health is a basic human right and called for a social target of a standard of health to be attained by all citizens of the world by the year 2000 to “permit them to lead a socially and economically productive life”. The 1978 Declaration of Alma-Ata reaffirmed that health is a fundamental human right but focused further on a specific approach concentrating on primary health care as the key to the attainment of that right and HFA.

Health for All is concerned not only with the provision of health care to everyone but also the provision of care throughout the entire life of each individual. This implies the right to know about health, to protection against major health risks, to access to promotive, preventive, curative and rehabilitative care, and to living conditions conducive to health. It also means empowering people to make the right choices in health, enabling them to cope with changing patterns of vulnerability, and building their capacity to keep themselves and their families healthy. This calls for various forms of social and economic support, and for fuller knowledge and awareness.

WHO has developed a set of basic indicators of primary health care, and Health for All attainment, which further link that goal with the fight against
inequities in health. Indeed these indicators are the best measures of the “right to health” which exist in the world today.

A United Nations Seminar on appropriate indicators to measure achievements in the progressive realization of economic, social, and cultural rights concluded that it was necessary to clarify the content of the right to health; to clarify the nature of States’ core obligations to ensure the satisfaction of, at the very least, minimum essential levels of the right to health; to develop plans to promote the progressive realization of this right; to improve evaluation and monitoring of progressive realization; and to identify and address violations. 65

Although WHO did not explicitly link its health action with the promotion and protection of human rights, the Organization has a long history of operationalizing the right to health. Its long-standing role in the practice of human rights can be illustrated through its action in such fields as: children’s rights, the rights of the mother, family planning, the Code of Marketing of Breast-milk Substitutes, essential drugs, pharmaceuticals in international commerce, the Codex Alimentarius, the International Health Regulations, the Narcotic Drugs Convention, and the Guiding Principles on Human Organ Transplantation. It is also evident in its programmes on AIDS, mental health, environmental safety, occupational health, safe water and sanitation, blood safety, and health legislation and ethics.

Nevertheless, the WHO Task Force on Health in Development considered that WHO must adopt a more proactive approach to ensuring respect for the right to health so as to ensure lifelong health security for all; it must promote equity as a basis for health and ensure action to redress the underlying inequities in our societies which lead to increased risk of morbidity and mortality; it must address the specific physical and mental health consequences of violations of human rights and promote partnership between the health and human rights actors. It should articulate more fully the content of health rights and obligations and identify the strategies necessary for their implementation. 66

In order to develop the WHO human rights agenda and engage in a broader cooperation among health and human rights agencies, WHO convened a Consultation on Health and Human Rights in December 1997.

The François-Xavier Bagnoud Center for Health and Human Rights of the Harvard School of Public Health has identified three dimensions of the complex relationship between health and human rights. The first considers the manner in which health policies and programmes can burden and violate human rights, the second recognizes that violations of human rights have severe health effects, and the third suggests that respect for and protection of rights and dignity is one of the
essential conditions which people require in order to be healthy. The realization of human rights and dignity appears to be a precondition, or a necessary facilitating condition for the promotion of health status.\textsuperscript{67,68}

This third aspect appears to us to be a fundamental one as it leads to the recognition that human rights are determinants of health. Attention to this interaction between human rights and health and the impact of human rights on health sheds new light on health determinants at the dawn of the 21st century and reorients thinking about major global health challenges.

3. CONCLUDING REMARKS

The World Health Organization, with its partner organizations, has made considerable progress towards Health for All but will need to renew its efforts in the future to further health programmes necessary to protect health rights for all members of the community. Whilst this is a formidable task, it must be pursued with vigour if we are to continue to make advances in the new millennium towards this worthy objective. To address the major improvements necessary to achieve this progress, we need to develop innovative legislative frameworks which seek to guide and regulate in the quest for maximum cooperation from all relevant parties in achieving the highest possible standards of health worldwide. This article reflects on such legislative strategy addressing the determinants of health.

In this reflection I have endeavoured to comment on certain issues which affect so many today, the majority of which most probably will become of increasing concern for many in the next century. In particular, continuing poverty, inequities in health and societal discrimination, uncontrolled urbanization, and the breakdown of family and cultural values have degraded health generally. It is absolutely essential that we, in the health community, continue to work on educational, preventive, and remedial services and redouble our efforts to slow down or even reverse the degradation of the environment. The achievements in telecommunications will highlight the improved dissemination of medical information and the monitoring of crisis situations such as outbreaks of new communicable diseases, etc. Information and communication technology will play an increasing role as a determinant of health in the 21st century. Heightened awareness of the consequences of the demographic evolution, of the disadvantaged sections of the world's population, and of the health issues relating to women will ensure that these areas receive greater attention in the future.

To meet these broad objectives, we cannot rely on the good will and best
intentions of health workers alone. We must provide the legislative support to partnership for Health for All. The dissemination of full information on the aims of public health policy and legislation and the encouragement of participation by the population will ensure that legislation is more relevant, simpler, and more effectively implemented. In order to ensure the closest match of decisions to local needs and conditions, decentralization should be encouraged as well as the use of flexible procedures to help lessen the time-lag between health legislation and events and needs. The extent of the contribution that health legislation can make in reaching Health for All will depend in large measure on choosing legal instruments that best suit the health objectives it is pursuing. In this respect, contracts or agreements setting up the basis for the participation of social support networks in the operation of health services are likely to become more important in the future.

We, the health professionals, must redouble our efforts to ensure that the necessary legislative frameworks are available as we approach the new millennium. The time is ripe for WHO to explore means of more effective implementation of public health improvements through increased standard-setting and development of model legislation, regulations, and implementing measures. In this way all the efforts of health professionals and governments will be steered into the most productive channels in this most worthy of endeavours, sustainable improvement in world health.
Figure 1

Selective significant FACTORS influencing HUMAN HEALTH

HEALTH SYSTEM
- H. policy based on H.F.A. values
- Community-oriented P.H.C.
- Balanced basic H. care & Public Health Functions
- Equity of access to care
- Quality of health care
- Intersectoral action for H.
- Info. & communication technology

INBORN
- Biological
- Physiological
- Genetic
- Gender
- Age

BEHAVIOURAL
- Knowledge about health
- Life-style choice
- Individual/social behaviour
- Value systems and ethics
- Abuse & Addictions
- Traumas & Violence
- Health Promotion & Education
- Personal hygiene

SOCIO-POLITICAL
- Peace-Safety-Security
- Respect for human rights
- Women's support against discrim.
- Political will & commitment to H.
- % of G.N.P. to health sector
- Dialogue/Social cohesion
- Global cooperation-gov./private

ENVIRONMENT
- Safe drinking water & sufficient water supply
- Basic sanitation needs
- Housing-shelter-habitat
- Food production & Security
- Pollution: Air-water-land
- Industry/Agricultural Practices
- Ecosystem degradation
- Industrialization/Urbanization

SOCIO-ECONOMIC
- Socio-economic development
- Social organization networks
- Income-G.N.P. per capita
- Poverty level % of population
- Social justice and equity
- Gender equality policy
- Family size & structure

SOCIO-CULTURAL
- Expenditure on education % of G.N.P.
- Adult literacy rate (total)
- Literacy rate among women
- Customs/beliefs/religion
- Health education & info.
- Counselling services
- Social integration-community involvement
- Intergenerational bonds

Health Status

Society

Community

Individual

Family
Figure 2

THE NEGATIVE CIRCLE OF POVERTY AND ILL-HEALTH

Malnutrition
- Deficiencies
- Chronic under-nutrition
- Under-nourished children
- Inadequate food intake
- Unsafe drinking water
- Poor sanitation

Poverty
- Low income & low living standards:
  - Inadequate basic commodities
  - Deprivation of access to essential care
  - Lack of access to credit

Disease
- Impairs growth, physical/mental
- Undermines health
- Diminishes work strength
- Lowers initiative for family food production
- Reduces overall resistance
- Increases vulnerability to:

Death
- Ends family income
- Leads to despair and premature death
- Aggravates already tenuous living conditions
- Causes profound distress

Misery
- (Extreme poverty)

Death affects poverty, which in turn affects health and malnutrition. This cycle perpetuates itself, leading to further deprivation and illness.
REFERENCES


8. **Supra ref. 1, at p. 136.**


12. **See supra ref. 7, at p. 66.**


15. **Supra ref. 13, at p. 185.**


28. See supra ref. 7, at p. 40.

29. *Supra* ref. 7, at p. 81.

31. Supra ref. 26, at pp. 18-31.
32. Supra ref. 27.
34. Supra ref. 33, at p. 75.
38. Supra ref. 1, at p. 1.
41. See supra ref. 1, Message from the Director-General, at p. v.
42. See supra ref. 1, at p. 136.
46. Supra ref. 39, at p. 36.
48. Supra ref. 1, at p. 83.
50. Supra ref. 11, at p. 13.


53. Supra ref. 52, at p. 17.


59. Supra ref. 7.


62. Supra ref. 58.

63. Supra ref. 56.

64. Supra ref. 7, at p. 83.


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THE PROPER USE OF LEGISLATION
IN THE PROMOTION OF HEALTH AND PREVENTION:
EXPERIENCE AND APPRAISAL OF A
PUBLIC HEALTH PHYSICIAN

Prevention: needs and potential — a personal itinerary

After completing my studies and clinical training in Switzerland, I discovered the medicine of the less favoured countries. I saw that the limitation of resources strongly influences what one can do and what must be done and I understood the

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decisive importance of the environment in its various dimensions — physical and biological, sociocultural, political, or economic. Confronted by pathological conditions that are often advanced and recurrent in nature, one has the impression of having been assigned a never-ending task and realizes the need to act at a collective level (public health perspective) as well as in a preventive manner with regard to problems that seem relatively simple with respect to their causes and the means of remedying them. Even if experience shows that solutions that are rational in our own eyes are not easily accepted or understood by those who have different frames of reference, the fact remains that prevention, particularly through sanitation, the supply of drinking-water, immunization, the improvement of nutrition, health education, and family planning, stands out as a priority field for the following reasons: it brings with it appreciable and, ideally, rapid progress; its cost is generally modest, whereas the therapeutic management of serious, and even hopeless, conditions is a burden, for patients and associates as well; and its educational side is attractive and constructive, the objective of ensuring that individuals have autonomy in the management of their lives and health being particularly relevant.

After working in a bush hospital in the Peruvian Amazon from 1968 to 1970, a year spent in a school of public health in the USA enabled me to look at this field experience with the benefit of hindsight and gain a better grasp of the complexities of attitudes and practices. I realized that no behaviour, however irrational and harmful it might be, is devoid of meaning; it always has a raison d'être and corresponds to a need or a rule. The problem of the grounds and circumstances whereby the “other person” may treat us with suspicion has stimulated debate. One must be heedful of the ethical challenges of the will to do things for people’s own good against their wishes (or to want people to be healthy despite themselves) and maintain a position of critical detachment. However, the methods of action suggested for medicine and public health are promising. Their expected benefits would seem at times to excuse “insistence” on compliance from the populations concerned. To take two examples: confronted with numerous deaths that might be termed “stupid” due to tetanus in newborns, one cannot but be disturbed and feel that the provision of care that is even a little authoritative and “compulsory” preventive measures would be a good thing, given the simplicity of the preventive techniques involved (immunization of the pregnant woman against tetanus; hygienic section; and clean dressing of the umbilical cord). In view of the physiological exhaustion of mothers who, without control over their own personal and sexual lives, are subjected to repeated pregnancies and in view of the high mortality of their children, the will to improve the
situation leads to consideration of programmes to encourage the spacing and prevention of births in order to avoid these tragedies and injuries. This raises major ethical issues, since the rights of individuals must be respected.

After my return to Switzerland in 1976, I collaborated in a range of activities concerned with prevention, particularly in the field of school health and involving the training, from the mid-1980s in the Canton of Vaud, of health facilitators (teachers responsible for encouraging and giving impetus to health education activities) and the introduction of interdisciplinary health teams in schools.

For three decades, we have had to face the problems associated with the use of illicit drugs and drug dependence, which raise complex issues (far more complex than certain simplistic and ideological arguments would have us believe) and which all agree stem from multifactorial and relatively non-specific causes related to the context of a person's life during childhood and adolescence and to the disturbances and traumatisms that can mark these periods. It is an illusion to hope that effective prevention will be brought about merely by providing a rational description of the harmful effects of drugs. Such an outcome is even less likely if we allow ourselves to be carried away by an attack on the "diabolic" nature of the products, thereby giving the impression that there is nothing further to the problem. Although such a view is incomplete and incorrect, it in no way detracts from the fact that substances with psychotropic effects, whether licit or illicit, represent serious health concerns and their use must be controlled.

After 1981, there emerged the constellation of issues connected with AIDS, which at first constituted a medical enigma concerning a handful of isolated cases, before becoming firmly established on the agenda of the public authorities around 1985, when it was realized that, physically, psychologically, or socially, HIV infection was the concern of each and every one. Prevention is particularly crucial here, since we do not yet possess a vaccine or curative treatments.

Prevention: in the name of which values?

Scientific and practical observations have helped to determine the challenges and risks linked to prevention as well as the middle courses to be adopted. We have moved on from the authoritarian approaches that, until recently, were deemed legitimate, if not indispensable. Table 1 of the Annex to this paper presents the principal values that may be used as a basis for a preventive approach (left-hand column), together with their justification (middle column), and the risks of imbalance or of things going awry (right-hand column). Several remarks are appropriate in this context. Thus, with regard to family health, and ill
treatment in particular, it is difficult to decide between restraint (this is traditional: thus, the Roman pater familias had the right of life and death over the members of his household) with regard to the right of everyone to live as he pleases in his own home ("a man is master in his own home") and timely action in pitiful situations where it clearly would have been better to refrain from "minding our own business". Tough decisions have to be made every day.

**The Ottawa Charter on Health Promotion (1986)**

Adopted in November 1986 at a Conference co-sponsored by WHO, Health and Welfare Canada (the Canadian Ministry of Health and Welfare), and the Canadian Public Health Association, the Ottawa Charter constitutes an important reference for all those concerned with promotion and prevention in the world. It illustrates a modern approach, underlining the importance of the environment in its various aspects, as well as the respective roles of the public authorities, the community, health professionals, and health services. It is appropriate to quote the following extracts:

... health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization[s], by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. ...

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services.

The participants in this Conference pledge:

* to move into the arena of healthy public policy, and to advocate a clear
political commitment to health and equity in all sectors:
- to counteract the pressures toward harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

A historical note is appropriate in connection with this Charter: "In discussing the right to health at a time when the concept was not yet in common usage, the medical historian Sigerist (1941) suggests that an essential element was lacking from the somewhat dirigiste approach taken by the promoters of the 18th-century public health movements, namely the desire and understanding of the people themselves for the betterment of their health, a commodity which could not simply be dispensed to them. It was over a century later that this notion was incorporated by WHO (1981) in the Global Strategy for Health for All [by the Year 2000]" in the following terms: "People have the right and the duty to participate individually and collectively in the planning and implementation of their health care. Consequently, community involvement in shaping its own health and socioeconomic future, including mass involvement of women, men, and youth, is a key factor in the strategy".

Prevention and legislation: relevant bases

As in the other fields of health and social action, legislation has an important role to play with regard to prevention and the promotion of health. In this connection, the different stages and methods of action involved in prevention
(hereinafter “prevention” generally means prevention and the promotion of health) should be clearly perceived in order to analyze on a case-by-case basis whether legislation is desirable and what type it should be. It is also necessary to study at what level legislative action is the most relevant, particularly in a decentralized political system. In certain cases, normative provisions adopted at the highest level are necessary, while in others it is preferable to have a framework text that permits a flexible adaptation in keeping with local characteristics. One of the essential elements to be taken into consideration is that most health disorders have multiple causes (“multifactorial etiology”), at personal, family, and community level. The fundamental question is often whether the improvement of the situation requires regulation in the health field or whether it is more a case of promoting legislation in other fields of socioeconomic life. The following remark effectively makes the point: “What we need is not so much a public health policy as a healthy public policy”.

**Different stages of prevention**

A preventive action may be primary (through the *a priori* elimination of the factors constituting a source of disease or accident, which obviously means that it is necessary to know the problem’s causes or factors), secondary (with the aim of detecting the disorder at an early asymptomatic stage, it being a condition that early treatment must be more effective and, if possible, easier than at a more advanced stage), or tertiary (i.e. rehabilitation with the aim of reducing to a minimum the sequelae of a disease or accident (this aspect of prevention will not be dealt with here)).

**Different methods**

It is essential to be aware that, for a given problem and at a given stage, a range of possibilities may generally be envisaged that are more or less authoritarian (normative), where the role of legislation and the public authorities is more or less extensive. These possibilities are more or less active with regard to the individual or group concerned and to a greater or lesser extent call upon the latter’s powers of comprehension and choice. This is not to say that the so-called active methods are necessarily always the best. In certain cases, normative measures (also termed “passive”, from the point of view of the individual) are very appropriate, effective, and economic. These include vaccinations, the iodization and fluoridation of salt or water, or the prohibition of the marketing of everyday
products that are hazardous. In other cases, particularly those relating to the consumption of alcoholic beverages or other "leisure" activities, the emphasis should be on actions that are informative, educational, and persuasive and take adequate account of the fundamental freedom of individuals.

The difficulties of prevention

It may seem surprising that prevention, in certain areas, does not receive more positive and firmer support on the part of the population or the decision-makers, but this is due to the following reasons: in the field of prevention, it is often not possible to give categorical assurances as to the protection obtained; the positive effects of prevention are observed in the long term, a beneficial outcome being far from obvious at the outset; and the multifactorial etiology of most diseases necessitates action of an intersectoral and multisectoral nature, which is not an easy thing for a decision-maker who must convince one or more of his colleagues to take action within their own fields as well.

The place of legislation in different situations

Health protection

The measures envisaged by this term come under the primary prevention that we call "passive". Here we are concerned mainly with protecting individuals against risks over which they have only a limited influence and which they cannot control by themselves. Thus, Section 29 of the Law of 29 May 1985 on public health of the Canton of Vaud lays down that: "The State shall take or encourage such preventive measures as are appropriate to maintain and improve the health of the population. The State shall take such measures particularly where the individual, the family, or the commune are unable to act effectively in isolation". In a very general manner, this has a bearing on the problems involved in the development and improvement of the living environment, namely: physical and chemical pollution, including radioactivity and noise; town planning and the preservation of natural areas; the environmental aspects of accident prevention; the control of industrial production (meaning not only production methods but also the quality and safety of what is produced); legislation regulating the manufacture of products the use of which is potentially harmful, and also advertising and marketing methods associated therewith (including taxation); and classic measures concerned with collective hygiene, sanitation, the quality of
housing, immunization, and the quality control of water and foodstuffs. Government action, particularly by legislative means, is especially appropriate in this field. Moreover, it may often be carried out in a relatively centralized manner.

**Active primary prevention (health promotion)**

This concerns all measures aimed at encouraging people to modify unfavourable attitudes to health and adopt healthier forms of behaviour. This applies to the way one eats, the consumption of various substances, physical exercise, sexual activity, and driving in traffic. Health professionals, followed by politicians (for examples of precursory documents in this respect, see references 7,8,9) have realized that, in industrialized countries in particular, additional progress with regard to the state of health of the community must come about via such changes in habit. One may wonder what the role of legislation is here. Since the decisions one takes on a daily basis concerning one's lifestyle are not laid down in legal instruments, it is difficult to legislate directly. However harmful certain everyday practices of our contemporaries may be, the principle of the freedom of individual determination must be preserved. Nevertheless, government action may greatly enhance progress, through the adoption by the authorities of positions with regard to an overall prevention policy or particular topics, and through the allocation of the necessary resources in the public sector or the granting of aids to private initiatives.

**Secondary prevention**

Certain early screening methods are of the active type, such as the self-palpation of the breasts for the detection of cancer. To this may be added the periodic checking of blood pressure or screening for glucose in the urine, when they are carried out in a non-medical environment. Activities of this type are undertaken, in particular, by self-help groups. As in the case of primary prevention, legislation appears to occupy a moderate place. It may be concerned, above all, with implementation and financing.

Methods of the passive type, for their part, include screening examinations carried out by health professionals and, where appropriate, imposed measures. Legislation may provide a contribution by assuring that the cost of benefits is covered by health insurance schemes or by creating services. Legislation introducing possible obligations occupies a place that corresponds to specific
groups at risk, for example, in the field of communicable diseases (tuberculosis), in occupational medicine, and in certain other cases (such as the obtaining or keeping of a driving licence).

Table 2, which has been taken from the report of the Seminar on Health Legislation held in Montpellier in 1986, provides a schematic overview, for various types of concerns, of the respective places of normative (binding) legislation and enabling legislation.

The prevention/freedom interface

When discussing legislation and prevention, it is important to tackle the above-mentioned topic (which was the focus of much attention in Switzerland in 1980, with regard to a referendum on the compulsory wearing of seat-belts). The question must be discussed from two standpoints at least, that of the freedom of the economy and that of individual freedom.

With respect to the freedom of commerce and industry, it is desirable to prevent health from being endangered by hazardous substances, devices, or vehicles. The fact should not be concealed that preventive measures may run counter to economic interests. There will be room for negotiation, but the outcome will be that attempts will be made to modify the product, the production method, and the commercial promotion for the product — tasks that are not without difficulty. One need only mention the obstacles encountered in regulating the sale of firearms in the USA and the political support enjoyed by tobacco growing and marketing in various countries through, inter alia, the medium of State-owned companies.

With regard to individual freedom, one may feel that the taking of risks should remain a more or less inalienable right, but one is quickly led to envisage borderline cases where the individual should not only refrain from presenting a risk for his fellow beings, but where it is extremely desirable that he should not expose his own health or life to excessive danger, in view, inter alia, of the potential costs involved, both hospital and social, a large proportion of which is borne by public money, even in countries with a liberal system of government. It should be noted that the argument of individual freedom is not one that can be used only against the advocates of more vigorous prevention. Indeed, one must also speak of the freedom to refuse: if one does not have the right to force people to adopt healthy forms of behaviour, it is equally necessary that there should not be excessive pressure in the opposite direction, incomplete information and advertising being used in order to take advantage of the public’s gullibility.
With respect to tobacco consumption, progress has been achieved by putting the emphasis on the rights of non-smokers. It was “discovered” that the right of the non-smoker not to be subjected to the harmful effects of tobacco was at least as great as that of the smoker to smoke out those around him. It should be noted, however, that certain “passive” smokers are not able to give effect to their rights. A particular case in point is that of the fetuses carried by women who smoke, whose state of health at birth will be decidedly inferior to that of the newborns of women who do not smoke. Subsequently, children who have to live in a tobacco-laden atmosphere will suffer more and more often than others from various disorders and allergies, particularly those of a respiratory nature. The rights of these children to a healthy environment may not be neglected. It should be remembered that one person’s freedom stops where another’s starts.

In concluding this section, we offer two illustrations of the prevention/freedom interface. One of these stands out today as being very, if not too, authoritarian. The other concerns the Tribunal fédéral, the Swiss Supreme Court, which accepted the legitimacy of compulsory preventive measures in the school environment:

— on writing the conclusion to a book on the history of prevention,\textsuperscript{12} we were struck by the limited attention that Dr Charlotte Olivier, an eminent pioneer in tuberculosis control in Switzerland, paid to what are today known as human rights. In 1917 she wrote: “The experience of a century has demonstrated that as soon as public health is at stake, particularly the health of children, nothing is more harmful than freedom. Constraint alone assures the health of the public”; further on, she continues: “In a State economy, the child is too precious a member for us to continue to abandon his physical development entirely to his parents”.\textsuperscript{13} Sensitivities then were not what they are today, to say the least!

— The Swiss Federal Tribunal recently defined the concept of health as being a public concern that justified the restriction of individual freedoms. Called upon to give a ruling on the compatibility of the Law of the Canton of Fribourg of 27 September 1990 on prophylaxis and school dental care with personal freedom, the Federal Tribunal considered that “State measures for the control of diseases have as their aim with respect to public interest the improvement of the health of citizens (‘public health’). Article 8(2) of the European Convention on Human Rights expressly sets aside measures in pursuance of this aim. It is a question of protecting the greatest number of people — if possible the entire population — from damage to their physical and mental health, and sometimes even of preventing a person from damaging his own health; these measures.
are thus aimed at improving the average state of health of the population ...'. It is striking to note the difficulty encountered by the Federal Tribunal in drawing the line between public interest and private interest in the health field. First of all, public health measures prove equally favourable where individual health is concerned. An immunization campaign prevents the spread of the disease and also directly protects the persons immunized. Secondly, such measures, if they are effective, make it possible to prevent the explosion of costs which, in the final analysis, is in everyone's interest.\textsuperscript{14}

**Promotion and cure: different contexts and imperatives**

Health promotion, as described above, does not mean "health indoctrination" and must not become so. Although a public health physician, the author is aware that a society that systematically made health its first priority (before, for example, the fundamental rights of the individual) would not be a healthy community: an "all health" society can become totalitarian. A promotional action implies, therefore, that one remains attentive to the autonomy of one's interlocutor.\textsuperscript{15,16,17} It is along these lines that Table 3\textsuperscript{14} highlights the different circumstances of the therapeutic relationship on the one hand, and advice with a motive function on the other.

In their summary of the principal concepts of ethics in the field of health, Bouvier and his colleagues draw attention to the existence of two major orientations, one utilitarian/consequentialist and the other deontological. Deontological approaches tend to give precedence to the moral obligations towards the individual vis-à-vis the interest of the community. One of the future challenges in the field of prevention is to assist in the search for better convergences than those of today between those who treat individual patients, who are all distinct and specific, and those whose mandate is more to be concerned with the "patient-community", namely, the community considered as a patient. In this latter respect, those responsible for public health also have the duty to ensure that resources are used in a manner that corresponds to the health priorities in the population and that is in keeping with the criteria of efficacy and efficiency (and not, for example, in accordance with the geographical or social accessibility — or political importance — of patients).

Attention should be drawn here to a problem that arises in numerous places with regard to preventive initiatives: it is often the social categories that are the best off that profit the most from the programmes offered. This is not necessarily the result of a deliberate intention, but the fact that the professionals who design
and run these programmes belong to the middle classes themselves contributes to the difficulty of reaching other social categories. This being so, a critical examination should be made of financing decisions, not only in terms of the scientific or technical qualities of the programmes, but also their potential capacity to attract the support and participation of members of disadvantaged or marginal groups. This corresponds to WHO’s concept of “positive discrimination”: those with the greatest needs should have access to more benefits. It is a question of equity as opposed to equality. Thus, it must be emphasized that, while there is an ethic governing the manner in which care should be provided to a person who is ill, there is also an ethic, with regard to the patient-community governing the appropriate (justifiable) use of the available resources. We are compelled to make both coincide as satisfactorily as possible.

Preventive and predictive medicine: the risks of discrimination

As techniques become more widely available and applied, it is necessary to be increasingly on the lookout for untoward side-effects. In addition to undesirable physical effects, there is the fear of the future stigmatization of those who renounce these means only to require, at a later stage, costly care that could, in principle, have been avoided by screening. Even if the spectre of such disapprobation is far from pleasant, situations will not always be straightforward. Thus, in the case of prevention and screening methods whose sensitivity, specificity, and acceptability are satisfactory, criticism of those who oppose them is not altogether out of place. These problems are indeed still hypothetical ones, but it is likely that they will arise. Today, it is important that we reflect on these problems, without seeking to formulate responses that would remain questionable and require detailed commentaries.

The attitude of the public authorities in cases where persons find themselves suffering from serious and costly diseases because they have refused preventive measures

May the community limit or withdraw its aid to citizens who make “bad” use of their freedom? One’s first impulse is to reply with a categorical “no”. However, the questions posed are not ones that have simple answers. It should also be noted that the law determines such limits in certain cases, such as maximum speeds, the wearing of a seat-belt, and the non-supply of alcohol and tobacco to children.
An initial case might be that of parents who refuse prenatal diagnosis in a situation where there is a high risk of disability (for example, in relation to trisomy 21). If an effective screening method exists, will society come to criticize parents who, by not using it, incur, as the result of their child's disability, avoidable costs for the community?

There are tests carried out at birth, in a simple manner, to detect a curable hereditary disease or one whose consequences may be alleviated through treatment. Thus, Guthrie's test makes it possible to detect phenylketonuria, a disorder the serious effects of which (mental retardation) are prevented by putting the child on an appropriate diet (one that is low in phenylalanine). Measures of the screening type are not always well received by parents today. What is one to think of parents who refuse the taking of the blood sample necessary for the Guthrie test and who, at a later stage, in addition to the distress of having a mentally deficient child, require considerable sums of money for the child's care? What can the physician, the health authority, and society do?

A similar case may arise with vaccinations. At present, compulsory vaccinations have become rare in our countries. Certain vaccinations are, however, strongly recommended and the public authorities cover the cost of the vaccine, parents retaining the right to refuse them. The diseases targeted (measles, mumps, rubella, poliomyelitis, diphtheria, whooping cough, and tetanus) may entail severe complications. Should those who pay in medicosocial matters be authorized, and under what conditions, to turn against the parents who refused to have their child immunized, if the latter has a serious disorder (which might have been prevented) and its sequelae?

We may also mention the possibility of reducing the disability allowances of patients who show that they are incapable of giving up the consumption of a product (alcohol or tobacco, in particular) that is the principal cause of their problems. From the standpoint of stimulating individual responsibility, which is an important factor, such decisions may seem justified. Even if their objective responsibility is clear, it must be admitted that these individuals are not entirely free in their choice. What criteria can be used to decide when such a reduction in an allowance would be acceptable?

Legislation should determine to what extent one has the right to derive benefit from one's personal, notably genetic, characteristics

The detailed knowledge of the human genome comes within the ambit of predictive medicine and scientists expect it to yield benefits in terms of
prevention. It nonetheless poses numerous problems to which insufficient thought was devoted before undertaking research programmes such as the Human Genome Project, launched in the USA in 1989. The danger against which safeguards must be installed at a sufficiently early stage is that the investigation of the genome contributes to the thrust towards a multi-gear community. Indeed, according to the logical operation of a liberal society, those who might be expected from youth to be the least likely to be ill (and consequently have, statistically, a more productive and longer professional life while costing less in health insurance) or to be the most intelligent, or again to be the least likely to exhibit deviant or disturbing behaviour, will be those preferred by those in charge of educational establishments, employers, or insurers, in particular.

A major question stands out in this context: is it acceptable to attempt to derive economic benefit from any one of our traits? Once again, what is at stake is individual freedom (which may be caricatured as “doing everything and anything”) as against a certain social interaction or solidarity. This is not surprising insofar as the major questions of political debate are: “How much freedom or how many freedoms? How much should be shared out and how much pooled?”.

With regard to the use that individuals might wish to make of good genetic mapping, limits should be laid down by, for example, the prohibition of the use of such information in order to obtain more favourable conditions in basic health insurance or with respect to contributions for public disablement insurance. In this connection, one could, theoretically speaking and indeed as part of the logic that the author wishes to dismiss, make the opposite request of persons who are unlikely to be very ill in their life, namely, that they pay higher contributions to the State pension scheme, since, statistically, they will benefit from it for longer. However, as with many of the ethical challenges that we must deal with, there is no clear-cut and categorical answer to the general question of whether one can derive benefit from one’s biological characteristics or use them on a commercial basis.

Let us take a few examples. Champion athletes use to their advantage what they are physically and mentally (without wishing to claim that their performances depend entirely on their genomes, the fact remains that, in addition to elements associated with training and culture in a broad sense, their genetic equipment plays a definite role). Leaving aside athletics on a purely amateur level, it is generally considered today that this is legitimate, and it is even considered normal that the artists who arouse the enthusiasm of their contemporaries should, as a result, enjoy material living conditions that are higher
than the average. Nearer to Mr and Mrs Average, is the case of the bouncer who is employed, among other things, because of his physical characteristics, which constitute an obvious advantage for the post that he occupies. This holds for many professions where physical strength, size, or sensory acuteness (such as eyesight) have an importance. Moreover, no one would dispute that an employer takes into account the intellectual skills of the candidates for a given post or that those in charge of universities endeavour to attract the most brilliant individuals to their establishments. To return to the insurance field, the medical examination of a life assurance candidate is a well-established practice and virtually inseparable from this line of business. Assessing the risks taken on in order to draw up the right policy and determine the right premium is of the essence of the profession. However, groups of insurers have abandoned certain examinations before preparing contracts up to specified amounts (there is a recommendation along these lines in Canada, up to an amount of 100,000 Canadian dollars). In the field of genetic testing, the history of insurance has begun (at the beginning of 1994, the French Federation of Insurance Companies adopted a moratorium of five years; a similar moratorium is in force in the Netherlands).

With a view to ensuring that our society retains a certain solidarity and a sufficiently humane character, it will be necessary to remove, by means of legal devices among others, the possibility that a good genetic identity card could be used in order to benefit from advantages that would be to the detriment of citizens who are biologically less fortunate: maintaining the principle of mutuality should be a priority concern in a number of fields.

An example: the place of legislation in the prevention of HIV infection

This pandemic has overturned generally accepted ideas. It has shed new light on the constellation of problems that may be associated with a communicable disease, particularly when the latter affects the intimate behaviour of private individuals. Moreover, it represents a major public health problem and it is logical that the question should arise as to the place of the actions of the public authorities in its prevention, in informative, pedagogical, or authoritative registers. Space does not permit a detailed presentation of this subject (which the author studied during the first decade of the pandemic and the general principles of which have not changed since), but the following comments provide an illustration.


Situations requiring specific legislation of the health control type

These are situations where, by means of a specific action that may be implemented under controlled technical conditions, it is possible to appreciably reduce or eliminate a risk of HIV infection. This is the case, for example, when a test is carried out for HIV detection on all blood donations and on all donors of organs, tissues, or cells (including sperm). Moreover, legislation may be promulgated in order to assure the quality of condoms offered for sale. In some countries, legislative or regulatory texts have been drawn up or existing ones amended in order to facilitate the availability of sterile syringes (freely sold in pharmacies or supplied in other places) to drug-dependent persons, who are exposed to a high risk of infection if they share or exchange equipment.

Situations that may justify official action or supervision

The question arises as to whether there are cases, in a State under the rule of law, where it would be legitimate to enforce binding legislation, authorizing, for example, measures against the will of the person concerned. In general, the mere fact of being seropositive to HIV does not constitute a contraindication to the practice of a health profession. In the context of the author’s own work, the health authority is not, as a rule, informed of such cases. However, the Cantonal Medical Officer (that is to say the responsible physician within the Cantonal Department of Health) may be consulted with regard to situations that present a problem, such as the case of a seropositive professional working in a high-risk sector (for example, in an emergency unit, an operating room, or in intensive care). According to circumstances, one might have to oblige such a person to choose a sector of activity involving a lower risk of contact with blood and the exchange of blood.

Another situation is that of the provision of information to the regular partner (within the framework of marriage or stable cohabitation) of a person diagnosed as seropositive. In France, medical confidentiality is absolute in nature, which means that professionals are not permitted to inform the partner. In Switzerland, on the other hand, the practitioner may, if he deems it appropriate, request to be released from medical confidentiality by a supervisory authority designated in each Canton. Such requests may be made if the seropositive patient categorically refuses that his partner be informed and if the physician considers that he cannot, from an ethical standpoint, refrain from informing the partner (the situation is particularly critical when the latter is also the patient of the physician, who must
thus assume a duty of diligence with regard to both members of the couple).

In both these cases which involve the taking of preventive measures in relation to a specific disease, it will be noted that it is general legal provisions that are implemented.

**Situations where legislation involving control has little or no place**

It is difficult to imagine that legislation of a mandatory nature could prove useful in preventing the risks of HIV infection through unprotected sexual relations, since the behaviour concerned is very private. It has often been pointed out that intentions along these lines might well run counter to the goal sought by forcing the persons who take risks to do so in greater secrecy. Thus, certain saunas are frequented by persons who have sexual relations under circumstances in which the taking of risks is not uncommon. It happens that such establishments are closed down, but such a measure only serves to move the problem elsewhere. We consider it important to establish contact with those who run such installations, with a view to optimizing access to the means of protection. A potentially effective measure is that of supervision exercised not by the public authorities but by an association that brings together these establishments. If, as in France, the saunas frequented by homosexual men strive to ensure that specific conditions are observed, a certain control may be obtained by awarding a label to establishments that conform to the required “good practices” (notably in terms of information and the availability of educational material and condoms).

Health education for children and adolescents, in schools in particular, will be developed preferably by including sexual education, contraception, and the prevention of other sexually transmitted diseases. Useful legislation will be that which allocates the appropriate resources, both human and material.

Another pillar of the control strategy in the sphere of HIV infection and AIDS is, as is the case in Switzerland, the promotion of solidarity in order to prevent the destructive social reactions of ostracism and rejection. Here again, it is not an attitude that is obtained by decree. It is interesting in this connection to bring up the idea of anti-discrimination laws, the possibility of which has been discussed with regard to persons living with HIV. The provisions of such laws should prevent the persons concerned from suffering disadvantages with respect to employment, accommodation, or access to various services. The problem that must be borne in mind is that a legal text on anti-discrimination, by the very fact that it must define the
group to be protected, sets the latter aside and may, therefore, lead to discrimination.

Prophylactic treatment in case of HIV infection: the will to prevent, the autonomy of the patient or his representatives, and law

As means become available that permit greater efficacy through intervention at an early stage of HIV infection, the practice of the test and the possibility that it may be refused, as well as the acceptance or otherwise of a treatment, take on increased importance. It is a question of reconciling the carer’s vocation of beneficence with respect for the patient’s autonomy (if and when information and persuasion remain ineffective).

What should be done in the case of a mother who is known to be HIV-seropositive and refuses to have her newborn child tested and, if necessary, treated?

The question is rendered all the more delicate by the fact that the decision is taken not by the person whose health is concerned, but by her legal representative. A number of points should be emphasized.

First of all, it will be noted that this mother had previously consented to being tested herself (gynaecologists generally offer their patients the HIV-detection test during pregnancy and it seems that this test is rarely refused). In the case of the newborn (or young child) for whom there are serious grounds for suspecting HIV infection, one may wonder whether it is possible to test and treat such a child against the wishes of his mother (or parents or legal representative). The situation frequently cited in this context is that of parents who are Jehovah’s Witnesses, who refuse blood transfusion and are also opposed to it as part of treatment dispensed to their children, even though such transfusion may be deemed indispensable by the physician. In such a case, one may envisage, indeed it is customary, requesting the tutelary authority (the Court of First Instance [Justice de Paix] of the Canton of Vaud) to temporarily restrict the parental authority of the parents in order to permit transfusion. There are, however, important differences between these two situations. Thus, refusing blood transfusion has, in the circumstances considered, dramatic consequences that are almost immediate. The outcome may even be death through massive haemorrhage, for example as the result of an accident. In the case of the refusal of the HIV detection test or an anti-HIV treatment, nothing as urgent is involved. Among other things, one can
always hope that, after several weeks or months, parents who are adequately informed will finally give their consent. While restricting or suspending parental authority is understandable where it is a case of removing an immediate risk to life, it is difficult to see, given current opinions, how suspension could be justified in the same way on the grounds of the refusal of the test or of an anti-HIV prophylactic treatment, since the negative consequences, although probable, remain relatively uncertain. It should also be remembered that efficacious treatments always entail the possibility of untoward side-effects, which may be considerable. This aspect is a weighty argument when considering the possibility of a treatment that the patient does not want. This brings us back to the essential dimensions of the therapeutic relationship, which are information, dialogue, and the possibility of convincing the patient by making him understand all aspects of the situation.

Children whose parents neglect medical monitoring and treatment

Although refusal is not explicit, the situations involved here are similar to the above-mentioned case. In concrete terms, the child does not benefit from the investigations or treatments that his condition demands from a medical standpoint. It should be borne in mind that, in principle, parents have the right to accept or refuse treatment for a child who is not yet capable of discernment. This also applies to implicit decisions. In serious life-threatening cases, the restriction or suspension of parental authority may be envisaged, in order to achieve a specific aim and, in principle, on a temporary basis. Could the fact of not presenting one’s child for monitoring in connection with HIV be considered as grounds for such restriction? Such a decision by the tutelary authority would be rendered all the more questionable by the fact that it would probably cover a long period. Except in the case of a child suffering from ill-treatment or negligence, preventing parents from living with their child would be a disproportionate response; furthermore, if they live with him, it is difficult to see how they could be forced to take him for medical consultations. The spirit of the times no longer permits us to contemplate doing this by force. The solution must again be sought in the emphatic provision of information.

The refusal of parents or legal representatives to allow a child capable of discernment to be tested, informed, or treated

A situation described to the author is that of a foreign adolescent of about 15 years of age who came to join his family in Switzerland. An HIV detection test
revealed that he was seropositive, although he was not informed of the nature of this test. The adolescent's seropositivity was announced to the father, who was against informing his child. What should the physician do? Note should be taken here of the strictly personal nature of the right, freely exercised by the person capable of discernment and by that person alone, to accept or refuse medical care. In Switzerland, there is no established legal standard with regard to discernment, but according to the predominant legal doctrine, a person is presumed to acquire the power of discernment at 14 or 15 years of age (or even younger, according to circumstances). Minors may, therefore, request or refuse a treatment without their parents' knowledge or against their wishes. From the medicolegal and medicoethical standpoints, it follows that the attending physician has the same duty to provide information (laid down, for example, by Section 21 of the Law of 29 May 1985 of the Canton of Vaud on public health\(^6\)) in the case of a minor capable of discernment as he has in the case of a person of full age. He is thus required to inform the young patient in a comprehensible and sufficiently comprehensive manner. It also follows that he is authorized to accept the therapeutic instructions of this young person under the same conditions that apply in the case of a person of full age. As far as possible however, one must endeavour to find, with respect to the human dimension and the relationships involved, the means of providing adequate information to parents or legal representatives, thereby ensuring that the child's progress is followed in an atmosphere of partnership and consensus.

A tough question: can one restrict or modulate information “for the good of others” with the aim of promotion?

This is a temptation that exists where the objective is to convince the public (or a particular target group) that it should modify behaviour that is detrimental to health. The general principle must be that of transparency, but this is not without difficulties. With regard to sexual relations and the risk of HIV infection or AIDS, a topic that is often taken up with young people, the available scientific data indicate that, statistically, the risk of being infected during an unprotected heterosexual encounter with a seropositive person is less than one in a hundred. If one takes account of the fact that the probability of seropositivity in a new partner who is not well known is of the same order, one sees that the risk of being infected by HIV during the course of a given sexual encounter is very low. From the prevention standpoint, one may fear that the motivation of young people to protect themselves through the use of the condom is considerably reduced if they
have these facts in mind. Given that in the case of tobacco dependence, it is known that not all smokers develop bronchial cancer or emphysema (even if all are aware of the deterioration of their physical condition), one may wonder whether this fact should be emphasized and percentages given. In the case of alcohol abuse, should the fact be discussed that police controls do not necessarily catch all drunken drivers or that certain of these drivers, owing to the tolerance they have acquired, have been able to drive for long periods without accident despite blood alcohol levels over the legal limit? In practical terms, the author’s attitude is that one should certainly not lie, but at the same time one should not indulge spontaneously in a detailed discussion of such statistical probabilities. His position is the same vis-à-vis contacts with representatives of the mass media. Moreover, it is doubtful whether the preventive effect would be enhanced by providing explanations based on the points in question (account also being taken of, for example, time constraints or the space devoted to the printed messages that the intended readership is likely to study attentively).

Conclusion

Health promotion and prevention are of particular interest from the standpoint of health legislation insofar as their objectives are pursued by different methods and the role of legislative action is varied. In its normative or binding form, legislation has its place when it is a case of protecting the individual against hazards over which he has no control, particularly if the latter may be removed by technical measures (for example, the control of water and foodstuffs, the control of pollution and other hazards associated with the environment, various aspects of road accident prevention, and mandatory vaccinations or screening in certain cases). At the other end of the continuum, there is the domain of health promotion (which may be termed “active prevention”, from the individual’s point of view), where it is enabling legislation that is particularly useful, namely, legislation that permits programmes to be established (financing or the creation of services). This is the case with actions concerned with health education, nutrition, sexuality, road traffic, or substances that are harmful to health.

These considerations are particularly relevant in view of the ever-increasing emphasis placed on the importance of obtaining the patient’s informed consent before any steps are taken to provide care. Anyone who wishes to work in health promotion, whether in the context of the public authorities or that of individual professionals, should pay particular attention to the autonomy of individuals, since it should be recalled that, in this field, people often do not make active demands
because they are not ill (or at least they do not feel ill). This in no way detracts from the need to make extra efforts in the fields of promotion and prevention. Such efforts must clearly satisfy the requirements of the provision of information to, and dialogue and partnership with, those to whom services are offered.

We have tackled the issues raised by the new field of predictive medicine, which is often conceived with a preventive intention. With regard to the study of the human genome, certain developments could, if safeguards (particularly legislative ones) are not put in place, give rise to undesirable, indeed unacceptable, forms of discrimination. Here is an example of biomedical advances that are potentially detrimental to equity. This major theme was discussed by the Council for International Organizations of Medical Sciences (CIOMS) at a Conference in Geneva in March 1997, devoted to ethics, equity, and the renewal of WHO’s Strategy of Health for All. Generally speaking, medicine has until now considered it judicious to do whatever produces positive effects, without worrying too much about who benefits from these effects. Physicians have not really been prepared for this kind of reflection by their training. In this day and age however, one cannot deny that it is highly probable that, if this principle is followed, necessary services will be provided to a single segment of the population, since this segment is close to the health system and because, for reasons of cultural and social homogeneity, relations with it are easy. At the same time, other groups may be left with inadequate care, or even without care, as is the case in, for example, the USA. In the author’s view, even if it means that resources are usefully and effectively employed, their preferential distribution for the benefit of one sector of the community alone is unacceptable. Even if overall efficacy is less, it is ethically preferable to assure the equitable distribution of resources, and thus health care, to the community as a whole. It is nevertheless a fact that, even in a relatively prosperous and homogeneous country such as Switzerland, we are frequently faced with a situation where money attracts money (we are, of course, speaking here of access to care and not material means). This is obviously a serious concern where legislation must use a variety of methods, including promotion and prevention, to protect the underprivileged and those who run the risk of marginalization or exclusion.
# Table 1: Prevention, in the Name of Which Values?

<table>
<thead>
<tr>
<th>VALUES/OBJECTIVES</th>
<th>COMMENTS</th>
<th>RISKS</th>
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<tbody>
<tr>
<td>Individual health</td>
<td>Right to endanger oneself</td>
<td>&quot;Helping people against their will&quot;</td>
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<tr>
<td>Family health</td>
<td>Legitimacy of preventing adverse effects on family members, especially the weakest</td>
<td>Interference in family life</td>
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<tr>
<td>Public health</td>
<td>Aims generally accepted and valued (collective well-being)</td>
<td>&quot;All health&quot; society (health tyranny)</td>
</tr>
<tr>
<td>Healthy society</td>
<td>Desirable, modern</td>
<td>&quot;Blame the victim&quot; (make him carry the responsibility for his health problems)</td>
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<tr>
<td>Granting individuals autonomy (Active prevention)</td>
<td>&quot;Positive discrimination&quot; (WHO)</td>
<td>Negative discrimination</td>
</tr>
<tr>
<td>Improvement of the chances of the least favoured</td>
<td>Desirable</td>
<td>It is often the middle classes that benefit most from the offers made</td>
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<tr>
<td>Equity, solidarity</td>
<td>Desirable, necessary in principle, but sometimes illusive</td>
<td>Inequitable/discriminatory rationing of care in the event of illness</td>
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<tr>
<td>Economy (limiting disease-linked expenditure)</td>
<td>Everyone is in favour of prevention (in principle)</td>
<td>Non-relevant actions, wastage</td>
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<td>Political challenges, possibly professional challenges</td>
<td>Popular demand</td>
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<td>TABLE 2. LEGISLATION AND HEALTH</td>
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<tr>
<th>No legislation (only exceptionally)</th>
<th>Enabling legislation (financing, organization)</th>
<th>Binding legislation</th>
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<tr>
<td>Private sphere</td>
<td>Health promotion</td>
<td>Health professions</td>
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<td>Leisure</td>
<td>Health education</td>
<td>Health establishments</td>
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<tr>
<td>Sports</td>
<td>(including programmes in the community)</td>
<td>Pharmaceutical products</td>
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<td>Illegal drugs</td>
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<td><strong>Self-help</strong></td>
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<td><strong>Prevention</strong></td>
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<td><strong>primary</strong></td>
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<td><strong>active</strong></td>
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<td><strong>passive</strong></td>
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<td></td>
<td><strong>Occupational medicine</strong></td>
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<td>School health/Maternal and child health care</td>
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<td><strong>Immunizations - Communicable diseases</strong></td>
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<td></td>
<td>Iodization/fluoridation</td>
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<td><strong>Potentially hazardous substances (for example, alcohol, tobacco)</strong></td>
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<td></td>
<td>Production, taxation, trade, advertising</td>
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<td><strong>Foodstuffs</strong></td>
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<td>Water supply</td>
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<td>Sanitation</td>
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<td>Toxic substances</td>
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<td>Industrial hygiene</td>
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<td><strong>Protection of the environment</strong></td>
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<td>Pollution (air, water, soil)</td>
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<td>Noise</td>
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<td>Ionizing radiations</td>
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<td>Town and country planning - urban development</td>
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<td>Road traffic: speed limits, protective devices,</td>
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<td>control of exhaust emissions</td>
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<td></td>
<td><strong>Screening and biological monitoring in</strong></td>
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<td></td>
<td>occupational medicine — screening for</td>
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<td></td>
<td>hereditary and congenital disorders</td>
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<td></td>
<td><strong>Tertiary prevention</strong></td>
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<td></td>
<td>Personal assumption of care (self-help)</td>
<td>Medical rehabilitation</td>
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<td>Involuntary admission (psychiatry)</td>
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### TABLE 3. PROMOTION AND CURE: DIFFERENT CONTEXTS AND IMPERATIVES

<table>
<thead>
<tr>
<th>HEALTH PROMOTION</th>
<th>CARE OF DISEASE ONCE ESTABLISHED</th>
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<tbody>
<tr>
<td>Sets out to take &quot;upstream&quot; action (while the damage that gives cause for concern is not yet visible)</td>
<td>Repairs &quot;downstream&quot;: the damage is obvious</td>
</tr>
<tr>
<td>Deals with persons who are &quot;on their feet&quot;, independent, and whose functions are not (yet) impaired</td>
<td>Addresses patients &quot;in bed&quot; (whether literally or figuratively), who are dependent and suffer dysfunction</td>
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<tr>
<td>Necessitates the participation of the individual, and changes in his habits</td>
<td>The patient's participation is (often) secondary or even not required (acute disorders or traumatisms)</td>
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<tr>
<td>No specific emphasis, overall approach (lifestyle)</td>
<td>Targets a specific disorder/organ</td>
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<tr>
<td>Is multisectoral and intersectoral. Accordingly, it may affect the interests of various socioeconomic sectors, thus giving rise to political challenges</td>
<td>Operates within the medical and health sector</td>
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<tr>
<td>Also occupies a place in the community in general</td>
<td>Operates within a care facility (consulting room, hospital) or in the patient's home</td>
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<tr>
<td>Seeks to create broad sociocultural support (public attitudes)</td>
<td>May do without such support</td>
</tr>
<tr>
<td>Sometimes raises ethical issues in connection with individual freedom</td>
<td>Raises fewer such issues (the patient is clearly the client)</td>
</tr>
</tbody>
</table>
REFERENCES


13. See supra ref. 10, at p. 75.


SUPPLEMENTARY BIBLIOGRAPHY


Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
While history may be marked by developments that are evocative of romance, the events themselves are of a dimension and gravity incommensurate with the happy or unhappy love affairs experienced by two human beings. This is the case with the protection of health and the protection of the environment. Their story could be summed up in a few words: they began by ignoring each other before realizing how important they were for each other and how much they had in common. They were originally local in nature, but have now gone beyond national and regional confines and attained a dimension that is often on a

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planetary scale. Finally, they have discovered that they are an inseparable couple.

Put more precisely, if not scientifically, we should recall that the origins of health legislation — even if it has not always gone under this name — go back a long way. At first fragmentary and local, then gradually becoming national, regional, and partially worldwide in the 19th century, health legislation did not really become universal until the end of the Second World War, when it experienced a form of institutionalization with the creation of the World Health Organization. Its approach is now a systematic one, endeavouring to cover all aspects of human health, from the implementation of the right to health to specific actions with worldwide or regional implications. Similarly, in responding to symptoms, it tackles the source of diseases and other problems that have an effect on health. In so doing, it converges with the law of the environment.

The protection of the environment, through legal means in particular, has developed in much the same way, albeit with something of a time lag. Starting from specific measures for the protection of spring waters or air in the urban environment, it has extended its action to include forests, sea fisheries, and also certain aspects of the protection of wild fauna and flora. However, the legislative measures taken in this context served a function other than the protection of the environment as we understand it today: their purpose was above all to benefit specific human activities — hunting, fishing, ship-building — while safeguarding natural resources which, moreover, were not yet designated as such. The environmental aim properly speaking, that is to say the protection of the environment for its own sake by virtue of its intrinsic value, only goes back as far as the 1960s. Unlike health legislation, regulation aimed at protecting the environment very quickly found a place at international level, both regional and worldwide. This difference in the process of development can be explained by the delay experienced by the protection of the environment compared with the protection of health. The awareness that our living environment was in danger dawned at a time when the international dimension of the major problems confronting humanity had begun to predominate: the “global village” had become a tangible reality in everyday life.

Admittedly, the convergence between human health and the environment was not obvious to everybody, at least not at the beginning. It should not be forgotten that the prime objective of the protection of the environment was the safeguard of nature, understood essentially as wild nature. The discovery of the problems of pollution affecting the oceans, continental waters, and the atmosphere, now considered as natural resources — thus as elements perceived as being in a relationship with man — has broadened the horizons and fields of action of
environmental protection. The dispute concerning the anthropocentric or ecocentric aims of environmental protection has somewhat obscured development towards global, long-term concepts, which would inevitably result in a recognition of the convergencies between environmental protection and the protection of human health. Finally, certain ecological disasters, notably the Chernobyl and Bhopal accidents, have demonstrated to the general public the impossibility of separating the two fundamental areas where action is essential: the protection of health and the protection of the environment, particularly in terms of regulatory action.

It should be noted that convergence was often an established fact. The rules of Ancient Greece protecting spring waters or those of the Middle Ages that condemned those polluting the air of towns may be regarded as forerunners in these two fields. The same is true of the national laws formulated at the beginning of the 19th century concerning buildings that are unhealthy, used for noisy or noxious purposes, or constitute hazards. These laws have since been redrafted by many countries, as well as by the European Community and a certain number of developing countries, the objective being to make certain activities subject to authorization, particularly those that are likely to affect health. Today, these laws are considered to be pillars of environmental protection. Conversely, in certain countries (Ireland, Italy, and the United Kingdom, etc.) until recently, a more or less important part of environmental protection was still based on health laws. Finally, more recent texts on environmental protection explicitly mention human health among the objectives to be safeguarded.

A decisive step was taken at the end of the 1980s with the fusion between environment and development, given that health problems have long been considered as constituting an aspect of development and, more particularly, the fight against poverty in the world. Principle 1 of the Declaration adopted by the United Nations Conference on Environment and Development (Rio de Janeiro, 3-14 June 1992), in affirming that human beings are at the centre of concerns for sustainable development — a concept that expresses the integration of the environment and development — thus seals the alliance between preoccupations and measures concerning, on the one hand, human health and, on the other, the environment.

These preoccupations and the corresponding measures — particularly legislative ones — that are intended to meet them complement each other in a certain number of fields. It is to this aspect that I intend to devote particular attention before discussing some of the techniques likely to be implemented in
order to assure cooperation between health activities and environmental protection.

I. Fields of common interest for health and the environment

At first sight, it appears that environmental legislation, both national and international, makes a distinction between, on the one hand, the control of pollution and, on the other hand, the protection of nature and animal and plant species in a wild state.

It is natural that pollution control should have given rise to a coming together of health legislation and environmental legislation. The approach on both sides is similar: it consists in the juxtaposition of two legal methods. The first entails the protection of the sea, continental waters — watercourses and lakes — and the atmosphere against pollution. The second entails an attack on pollutants themselves, principally the products of human activities and, sometimes, certain of these activities themselves.

In the case of the pollution of the sea, both domains join forces in order to assure the cleanliness and hygiene of beaches, as well as the safety from the health standpoint of food resources obtained from the sea: fish, shellfish, and crustaceans. All pollution of the sea may in effect present a health hazard, either directly or indirectly. This is the case, in particular, with the dumping of waste at sea and especially pollution from land-based sources, that is to say wastes or other matter directly discharged into the sea from the coast or transported by watercourses.

One of the most clear-cut examples of the convergence between health and pollution problems is the freshwater sector. WHO has targeted its activities in this field in order to promote the supply of drinking-water to the broadest possible sector of the world population, to prevent pollution by wastewater, by fertilizers, and more particularly by certain chemical substances such as synthetic organic materials, fluorine, arsenic, lead, nitrates, and pesticides, and to control certain diseases associated with the poor quality of water (malaria, dengue fever, schistosomiasis, etc.).

International instruments concerning continental waters, which are considered as belonging to the law of the environment, show a certain amount of variety. Some of them envisage the use of international watercourses in general terms, by advocating an equitable sharing out of the resource and the prevention of pollution within the framework of cooperation between the States Parties. This is the case with recent instruments having universal, regional, or subregional
applications. Thus, Article 21(2) of the United Nations Convention on the Right to Use International Watercourses for Purposes Other Than Navigation, adopted on 21 May 1997 by the United Nations General Assembly, is aimed at preventing, reducing, and controlling “the pollution of an international watercourse likely to cause significant damage to other states of the watercourse or to their environment, including damage to human health and safety”. At regional level, the Convention of 17 March 1992 for the Protection and Use of Transboundary Watercourses and International Lakes (the Helsinki Convention), drawn up within the framework of the United Nations Economic Commission for Europe, includes in the definition of “transboundary impact”, which is to be prevented, controlled, and reduced, “effects on human health and safety” (Article 1(2)). Finally, the Convention of 19 June 1994 on Cooperation for the Protection and Sustainable Development of the Danube (the Sofia Convention), a subregional instrument, includes in the definition of hazardous substances materials having toxic, carcinogenic, mutagenic, or teratogenic effects or producing bio-accumulation (Article 1(d)). Legal measures are to be adopted in order to control the discharge of materials into the Danube and its tributaries (Article 5). Industrial sectors and the substances and groups of hazardous substances are listed in Annex II to the Convention: the principal selection criterion adopted is evidently the effect that these substances have on human health. A Community Directive of 4 May 1976 concerning pollution in the aquatic environment of the Community and the Convention of 3 December 1976 on the protection of the Rhine against Chemical Pollution (the Bonn Convention) had already prepared the way in this direction, although they only took account of polluting substances and did not include activities likely to constitute a hazard. The same concerns are present in other instruments of the European Community: Directives concerning discharges of mercury, cadmium, and hexachlorocyclohexane, etc. Many countries have also regulated the discharge of certain hazardous substances into water. In certain cases, the regulation of discharge into the water has been supplemented, and sometimes even replaced, by another method — the determination of water quality objectives. However, such quality may only be determined in relation to the uses to which the water is to be put. Accordingly, a series of European Community Directives have been adopted in which water quality criteria are based on specific health considerations. These concern: surface water intended for the production of drinking-water, water intended for human consumption, bathing water, fresh waters suitable for supporting fish life, and shellfish waters.

A third sector of pollution control is the control of air pollution. The threats
inherent in this form of environmental deterioration were initially perceived as an essentially local problem. Air pollution in conurbations and industrial areas is central to WHO’s concerns: it places particular emphasis on the health consequences of pollution caused by means of transport, energy production, and major industrial plants that require considerable energy consumption.\textsuperscript{26}

Concurrently with this approach, the law of the environment considers the problem of air pollution from an essentially national standpoint within the context of national legislation.\textsuperscript{27} While the rules applicable in this matter often derived from general legislation aimed at protecting the environment,\textsuperscript{28} a certain number of countries have also adopted special regulations in order to control air pollution, in certain cases directed at specific installations or activities.\textsuperscript{29} It is quite clear that all these rules have as their primary — if not exclusive — aim the protection of human health.

However, certain emissions of pollutants have been regulated not only by the internal legislation of different countries, but also by international conventions. This is the case with sulfur dioxide, nitrogen oxide, and volatile organic compounds whose emissions and transboundary fluxes should be reduced in pursuance of the Geneva Convention of 13 November 1979 on Long-range Transboundary Air Pollution, and its Protocols.\textsuperscript{30} The reduction of emissions of these pollutants is among the objectives to be attained by WHO for specific areas. International regulation concerning the protection of the stratospheric ozone layer, which bans chemical substances that destroy ozone molecules at very high altitude,\textsuperscript{31} corresponds to the concerns expressed by WHO with regard to the effects on health of the increased intensity of ultraviolet radiation on the surface of the planet.\textsuperscript{32}

In addition to the protection of certain sectors of the environment against pollution, the law on the environment also includes an important aspect concerned with a fourth sector: the protection of wild flora and fauna, which since the Rio de Janeiro Conference has been extended to embrace the protection of biological diversity in its entirety. This last sector could prove highly profitable for human health, if only because of the possibility of using existing or yet to be discovered animal or plant substances as medicaments. It would be useful for WHO to explore this field, if it is has not already done so.

National, regional, and universal legislation aimed at protecting the principal sectors of the environment, however indispensable it might be, has its limits. In the first place, each sector is not a watertight compartment: the pollution of rivers sooner or later affects the sea; that of the air is either deposited directly on surface waters — seas, watercourses, and lakes — or affects aquatic environments.
after it has been deposited on the soil. Secondly, certain substances may pollute all media at the same time or move by themselves, or even be intentionally transferred, from one medium to another. Finally, polluting substances and activities may themselves be exported, particularly to countries that do not possess sufficiently rigorous environmental legislation. It is, therefore, necessary to launch an attack on the polluting substances themselves by means of across the board legislation applicable to all sectors that must be protected.

In the law of the environment, the first texts on potentially polluting or dangerous substances dealt with the information to be communicated with regard to their possible effects on the environment and on health and safety, as well as restrictions on the marketing and use of certain dangerous substances and preparations. However, pending a new order, no compulsory rule of universal application has been adopted, except in the context of regulating the transportation of hazardous substances by road, rail, sea, river, or air. Thus, the matter is above all governed by national rules, often inspired by principles formulated within international organizations, as well as by codes of good practice devised by professional organizations. At universal level, it is essentially the transboundary movement of hazardous wastes and their disposal that are subject to regulation, owing particularly to the Basel Convention of 22 March 1989 on the Control of Transboundary Movements of Hazardous Wastes and their Disposal. This instrument establishes a close link between the threats and risks that may be constituted by hazardous wastes and emphasizes the need to protect human health and the environment against the hazards that such wastes represent. Annexes I (Categories of wastes to be controlled) and III (List of hazardous characteristics) to this Convention are largely based on health criteria. It should be noted that, in accordance with the position adopted by WHO, clinical wastes deriving from medical care dispensed in hospitals, medical centres, and clinics are at the top of the list of the categories of wastes to be controlled.

It should also be noted that there are numerous points in common between the law of the environment and health law with regard to dangerous activities and the prevention of accidents. The Seveso accident led the European Community to adopt a Directive aimed at preventing major accidents likely to be caused by industrial activities and the Chernobyl nuclear disaster provided the incentive for States to draw up two Conventions on, respectively, the early notification of a nuclear accident and assistance in the case of a nuclear accident or radiological emergency.
II. Legal principles and techniques

In its Chapter 6 (Protecting and promoting human health), Agenda 21 proposes the basis for action, objectives, and activities for reducing risks to health caused by pollution and ecological threats. The general objective is to limit these risks to a minimum and preserve the environment at a level that does not endanger human health and safety and which encourages development. All the activities proposed in Section 6.41 for attaining this objective entail the development of appropriate pollution control technologies.

It is obvious that such technologies inevitably have legal aspects. Before reviewing them, it is appropriate to recall the two principles that constitute the very foundation of current environmental law and health legislation, namely, the principles of prevention and precaution. The first requires pollution to be controlled at the source of emission — or that epidemics and other diseases be tackled by means of preventive measures and care. The second, formulated more recently and enshrined in Principle 15 of the Rio Declaration on Environment and Development, imposes the obligation, even in the absence of full scientific certainty, of taking effective measures to prevent environmental degradation where there are threats of serious or irreversible damage.

To these two basic principles should be added two others concerned equally with the protection of health and the environment: the need to provide specialized training (capacity building) and to disseminate ample information to the general public. On this last point, it will be recalled that Principle 10 of the Rio Declaration proclaimed that “at the national level, each individual shall have appropriate access to information concerning the environment that is held by public authorities, including information on hazardous materials and activities in their communities”. The examples cited above with regard to hazardous substances and industrial accidents demonstrate that this requirement is often present in environmental rules. It may be added that a genuine right of the public to information is in the process of emerging in environmental law.

Both fields, health law and the law of the environment, have developed techniques that could be mutually advantageous. Thus, the law of the environment has developed and generalized impact assessment procedure, thereby making it possible to evaluate the environmental risks of projects on a major scale. Starting at national level, this legal technique rapidly became widespread and was used not only by national legislation, but also by the European Community. It was even advocated by Principle 17 of the Rio Declaration. In international law, it was the subject of a special convention on environmental
impact assessment in a transboundary context (Espoo, Finland, 25 February 1991), which is not without relevance for human health. The activities subject to the assessment procedure, which are listed in Appendix I, are often those likely to have harmful effects on human health and the general criteria for determining the extent of the environmental impact of activities not included on the list in Appendix I include the serious effects on human beings referred to in Appendix III. One may also mention the legal techniques, such as the best available technique, or the best environmental practices recognized and used by certain instruments of environmental law, whose extension to the field of health law could well be envisaged.

WHO, for its part, has adopted standards which, are either used directly by instruments to protect the environment or serve as references or models for the latter. The legislative texts on the pollution of continental waters referred to above may serve as an illustration in this respect. Finally, WHO's system of alert with regard to epidemics should have its counterpart in the field of environmental protection, since the latter only possesses compartmentalized networks in the various sectors whose effects often do not go beyond national or regional confines.

Conclusions

At the end of this rapid survey of health and environmental legislation, one is struck by the large number of convergencies between the two fields, which are closely linked by their very nature. Often, the rules of one are applicable in part to situations encompassed by the other field and may contribute to a reciprocal development by providing models for rules or legal techniques. Nor should it be forgotten that both fields now form part of the concept of sustainable development, a concept that constitutes a common objective for a policy of development, health, and the environment.

However, on this last point, it has to be admitted that there is a fundamental difference between the protection of the environment and the protection of human health. Thanks to States' clear-sightedness, health has benefited since 1948 from the presence of an organization that is international, universal, and independent, but supported by the United Nations Organization and other specialized agencies of the United Nations system. It may, therefore, formulate a coherent policy, adopt plans for integrated health protection, and plan long-term actions. Such is not the case for the environment, which sadly lacks a comparable organization capable of centralizing the policies implemented in different sectors and different
regions. One should in no way ignore or fail to appreciate the genuine value of the efforts undertaken and results obtained by the United Nations Environment Programme, the catalyst body, and by the Commission on Sustainable Development, but their means — in all senses of the term — are far from equal to those of the major specialized agencies and are not adequate for the formulation of policies — or better still, a single long-term policy whereby progress can be made towards integrated protection of the environment. Given this shortcoming, it is not by chance that all major world conventions have equipped themselves with their own institutional structures enabling them to function efficiently, albeit at the risk of creating divergences and duplication of effort. It is here that the convergence between the two fields comes to an end and it is here that one of the major difficulties arises when it comes to implementing a world policy of sustainable development.
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4. The Public Health Act 1878.


7. CHINA: Presidential Decree of 26 December 1989 promulgating the Environmental Protection Law of the People’s Republic of China (Sec. 1) (IDHL, 41(3): 499-503 (1990)); CONGO: see supra ref. 3 (Sec. 1); GUATEMALA: Decree No. 68-86 of 5 December 1986 promulgating the Law on the protection and improvement of the environment (Sec. 7) (IDHL, 40(1): 208-211 (1989)); GUINEA: see supra ref. 3 (Sec. 3(1)(ii)); LIBYAN ARAB JAMAHIRIYA: Legislative Act No. 7 of 1982 on environmental protection (Sec. 1) (IDHL, 37(2): 337-342 (1986)); and MALTA: the Environment Protection Act, 1991 (Sec. 2(f)) (ibid., 43(1): 154-155 (1992)).

8. See, for example, Council Directive No. 76/160/EEC of 8 December 1975 concerning the quality of bathing water, the provisions of which are applicable both to freshwater and seawater (IDHL, 27(4): 709-717 (1976)).


10. See, for example, the Convention of 1972 on the prevention of marine pollution by dumping of wastes and other matter (the London Convention). The dumping of
the substances and matter listed in the Annexes is prohibited or regulated essentially by virtue of the hazards that they represent to human health.

11. See, for example, the Convention of 22 September 1992 for the Protection of the Marine Environment of the North-East Atlantic (the Paris Convention), Article 3 and Annex I (Article 3(a)) of which together provide for the prevention and elimination of the use of toxic substances from land-based sources likely to give rise to bio-accumulation (IDHL, 44(1): 112-116 (1993)). See also WORLD HEALTH ORGANIZATION. Health and Environment in Sustainable Development, Five Years After the Earth Summit. Geneva, WHO, 1997, p. 55.

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25. *Supra* ref. 9.

26. *Supra* ref. 12, at pp. 81-90.

27. See *supra* ref. 20, at pp. 367-373. For non-European countries, see also GUINEA: *supra* ref. 3 (Section 41); LIBYAN ARAB JAMAHIRIYA: *supra* ref. 7 (Section 13); and MEXICO: *supra* ref. 3 (Section 110).

28. See *supra* ref. 20, at p. 367.

29. See *supra* ref. 20, at pp. 368-371.


32. *Supra* ref. 12, at pp. 125-126.


36. *Supra* ref. 12, at p. 95.
37. *Supra* ref. 12, at p. 67.


40. See, for example, Council Directive 90/313/EEC of 7 June 1990 on the freedom of access to information on the environment (*Official Journal of the European Communities, No. L 158, 23 June 1990, p. 56*). A statement on access to information and participation by the public in the field of the environment was adopted in Sofia on 25 October 1995 by the Pan European Conference of Ministers of the Environment. Negotiations are currently under way to convert it into a treaty. The European Charter on Environment and Health, adopted in Frankfurt in 1989, also affirms that all individuals should have the right to information and consultation with regard to the state of the environment.


42. See the Rio Declaration, Principle 17: “Environmental impact assessment, as a national instrument, shall be undertaken for proposed activities that are likely to have a significant adverse impact on the environment and are subject to a decision of a competent national authority” (*IDHL*, 43(3): 666-669 (1992)).

43. See *supra* refs. 14-23.

44. *Supra* ref. 12, at pp. 177 et seq.

*Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.*
HEALTH LEGISLATION AND COMMUNICABLE DISEASES:
THE ROLE OF LAW IN AN ERA OF MICROBIAL THREATS

"Everybody knows that pestilences have a way of recurring in the world", wrote Albert Camus in his 1947 novel The Plague, "yet somehow we find it hard to believe in ones that crash down on our heads from a blue sky. There have been as many plagues as wars in history; yet always plagues and wars take people equally by surprise". During the mid-twentieth century, dramatic developments led many to conclude that the era of contagium was coming to a close. Smallpox

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was eradicated, polio was curbed, and cases of tuberculosis markedly declined in Europe and North America.

Microbial threats, however, continue to emerge, and re-emerge. "During the past twenty years, at least 30 new diseases have emerged to threaten the health of hundreds of millions of people. For many of these diseases there is no treatment, cure, or vaccine and the possibility of preventing or controlling them is limited." HIV/AIDS, first discovered in 1981, is now a pandemic that reaches every corner of the earth. A fresh outbreak of Ebola, one of the most virulent infections known to humankind, recently occurred in the former Republic of Zaire. Diseases that were once presumed under control — such as cholera, dengue, and yellow fever — are now pervasive. Tuberculosis was declared a global emergency by WHO in 1993. In the 1997 World Health Report, the Director-General wrote, "We dare not turn our back on infectious diseases for they will return with a vengeance if we do". Indeed, infectious diseases remain the world's leading cause of death. Over one-third of all deaths worldwide in 1996 were due to communicable diseases.

A confluence of social and ecological factors has spawned an era of microbial threats: (i) population growth, urban migration, and overcrowding in the congregate settings of prisons, homeless shelters, mental institutions, nursing homes, and child care centers facilitate person-to-person transmission of disease; (ii) international travel, migration, refugee movement, and commercial transport of goods and animals allow disease to move across State, national, and regional boundaries; (iii) war, poverty, malnutrition, homelessness, poor sanitation, an aging population, and the global spread of HIV infection and tuberculosis result in increased immunosuppression and susceptibility to disease; (iv) risk behaviors such as unprotected sex and sharing of drug injection equipment provide efficient modes of disease transmission; (v) changes in the ecosystem — such as deforestation, flood, drought, and climatic warming — alter natural environments and increase human exposure to insect vectors and animal reservoirs; and (vi) widespread use of broad spectrum antimicrobial medication cultivates new forms of drug-resistant organisms.

The public health infrastructure, both nationally and globally, is ill-prepared to curtail future epidemics. The current surveillance system lacks the means to recognize, monitor, and react to disease outbreaks during the earliest stages. Moreover, the capacity for laboratory work, screening, reporting, and research is deteriorating. Developing countries often lack the infrastructure — including trained scientists, laboratories, reporting systems, and basic infection control techniques and equipment — to prevent or detect disease outbreaks, or to contain
localized epidemics before they erupt in other geographic areas. International support for a global programme to monitor emerging diseases promises to benefit all peoples.\textsuperscript{20}

Compared to the pressing concerns of the public health system, the role of law in an era of microbial threats is less often discussed.\textsuperscript{21} Scrutiny of the legal framework may not pose the same urgency as does the need to improve the public health infrastructure or to increase public health resources. Communicable disease law, however, contemplates core and consequential issues: the responsibilities of individuals, the duties of the State, and the obligations of international health agencies to act for the health of a global society. This article defines the discipline of communicable disease law, reviews the role of WHO in fighting communicable disease, and discusses international law used to control infectious diseases and safeguard human rights.

The discipline of communicable disease law

Communicable disease law is deeply rooted in the field of public health.\textsuperscript{22} As a distinct discipline, public health possesses a perspective that may be distinguished from, say, the field of medicine. Medicine is fundamentally an individualistic pursuit. It is the art and science of preventing or curing disease in particular patients. Public health shares medicine's goals of preventing and alleviating disease, but its focus is not the individual patient. Instead, public health concentrates on the community at-large,\textsuperscript{23} by targeting population-based health threats. Public health, for instance, examines the etiology and distribution of diseases, and devises and implements interventions that impede the spread of disease.\textsuperscript{24,25} As the Institute of Medicine has stated, public health is what "we, as a society, do collectively to assure the conditions for people to be healthy".\textsuperscript{26}

For most of its history, communicable disease control was governed almost entirely by sovereign States. States characteristically controlled infectious disease threats by empowering public health authorities to test and screen; to require notification or reporting of cases;\textsuperscript{27} to mandate medical examinations, vaccinations, or treatment;\textsuperscript{28} and to isolate or quarantine persons with infectious conditions.\textsuperscript{29} From independent efforts to control infectious diseases within national borders evolved a discipline called communicable disease law. Although this law developed differently in each State, it demonstrated common characteristics.\textsuperscript{30} Thus, communicable disease law may be defined as the study of the State's power or duty to identify and mitigate community health risks, and the limits on the State's authority to constrain an individual's liberty, autonomy,
privacy, or other legally protected interest on behalf of the public health.\textsuperscript{31}

Despite their efficacy in controlling infectious diseases, national laws could never suffice.\textsuperscript{32} Microbial infections know no geographic boundaries and, as the global community came to merge through international travel and commerce, an international approach became imperative. This international endeavour took the form of a global health organization buttressed by an international legal system intended to govern the agency, its activities, and the relationships between Member States in controlling infectious disease.

**The World Health Organization: 50 years of fighting communicable diseases**

The international effort to control communicable diseases harks back to at least 1851, when the First International Sanitary Conference was convened in Paris.\textsuperscript{33} The goal was to formulate uniform quarantine procedures for Mediterranean ports, including a minimal time frame for quarantine. The first convention, and subsequent international sanitary conferences, were guided by a basic precept: to provide optimum protection while imposing minimum intrusion on trade.\textsuperscript{34} A series of organizations, WHO’s early predecessors, continued this effort: the Pan American Sanitary Bureau in 1902,\textsuperscript{35} the *Bureau International d’Hygiène Publique* (OIHP)\textsuperscript{36} in 1907, and a health organization under the League of Nations in 1920.\textsuperscript{37} The International Red Cross, perhaps the earliest humanitarian organization, administered multiple international conventions and agreements to prevent the international transmission of disease.\textsuperscript{38}

In 1945, the United Nations identified international cooperation on health as one of its primary objectives. Article 55 of the United Nations Charter states that the organization is to promote, among other things, solutions to international health problems.\textsuperscript{39} The Charter also provides that specialized agencies are to be established by intergovernmental agreement and are to have wide international responsibilities in a variety of fields, including public health.\textsuperscript{40} WHO became the first specialized agency created under the United Nations system.\textsuperscript{41} Its Constitution was signed on 22 July 1946, and entered into force on 7 April 1948.\textsuperscript{42}

The Constitution of WHO declares its objective to be “the attainment by all peoples of the highest possible level of health”.\textsuperscript{43} A central part of this objective is the eradication and control of communicable diseases: “the functions of the Organization shall be ... to stimulate and advance work to eradicate epidemic, endemic, and other diseases”.\textsuperscript{44} During its first 50 years, WHO has become the definitive international organization in identifying, preventing, controlling, and
researching health threats. Its role has changed from funding and coordinating international efforts for disease surveillance, vaccination, and prevention to setting standards for treatment, mobilizing research, and defending human rights.

Perhaps more than any other statement of purpose, the 1978 Declaration of Alma-Ata on Primary Health Care sets forth the mission of WHO in regard to communicable disease. This Declaration:

... stressed that measures for communicable disease control should form part of primary health care, being as they are, inextricably bound up with the provision of comprehensive health services, the promotion of clean environment and water, and the application of appropriate agricultural and nutritional policies.45

The Declaration states that primary health care includes “immunization against the major infectious diseases; [and] prevention and control of locally endemic diseases”.46

The year following the Declaration of Alma-Ata, the World Health Assembly adopted the “Global Strategy for Health for All by the Year 2000”.47 This reaffirmed the primary constitutional objective of WHO, as set out in a resolution of the Thirtieth World Health Assembly, which stated that the “main social target ... of WHO in the coming decade should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”.48 WHO is currently devising a new strategy for “Health for All in the 21st Century”.

International law regarding communicable diseases

The central role of international communicable disease law is to facilitate effective strategies for surveillance and epidemiology, counselling and education, vaccination and treatment, and biomedical and population-based research. This law, to be sound, must be grounded in solid scientific and epidemiological principles. But well-considered law is also based upon normative principles that, for instance, reject interventions based on stereotypes and prejudices that unduly infringe upon the rights of individuals or populations, unnecessarily impinge on the sovereignty of Member States, or hinder travel and commerce among States.

The objectives of international communicable disease law, then, are to: (1) enable international agencies to mobilize and coordinate resources and strategies for disease prevention and health promotion; (2) facilitate regional and
national activities for disease prevention and health promotion; and (3) ensure that Member States do not interfere with the sovereignty of other States or the rights of individuals.

Two primary sources of international law govern the control of communicable diseases and the protection of human rights: the International Health Regulations and international human rights law.

- **International Health Regulations**

The origins of international public health law are often traced to the International Sanitary Conference of 23 July 1851. Despite numerous attempts at international conferences, international rules for controlling infectious diseases did not emerge until the International Sanitary Convention, signed on 3 December 1903. This Convention devised a plan for international surveillance and notification of cholera, plague, and yellow fever.

The Constitution of WHO authorizes the agency to adopt regulations concerning "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease". Pursuant to this authority, WHO has adopted two international regulations: the Nomenclature Regulations and the International Health Regulations.

In addition, under Article 19 of the Constitution, the World Health Assembly (WHA) is empowered "to adopt conventions or agreements with respect to any matter within the competence of the Organization". WHO, however, has preferred to exercise its authority using the less formal recommendation mechanism of Article 23. WHO has explained its rationale as follows:

No international conventions or regulations were adopted by the World Health Assembly during the second ten years ... Where it has been necessary to elaborate and promulgate international norms or standards, the tendency has been to rely on the procedure provided under Article 23 of the Constitution relating to recommendations. This procedure appears to be adequate when questions of reciprocity are not predominant, and it has the advantage of flexibility, since a recommendation may be modified, without any formalities having to be observed.

In 1951, the WHA adopted the International Sanitary Regulations (ISR), replacing the patchwork of conventions previously in force. The first two decades of WHO were dominated by mass campaigns against tuberculosis,
malaria, yaws, syphilis, smallpox, and leprosy.\textsuperscript{57} By the late 1960s, however, due to “advances in medical science and technology and the increasing volume and rapidity of international travel”,\textsuperscript{58} WHO recognized the need to consolidate and revise the ISR, renaming the updated regulations the International Health Regulations (IHR).\textsuperscript{59} The purpose of the IHR is to “ensure maximum security against the international spread of disease with a minimum interference with world traffic”.\textsuperscript{60} Today, the IHR remain the “only international health agreement on communicable disease that is binding on Member States”.\textsuperscript{61}

The IHR impose two key obligations on Member States of WHO: (1) to notify WHO of cholera, plague, and yellow fever outbreaks; and (2) to respond to disease outbreaks in other States as designated in the IHR. Modern disease threats and patterns of risk for transmission, however, present challenges that did not exist when the IHR were enacted or last revised.

Given the dramatic changes in the global health situation, the increase in international travel, and the advances in epidemiology and medicine, the IHR have come to be regarded as increasingly inadequate as a body of law to effectively control the spread of infectious diseases worldwide. The current IHR, for instance, do not specify the procedures necessary to manage new and re-emerging diseases. By limiting notification requirements to the specified diseases of cholera, plague, and yellow fever, the IHR fail to mandate documentation of a sobering number of diseases presenting a risk of international transmission.\textsuperscript{62}

**Revision of the International Health Regulations**

WHO is undertaking a significant revision of the IHR. In May 1995, the World Health Assembly adopted resolution WHA48.7 requesting the Director-General to initiate plans to revise the Regulations. WHO subsequently convened an informal consultation of medical, epidemiological, and public health experts to study and recommend changes.\textsuperscript{63} The panel determined that the original principles upon which the IHR were grounded — to ensure maximum protection with minimum interference — remain valid, but that revision of the IHR was warranted.

In the light of the consultation’s recommendations, a small working group of experts has been created to advise on the proposed amendments and provisions. Although the revised IHR will include many of the current IHR’s public health provisions, two significant changes are proposed. They include:\textsuperscript{64}
(a) Notification

The revised IHR will mandate immediate reporting of several defined clinical syndromes that pose an international public health threat. These include haemorrhagic fever, acute respiratory, gastrointestinal, or neurological syndromes, and disease outbreaks of unknown origin where international travel or trade is potentially at risk. The specific definitions of the syndromes for the purposes of notification under the IHR are currently being developed through international consultation.

(b) Structure of the revised IHR

The proposed structure for the revised IHR will take the form of: a framework document containing general principles on appropriate public health measures and legal provisions relating to the operation and amendment of the IHR; and a series of annexes describing technical provisions and specific requirements, which will form an integral part of the IHR. In addition, there will be operational guidelines to accompany the IHR and assist in their application.

The new structure is intended to provide generic regulations that will remain valid over time. But the annexes, subject to regular review and modification, will allow flexibility; they may be modified rapidly to respond to changing needs or knowledge.

Following evaluation of the new approach based on syndromic notification and any necessary redrafting, the Committee on International Surveillance of Communicable Diseases will convene, probably in 1998. Its recommendations on the proposed IHR are expected to be submitted to the World Health Assembly in 1999.

The Division of Emerging and Other Communicable Diseases Surveillance and Control (EMC)

WHO recently established the Division of Emerging and Other Communicable Diseases Surveillance and Control (EMC). Its mission is to reinforce and coordinate national and international efforts in the surveillance and control of emerging and re-emerging communicable diseases. EMC's activities include technical support, training, and educational programmes to strengthen disease surveillance and control measures and to improve the capacity of public laboratories; coordination and publication of current and timely information on
communicable disease situations and countries’ experiences; efforts to enhance the monitoring of communicable diseases and antimicrobial resistance worldwide; promotion of research to develop new disease surveillance and control strategies; and a rapid-response unit to combat new and re-emerging diseases and improve disease containment efforts.\textsuperscript{48}

- International human rights law

International law must enable a rich and varied global response to communicable diseases; concomitantly, it must ensure respect for the human rights of individuals and populations. The United Nations High Commissioner for Human Rights and the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) recently wrote:\textsuperscript{69}

\textit{The Universal Declaration of Human Rights begins with a recognition of the inherent dignity and the equal and inalienable rights of all people. This is also where the fundamental relationship between human rights, health, and non-discrimination is embedded ... We ask our respective communities to see the synergy between public health and human rights and to embrace both in their important work. The journey begins with a recognition of the inherent dignity and equal rights of all people and an understanding that the protection of human health is indispensable for the protection of the human rights and fundamental freedoms of everyone.}

Thoughtful observers have identified at least three ways in which public health and human rights are intertwined.\textsuperscript{70} The first is that health policies and programmes may directly infringe on the human rights of affected individuals. This is perhaps most clear in the case of coercive measures to control communicable diseases — such as mandatory testing, compulsory treatment, and quarantine or isolation — that deprive individuals of their human rights. The second relationship is that human rights abuses may directly or indirectly endanger the health of individuals leading to morbidity and mortality, as well as the psychological sequelae. Human rights abuses may, for instance, produce death or dismemberment, or deter individuals from seeking medical care due to fear of reprisal. The final interconnection is that health promotion requires the protection of the human rights of vulnerable individuals or populations. Safeguarding human rights, for example, empowers individuals and enables them to take steps to improve their own health, such as seeking voluntary testing or
immunization. Rather than conceptualizing public health and human rights as conflicting principles, contemporary analysis sees a synergy and an inextricable link between the health and the rights of populations.

"Positive" and "negative" rights

All persons are born with and possess throughout their lives a set of entitlements which the international community terms human rights. Human rights encompass a corpus of intrinsic claims to life, liberty, and equality of opportunity that cannot be taken away by the Government, persons, or institutions. Two distinct areas of human rights are protected under international law: civil and political rights on the one hand; and social, cultural, and economic rights on the other. Civil and political rights typically safeguard individuals from restraint, loss of freedom, and discrimination. Regulations issued in the name of public health can assuredly result in physical restraint, loss of freedom, and discrimination. For example, public health regulations can deprive individuals of: (1) the right to travel (e.g. when a State requires HIV testing of travellers prior to their crossing a border); (2) the right to autonomy (e.g. when public health authorities carry out compulsory screening or physical examinations for sexually transmitted diseases); (3) the right to privacy (e.g. when public health professionals conduct compulsory contact tracing or partner notification); and (4) the right to liberty (e.g. when public health officials mandate isolation or quarantine). Public health powers can be wielded in ways that result in discrimination, as when criminal laws are disproportionately directed at vulnerable groups (e.g. commercial sex workers, gays, intravenous drug users). This is not to suggest that States should never adopt compulsory measures. Before resorting to compulsion, however, States should ensure that public health measures comport with sound science, and comprise the least restrictive measures necessary to control the health threat.

Human rights, however, are broader than the right to be free from governmental restraint and discrimination, or what lawyers call “negative” rights. Human rights, properly defined, include “positive” rights as well (e.g. the right to life, health, education, and work). Article 12(1) of the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes this affirmative dimension; it proclaims a right to the enjoyment of the highest attainable standard of physical and mental health. Under this positivistic human rights framework, government possesses an obligation, within the constraints of its resources, to provide an environment conducive to the public’s
health and well-being. The specific responsibilities range from health promotion and disease prevention to ensuring access to health care, basic housing, and nutrition. Economic, social, and cultural rights manifest as powerful human rights concerns, particularly in poorer communities in developed and developing countries. The right to health, however, presents as a pre-eminently human rights concern.

The right to health

The right to health reflects an international legal obligation for nations to protect and promote their population’s health. The legal basis for this right derives from a number of international documents. The Preamble of WHO’s Constitution, adopted in 1946, states: “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 Universal Declaration of Human Rights (UDHR) proclaims that everyone has a right to “a standard of living adequate for the health and well-being of himself and of his family” (Article 25). Article 24(1) of the Convention on the Rights of the Child recognizes the right of children to the enjoyment of the “highest attainable standard of health”. Article 12 of the ICESCR recognizes “the right of everyone to the highest attainable standard of physical and mental health”. States Parties agree to take steps to fully realize this right, including those “necessary for ... the prevention, treatment and control of epidemic, endemic, occupational and other diseases”.

Moreover, a variety of international documents emphasize the role of non-discrimination in promoting and protecting the right to health. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, for example, pledges States to take all appropriate steps to eliminate discrimination against women in health care and to ensure women access to appropriate services in connection with childbearing. Similarly, Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination proscribes racial discrimination in the enjoyment of the right to public health, medical care, social security, and social services.

The concept of health as a human right, and not simply a moral claim, suggests that States possess binding obligations to respect, defend, and promote this right, and to treat all human beings equally in protecting their health. Although Article 2(1) of the ICESCR imposes international duties upon States to assist other nations in realizing the rights recognized in the Covenant, including the
right to health, the primary obligation lies with Member States to realize the right to health within their own populations.\(^8\) Current global health challenges, however, suggest that the international community cannot theoretically or practically isolate the health concerns of one country from another.\(^9\) A State's obligations to provide the conditions for its population's health may entail multilateral aid to the health sectors of other nations.\(^8\) Certainly, the international community, through United Nations agencies, can legitimately inquire whether individuals and populations are protected against infectious disease through adequate surveillance, prevention, control, and treatment.

As a forum for the creation of national and international law relating to communicable diseases, WHO has a critical role to play. Its legislative initiatives include: coordinating and encouraging Member States to devise and carry out appropriate disease control measures including detection, early notification, surveillance, and response; actively advancing international treaties that articulate national health and human rights obligations that are reinforced by application requirements; and, where necessary, providing intensive guidance such as administrative support. Finally, WHO is working to further compliance with international standards by, among other measures, effectively supervising State efforts and serving as the authority for surveillance of the implementation of international health legislation.

**Conclusion**

Humanity, not long ago, had the hubris to believe that it could control or even conquer infectious disease, even though microbial infection appears as ancient as humankind itself. Ironically, not only have long-standing diseases, such as tuberculosis, re-emerged, but we have witnessed a remarkable resurgence of old and new viruses, drug-resistant bacteria, and protozoans — ranging from group A streptococcus, *Escherichia coli* bacteria, *Cryptosporidium*, and hantavirus to Legionnaires' disease, Lyme disease, and AIDS.\(^8\) The public health consequences of communicable diseases are most striking in developing countries where war, poverty, overcrowding, and poor sanitation have served to incubate epidemics of cholera, dysentery, and malaria. As WHO recently warned, "cautious optimism has turned into a fatal complacency that is costing millions of lives every year".\(^8\)

Communicable disease law is not, of course, the most critical aspect of global efforts to control infectious disease. Yet complacency about communicable disease law can thwart public health efforts. The global nature of emergent and
re-emergent diseases suggests that international law can and must play a pivotal role in controlling communicable diseases. Communicable disease law can advance the mission of public health, help guide prevention activities, mobilize resources, and protect human rights.

WHO is well-placed to exercise its constitutional authority as a catalyst for global health by serving as a locus for policy debate, consensus, and codification of public health law. As an international agency, WHO possesses limited authority to direct the allocation of resources on a national level, but it can advance human rights — including the right to health — and exert considerable influence over Member States by using its organizational authority and legitimacy to nurture and guide State action. Encouraging national and international initiatives on health through law will help to authenticate and realize international health objectives. As the World Health Organization prepares for “Health for All in the 21st Century”, examination and reform of international communicable disease law is a sound and welcome priority on the agenda to foster global public health.

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7. See supra ref. 6.


10. See supra ref. 6, at p. 1.


43. See supra ref. 41, at p. 2.
44. See supra ref. 41, at p. 2.
49. See supra ref. 33, at p. 3.
51. See supra ref. 41, at p. 7. See also Article 22 of the Constitution (“Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice”).
52. See supra ref. 41, at p. 7.
57. See supra ref. 8, at p. 87.


65. See *supra* ref. 63, at p. 2.

66. See *supra* ref. 61.


68. See *supra* ref. 6, at p. 64.


73. See *supra* ref. 41, at p. 1.
74. See supra ref. 71, at p. 6.


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82. See supra ref. 42, at p. 311.


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TOWARDS A RECONSTRUCTION OF THE
"GENETIC FAMILY”: NEW PRINCIPLES?

INTRODUCTION

Nobody who has not been in the interior of the family can say what the difficulties of any individual of that family may be.

— Jane Austen (Pride and Prejudice, 1813)

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INTERNATIONAL DIGEST OF HEALTH LEGISLATION, 1998, 49 (1)
We are fast approaching the post-mapping era and moving towards functional genomics, with more precise gene identification requiring population and family studies. But, family relationships may be equally, if not more complex and variable, than the very genetic conditions under study. Indeed, while Jane Austen's insightful writings revealed the intricacies of genealogical, familial relationships, modern families are increasingly sociological in nature. Kinship through blood ties is slowing being replaced by reconstructed and blended families.\(^1\) In addition to these new family forms, there is also greater geographical mobility, making the scientific accuracy of oral family histories or questionnaires and interviews increasingly suspect. This makes the drawing of traditional genetic pedigrees, to say nothing of familial recruitment for research, an unreal, if not surreal endeavour. In the absence of a direct mutation test, a genetic diagnosis test requires actual access to family members, to their medical files, and to DNA samples. In short, the genealogical family is currently being reconstructed through genetic studies. Yet, the principle of mutuality, that is the notion of heightened filial duties of responsibility and sharing between biological relatives (as distinct from contractual or even legally imposed obligations), can no longer be presumed as a cultural value or norm. Ironically, this is happening at a time when, under both law and ethics, sensitivity to individual autonomy and privacy issues has reached its apex.

These combined factors necessarily shape the background for this brief study of the reconstruction of the genetic family through recruitment for genetic research and through an emerging duty to warn for health professionals. It is against these scientific and sociological configurations that several models of familial recruitment and professional duties are emerging in actual practice. Four approaches are currently evident in practice: the first is the classical model of easy access, the second a more balanced ethical model, the third a legal model maintaining strict confidentiality, and the fourth the cascade model. Family members are not alone in facing emerging ethical principles and their accompanying responsibilities. Physicians, faced with increasing familial genetic information as part of medical treatment of their patients, are revisiting the sacrosanct contract of medical confidentiality. Indeed, under certain conditions, the principle of reciprocity, that is the sharing of information between the physician/researcher and the patient/participant could soon be reaffirmed as limited or extended to the at-risk genealogical family.
PART I. FAMILIAL RECRUITMENT: THE REVIVAL OF MUTUALITY?

As concerns familial reconstruction, there was, under the classical model of familial recruitment, easy access to patients’ medical records, which facilitated the discovery of the identity of other potentially at-risk family members. In most cases, they would be contacted directly by phone or letter by the researcher, often without patient consent or even notification. This same model of direct solicitation also included direct contact by the family physicians of different members at the request of the researcher when a study of the medical records revealed their identities. Little thought or concern was given to the impact of this contact on personal or familial privacy. Furthermore, ignorance of family dynamics and communication and of the possible cultural and personal interpretations of belonging to a “genetically-diseased” family prevailed. Based on paternalism and on the presumption that such intrusion and information were scientifically founded, medically justified, socially acceptable, and even expected of professionals, this model greatly facilitated familial recruitment.

With the advent of both increased legal attention to privacy and to the vulnerability of patients and participants in medical research as well as the development of codes of conduct and procedures for review, a more ethical approach evolved. The culmination of this can be illustrated by the 1997 proposed “Code of Ethical Conduct for Research Involving Humans” in Canada which states:

Because genetic counselling and research studies begin with a family history provided by a family member, medical genetic charts will reflect the health and social history of the entire family, not just the individual. Because linkage and mutation analyses involve biological relatives, interpreting the results may not be possible without the co-operation of the family or the cultural group. The researcher should be aware that in certain situations members within a family may be coerced by other members to join the study. Further conflict within a family may exist if some members hold the rights of the family to genetic information override the rights of the individual.

When the wishes of the family or group are in conflict, enhancing communication is preferable to compelling either the group or the individual to concede their position. The researcher should recognize the potential for conflict within a family regarding participation in research endeavours but, above all, should honestly present to family members the goals, advantages, and disadvantages of research. (Section VIII-2)
This proposed Code of Conduct goes further in specifically recommending "that researchers and genetic counsellors involving families and groups in genetic research studies must reveal potential harms to the REB [Research Ethics Board] and outline how such harms will be dealt with as part of the research project" (Section VIII: Article 8.3). Finally, as noted in the proposed Code, "[t]hese problems are presently made more difficult in cases ... where confirmation of high risk or carrier status cannot be followed by any therapy or prevention" (Section VIII-3). This approach then is sensitive to the tensions within families, the anxiety that genetic information provokes, the possibility of survivor guilt, and the possible disruption of relationships.

The preferred mechanism for communication under this ethical model can take two forms. The first involves using the individual patient as contactor of other family members for recruitment. The patient can either authorize contact by the researcher by personally providing the identities of such members or the researcher can go through the family physician of the identified parties. For family studies at the level of populations, another avenue is to request the physician to send out a circular to patients describing the condition presumed to be present in the research population and request replies directly to the research team. Under either approach the family members contact the researcher and the fact of participation is not known to the physician. This is done so as to avoid undue influence on the physician-patient relationship.

The third model is the legal one based on a strict interpretation of the principle of medical confidentiality. The physician's legal obligation is to maintain the confidence and confidences of the patient unless authorized by the patient to do otherwise. This model also demonstrates a growing respect for autonomy as reflected in the development of the "right not to know" in the arena of human genetics and can be found in both the private physician-patient relationship and in the public health context. As concerns the former, oral authorization by patients to contact other family members may in actual fact be quite untrustworthy. What was presumed to have been communicated and what was actually said or understood, are often quite different. The researcher may well be on hazardous territory if he ventures forth into contact with unknown family members solely on the basis of such verbal authorization. Untoward outcomes might be avoided by providing the research participant with a pamphlet describing the research project along with a form to be signed by the family member authorizing contact. Only upon receipt of this signed authorization would contact be made.

In the public sector, new legislation has strengthened consent requirements without providing for any therapeutic exceptions. When combined with privacy
and data access legislation, contacting family members in the absence of a specific authorization by the patient becomes completely impossible. Thus, when epidemiological or demographic studies combined with anonymized or even coded genetic data on a population point to aggregates of risk or even, in some cases, to specific clusters of families at defined geographical locations, no contact is permitted. This is all the more serious when the conditions are preventable or treatable. Unless consents to be “found” were provided at the outset, these at-risk families are left alone because of the legal requirements. At best, only general warnings in clinics and newspapers or on television of an increased incidence of even a treatable or preventable condition in the region that request individuals who consider that they fall into this category to identify themselves can be used as a communication tool. Here it is not the principle of family mutuality that is eroded, but rather that of solidarity between citizens and the State where before there was the possibility of exception in the case of public health issues in the collective interest. As within families, where lies the balance? Must or should individual rights always override?

A final and more experimental approach to population studies that seeks to identify at-risk families is that of cascade testing. This is currently illustrated in the form of a pilot project on hereditary tyrosinemia in the eastern region of Quebec. Tyrosinemia is an autosomal recessive disease for which there is palliative treatment through a special diet and for which there may, eventually, be the possibility of a liver transplant. Since in Quebec it meets the internationally recognized paediatric norms for inclusion in newborn screening programmes, all Quebec newborns are tested at birth. Of the cases detected at birth, 50% are concentrated in Eastern Quebec where one in 20 persons is a healthy carrier. In 1997, five years after the discovery of the prevalent mutation in the FAH gene (fumaryl aceto-acetase hydrolase), the largest regional clinic of the Quebec Applied Medicine Network put into place a pilot project. The unique opportunity for the application of the cascade approach was due to the mode of transmission, the known mutation, the recognized interdependence of individuals within families, and the largely homogenous cultural values found in the region.

This approach involves primary contact by the paediatrician in informing families with an affected child by letter and information brochure of the availability of the test, the parents themselves necessarily being carriers. The letter mentions the familial nature of the condition. The parents are asked to contact the researcher should they so desire, in order to complete a questionnaire and undergo a finger prick blood test to identify the particular mutation which is present in 95% of the population. Counselling is available at all times. Once the
results are communicated, the parents are then asked to contact the next wave consisting of brothers and sisters, uncles and aunts, and grandparents. The following wave includes more distant relatives, such as cousins, nephews, nieces, and so on. The partner of a carrier may have access to the test at any time, especially prior to conception. The advantage of this method of recruitment is that it minimizes the number of tests in the population and yet increases efficacy. Indeed, with a theoretical efficiency of at least 50%, sequential familial screening could identify the great majority of carriers (estimated at about 85-90% of all carriers in the general population, comprising all families) in a given, isolated, culturally close-knit society with a founder effect. It remains to be seen whether this approach would be efficient outside the context of such culturally homogenous populations.

Finally, the consent form in this pilot project provides a choice for participants to permit access by other family members to personal genetic information for a period of 25 years. It is interesting to note that in Quebec, even in the case of refusal to share medical information during the lifetime of a person, health legislation holds that, for familial and genetic conditions, such refusal is not binding after death, thus providing access to familial data.

Whereas the "classical" model failed to take into account and respect personal values and choices with regard to medical information (values that may be even more important in the context of human genetics), and literally constituted an open-door policy, the new legal model is, in some respects, unnecessarily individualistic and restrictive. It presumes and reinforces the idea that blood relatives are but third parties and so diminishes the principle of mutuality.

What is certain is that past abuses together with present phobias leading to overprotectionist and individualist norms have created an urgent need to re-examine the duty to prevent harm in the context of human genetic research within families. Having initiated a process of familial communication, researchers must be more than sensitive to its dynamics and implications. Clear understanding by researchers and by research participants of these implications should be a prerequisite prior to the development of these studies or patient entry. Depending on the nature of the genetic condition under study, classification of roles and responsibilities may vary.

Irrespective of the approach taken, what is also at issue in the recruitment of families for genetic research is the question of the ongoing, if not untoward, ethical and legal obligations genetic family studies raise for the professional. Contrary to general research via open solicitation, family studies imply that an affected family member exists and is known. Recruitment for family studies then
implies a deliberate searching out of these individuals but within a context of unknown present and long-term implications for such family members. In addition to the usual complex effects of genetic testing, there are the added dangers of coercion and of disturbance of relationships. Indeed, to the usual problems of detecting non-paternity are added incidental findings of at-risk status for other genetic conditions. With the refinement of genetic tests also comes the possible need to warn or recontact. Thus, at the same time that genealogical families are being recreated through genetic studies, there is a concomitant pressure on professionals to extend the relationship to include family members. Professional ethics are beginning to waver with respect to a duty to warn identifiable at-risk family members of foreseeably preventable, treatable conditions, and so affect medical confidentiality.

PART II. MEDICAL CONFIDENTIALITY: RECIPROCITY REVISITED?

As noted, genetic information reveals genetic risk information about the individual and his or her relatives as well. This personal, yet simultaneously, familial information, raises new and profound questions with regard to the health care professional’s legal and ethical obligations to disclose genetic information to at-risk relatives. The principle of reciprocity in the physician-patient relationship, of exchange and sharing information, could well be extended to include other at-risk family members. Three models can be discerned. The first is “atomistic” and upholds strict confidentiality. The second is familial and postulates a positive duty to warn. The third, a mixed model, takes a middle position since it maintains that, under certain conditions, a warning may be ethically permissible.

Complicating the medical, legal, and ethical issues surrounding the disclosure of genetic information to at-risk relatives are the inherent limitations of test results in predicting the onset, severity, or complexity of a disorder. Like all medical conditions, genetic conditions rarely exhibit homogeneity in terms of how the disease process is manifest. Since some genetic conditions are caused by not one but several genes, the combination of individual variations produces an even more complex set of potential clinical outcomes and often leads to more unknowns than definitive predictions.

Before examining the three models, it is important to consider the very real possibility that, within a family group, knowledge may constitute a greater harm than non-disclosure, particularly in the case of family members who do not want to know. Harm from disclosure may include psychological, social, and financial harm as well as the possibility of stigmatization, discrimination, labelling, and the
potential loss of or difficulty in obtaining employment or insurance.

Yet, failure to disclose may also lead to harm. In terms of reproductive choices, children who may otherwise have been spared the effects of a genetic condition will have to endure them, and couples who would otherwise choose not to conceive would be denied such an option. Failure to warn may also lead to irreparable harm where opportunities for avoidance, treatment, or prevention of the genetic condition are limited because of non-disclosure.

The duty to maintain confidentiality extends as far back as the Hippocratic Oath and, in the absence of statute, is based upon theories of contract and the fiduciary nature of the health care of the individual professional-patient relationship. Under this first approach of strict confidentiality, it should be remembered that legislation, in protecting the confidentiality of medical/genetic information generally, only exceptionally permits health care professionals to disclose otherwise confidential information without incurring liability. Physicians are required, on the basis of clear public policy interests, to report communicable diseases, gunshot and other wounds, and evidence of child abuse and neglect to the appropriate authorities. Similarly, Codes of Ethics only exceptionally permit physicians to disclose otherwise confidential information. This is because genetic information is protected by the legal and ethical principle of confidentiality that exists within the patient-physician relationship. There is a commonly held view that without an expectation of confidentiality, patients will be less forthcoming in disclosing sensitive personal information. Thus, under this atomistic approach, there are sound ethical and legal reasons to respect the individual's refusal to communicate genetic information to at-risk blood relatives.

Under this atomistic model, confidentiality is absolute. All medical information is strictly private. The health care professional is obliged to inform the patient of the implications of his/her genetic test results and potential risks to family members. However, confidentiality prevents the health care professional from disclosing any genetic information to relatives; the health care professional has a duty not to breach confidentiality, from both an ethical and a legal viewpoint.

The second approach maintains the existence of a positive ethical duty to warn within families. This approach is largely based on the notion that genetic information is "family" property. Treating genetic information as "family property" extends the traditional boundaries, definitions, and obligations of the patient-health care professional relationship to include family members, leaving the health care professional (family physician, geneticist, genetic counsellor, nurse) in a position of potential conflict between the best interests of his
traditionally-defined “patient” and his newly-defined “patients”. Rarely, has this familial position been translated into a positive legal obligation, though its general acceptance could become part of the professional standard and so impact on legal liability. This model could perhaps be translated into practice by the clear communication of the nature of genetic information to the patient or research participant before testing. The patient would be informed of the presumption of familial medical disclosure by the professional in the event of an individual refusing to do so.

Internationally, the World Medical Association in its Declaration on the Human Genome Project, and experts advising the World Health Organization on their proposed guidelines on medical genetics and genetic services, recommend that confidentiality of genetic information be maintained except where there is high risk of serious harm to family members at genetic risk, and the information could be used to avert this harm.

At the regional level, in 1992, the Council of Europe, while maintaining that confidentiality of genetic information must be ensured at all times and protected by the rules governing medical data, made allowance for disclosure in the case of severe genetic risks affecting the health of family members or their future children. Statements from countries such as the Netherlands, Japan, Australia, and the United Kingdom underscore this middle road model. Finally, this familial model can also be legally buttressed by the existence in certain countries of a civilian tradition of a duty to rescue endangered persons.

An alternative to the atomistic view of professional-patient confidentiality or to the familial approach is that first proposed by the 1983 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research of the United States. The President’s Commission stated that where the patient refused, disclosure by a health care professional to at-risk family members could take place only when:

1. Reasonable efforts to elicit voluntary consent to disclosure have failed;
2. There is a high probability that harm will occur if the information is withheld, and the disclosed information will actually be used to avert harm;
3. The harm that would result to identifiable individuals would be serious; and
4. Appropriate precautions are taken to ensure that only the genetic information needed for diagnosis and/or treatment of the disease in question is disclosed.

Under this mixed model, there is not a legal duty to warn; but simply a set of circumstances under which it would be permissible to do so. Such criteria have been translated into a consideration of the following factors: the seriousness of
the defect, the likelihood that the relative has the genetic defect, whether or not the defect is likely to be detected by other means, the availability of treatment, and the seriousness of the harm to be suffered by third parties. Disclosure without consent is therefore justified where the information reveals that the relative is at a substantially higher risk of suffering from a serious and otherwise undetected genetic disorder and where treatment or prevention is available. Recently, this position has been reaffirmed by the American Society of Human Genetics.11

In short, under the individualist approach to consent and privacy, there is no duty to notify at-risk family members. While at first glance the familial model generally resembles the mixed model without further refinement, the "familial" complexities of human genetics and of human relations might, however, make the second approach too open-ended and ambiguous. Thus, the adoption of the clearly delineated standards of the mixed model constitute a first step in what is necessarily a topic that requires further debate. The ramification for patients, families, and physicians are too great to simply maintain that genetic information is "family property".

Conclusion

While we might want to argue in favour of the recognition of the principle of mutuality amongst at-risk family relatives or the expansion of the principle of reciprocity in the exchange of information in the physician-patient relationship, the underlying obstacle to the achievement of both remains the perceived stigmatizing nature of genetic information. While undoubtedly familial, transgenerational and sensitive, why is it not considered to be part of the mainstream of "normal" medical information? Even "normal" medical information can be about risks and have implications for others. What really is "at-risk" in the collection and diffusion of genetic information, what really causes hesitation to share or to warn, are the potential socioeconomic implications. Until the reception and understanding of such information by employers and insurers is handled in a transparent and legitimate fashion, the surrounding uncertainty undermines the integration of genetic information into the mainstream. This failure is compounded by two other factors, both firmly entrenched in the social fabric, and this irrespective of culture. The first is that of genetic fatality and superiority, the historical notion of a genetic condition somehow being related to punishment or a sign of inferiority. The second, closely related to the first is that of handicap, our collective failure to support disabled persons (however the disability may be caused) being clearly demonstrated in inadequate social
security, care, and integration into our communities. It is no wonder that the equation underlying genetic reductionism: gene = disease; disease = person; person = gene has hampered the “normalization” of genetic information.

While replacements for these systemic underpinnings cannot be found immediately, the reality of familial recruitment and the concomitant revival of mutuality, together with the expansion of the physician-patient relationship to include the at-risk family, point to the emerging phenomenon of the reconstruction of the genealogical (biological) family through genetic testing. There is no doubt that it is from this level, that of the citizen and involved professionals, that the ultimate political pressure will manifest itself to bring about the necessary systemic changes. In the meantime, new families and professional relationships must strive not only to respect autonomy and privacy, but to encourage mutuality and reciprocity. Ethical principles in action are preferable to imposed legal obligations.

Cain asked God with respect to his brother Abel: “Am I my brother’s keeper?” (Genesis 4; verse 10). This question can no longer be avoided by physicians/researchers or by patients/participants. Who today is the brother’s “keeper”? 
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11. AMERICAN SOCIETY OF HUMAN GENETICS. Points to consider: professional disclosure of familial genetic information. American Journal of Human
Genetics, November 1997 (in press). A portion of Part II derives directly from the work of the Social Issues Committee on this issue as published in this "Points to consider" (Chair: B. M. Knoppers).

Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
We have rights that must be recognized and respected under all circumstances. We have the right to eat, to be looked after, to be protected. No to arms, yes to peace; we do not want to be prisoners of war. Each of us has the right to a nationality: our parents or those who act in their stead must advise us, guide us, respect us. There must no longer be child victims of war, of famine, of drugs, of prostitution, of lack of medical care, education, protection, and affection. We demand that the Convention on the Rights of the Child be adopted, signed, ratified, and, above all, applied in all countries of the world.

Declaration submitted to the Secretary-General of the United Nations by a delegation of children from different countries (New York, 1990).

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In presenting this Declaration, these children solemnly affirmed one of the essential rights accorded to them by the international community: the right to speak. It is a right that establishes the child’s status, promoting him from being an object without a voice (it may be noted that the word “infant” comes from the Latin infans, which literally means “unable to speak”).

The right to speak

The United Nations Convention on the Rights of the Child recognizes that the “child who is capable of forming his or her own views” has the “right to express those views” (Article 12(1)) and the “right to freedom of expression” (Article 13(1)). The right to speak is a paradoxical right and, for this reason, it is sometimes controversial: in many cultures, the young are not allowed to speak in the presence of their elders. To do so would be to show a lack of respect for them. M. Durojaye, a Nigerian psychiatrist, emphasizes the contradiction, which is difficult to live with, between this silence imposed in the family and the clan and the encouragement to speak in school. It is, moreover, a right that it is often difficult to exercise. According to R. Illsley, a British sociologist, children from underprivileged environments are in contact, at best, with a vocabulary of fewer than 300 words, many of which are deformed or used incorrectly. There again, it is an entirely different language that school attempts to inculcate. Finally, it is a limited right. What is the point of speaking if no one listens? This is, however, the fate of many children in cultures where their freedom of speech is not contested, but where adults, occupied with “serious” matters, take little notice of the remarks or questions of little ones. They are told “be quiet!”, “wait a moment!”, or “later!”. However, as G. Mistral, a Chilean poetess, puts it so well, “the child cannot wait, his name is today”. At the other extreme, the right to be heard and understood does not necessarily imply the right to have others comply with one’s wishes. What a child says is not always in his best interests, either immediately or in the future.

Speech affirms the child’s autonomy: the right to speak allows the child to “have a say in the matter”. He may speak for himself, without the inevitable intermediary of an adult. While it was already recognized that the child had rights with regard to his protection — for example, laws against his exploitation as a labour force or the constitution of a form of criminal law for minors — the rights concerned were above all “derived rights”. They were an extension of rights intended for adults, and children could benefit therefrom in that they were human beings. Again, it should be noted that most legislations
place them, without distinction, in the same category as dependent elderly persons ("those in their second childhood") and incompetent persons of full age!

The United Nations Convention on the Rights of the Child (UNCRC) now makes the child a holder of rights, ipso jure: a little person it is true, but a person in his own right that society must accept as such. This constitutes considerable progress, at least on paper.

The child citizen

Another founding right, already present in earlier international texts but affirmed with a greater force in the UNCRC, is the right to identity. This is a complex right, as is identity itself. Indeed, while all children are unique and must be recognized and treated as such, they are first of all boys or girls. This essential sexual identity leads to the recognition of, and the fight against, the inferior status of girls and women in most, if not all, societies. All those, both men and women, engaged in combating, together with WHO, "all forms of discrimination against women" may use the UNCRC as a basis for conferring upon half the world's children rights to which they are entitled by the same token as members of the opposite sex. This fight is all the more important since sex and age too often combine to make the girl child a subject who, for two reasons, has no rights.

International legal instruments link this right to identity to another, the right to nationality. This again is a founding right, since it places the child within an extended community which must serve as the guarantor of the child's rights. It is, however, regrettable that the UNCRC did not go further at the outset in recognizing the right to citizenship, a complex governed by laws from which are derived rights and duties with regard to all those who are citizens. To have done so would also have been to recognize the role that children and adolescents can play in the construction of the "common home", beyond even the membership of a particular nationality: being a citizen of Russia or China, Burkina Faso or Colombia, does not stop one from being a citizen of the world at the same time!

The child and development

Another characteristic of the child, which we shall see as being central to the realization of his rights, is the fact that he is a subject in the process of development. For him, health, growth, and development go hand in hand and his needs for the purposes of a harmonious development create as many rights as the UNCRC lists throughout its Articles. Childhood in fact progresses by stages,
each preparing the next, a process that is handicapped if a new stage is approached before the acquisitions of the preceding stage have been secured. At first an embryo, then a fetus — stages of development that the UNCRC does not take into account owing to the impossibility of reaching international consensus on the protection of human existence before birth — the child is, in turn, a newborn, a little child, a child of school age, a pre-adolescent, and then a confirmed adolescent before attaining the status of adult, this transition being at an earlier stage physiologically than socially in modern societies, contrary to the situation in traditional societies in which a logical link was established between access to both these stages. It is, therefore, worthwhile studying the needs of the developing child in keeping with these various stages and deducing the rights that derive therefrom. This is the approach suggested by WHO in emphasizing the manner in which health problems and needs should be tackled according to the successive stages of the personal and family life cycle.

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3. Trust, which is natural on the part of every child with regard to those who take care of him, is reinforced when these persons acknowledge him and treat him as a unique human being, different from all other children, and interact with him. It sets in motion the dynamics of development, whereas mistrust blocks it. Autonomy is born of security and of the assurance of being loved sufficiently well to assert oneself and break away from the primitive symbiotic relationship. It is during this period of infancy that the will is forged. During the age of play, initiative develops and furthers the acquisition of the instrumental, cognitive, and social skills that will provide aims for activity. This is followed, with the knowledge acquired during schooling, by the application of these various facets of knowledge: this leads to competence. The capacity to adapt is in the making throughout these stages of development.

A somewhat tragic reality

However important these general considerations may be, they must not allow us to lose sight of the situation of hundreds of millions of children in the world today who are displaced, refugees, orphans, and victims of conflicts between adults, famine, malnutrition, disease, and lack of care and education. There are so many denials of rights denounced year after year in the reports presented by the Director-General of WHO on health in the world and by the Executive Director of UNICEF on the situation of children in the world. Remarkable progress has of course been achieved since the end of the Second World War, and WHO is no stranger to this.
Its programmes of maternal and child protection have been adopted by most
countries of the world and its expert reports, studies, research, and numerous
publications have given substance to a veritable health policy for the benefit of
children, women, and families. However, there is still much to be done. Can the
UNCRC help here? What can it change? These are questions put by the present
author in an article that appeared after the ratification of the Convention\(^4\) and they
are still relevant today. The UNCRC is, indeed, a strong legal instrument. It is
more binding than the Declarations that preceded it. It not only requires the
countries that have ratified it to implement it, but also to adapt their own legislation
to it. Violations of the Convention may be submitted for arbitration by the
Committee on the Rights of the Child, the membership of which the UN is in the
process of increasing in order to make it more efficient. Another encouraging sign
is that regional entities have adapted the UNCRC to their geopolitical context. This
is the case, for example, of the Organization of African Unity, with the African
Charter on the Rights and Welfare of the Child,\(^5\) and the Commission of the
European Communities, with the European Charter on the Rights of the Child.\(^6\)

Many nongovernmental organizations, for their part, are active in ensuring that
the UNCRC is better known and implemented. Foremost among these are
Defence for Children International and the International Catholic Child Bureau,
which played a major role in preparing the text. However, if the Convention is to
be accorded its full value, it is the children themselves that must take the credit.

What does the UNCRC say?

The various Articles of the UNCRC are often classified in three groups, each
under the letter “P”: Protection, Provision of Benefits, and Participation. This
requires explanation. Protection, which is total for the first few months of life,
will be progressively harmonized with promotion, a dynamic approach that
involves, within the limits of what is possible, the child’s responsibility. This is
particularly true for health. This needs to be protected by the collectivity (State,
society, community, family), particularly against risks over which the individual
has little influence owing, for example, to his immaturity; it also needs to be
promoted and developed through sensible behaviour. Again, the subject must
have acceptable living conditions and sufficient potential, enhanced by education,
in order to manage his health capital. This is even truer in the case of the child,
since this education is aimed precisely at the gradual acquisition of autonomy.

The provision of benefits in the field of health and social welfare varies
considerably from country to country. Further on in this article, we shall examine
how they may be linked to different stages of development and how the various Articles of the UNCRC justify and explain them. As modern societies develop, the State assumes ever-greater responsibility for tasks in the fields of health, education, organization, and leisure — tasks that formerly devolved upon families. This presupposes unflagging respect for the private domain as well as trusting cooperation between the family and the various institutions involved, in one way or another, in the child's development, failing which, the child is pulled this way and that by divergent, sometimes contradictory, influences and is destabilized, losing the bearings that he needs in order to forge his personality. This is too often the case with the children of emigrant parents or disadvantaged families.

The participation of children in family, community, and social life is not a matter of course. It is sometimes denied, adults reserving — regardless of the UNCRC — the right to decide for them: this is still true, particularly for girls, in a great many cultures. In other cases, a child's participation may be too demanding; this happens, for example, when the child is set up as judge in conflicts between his parents or when, being the only one to speak the language of the host country, he is forced to become the mediator between the emigrant family and the reception services of that country. It is sometimes difficult to arrange, but it is essential that a child who is seriously ill be made to participate in decisions concerning his treatment. Participation also presents a problem with respect to the value and weight of the word of a child who complains of ill treatment or abuse on the part of his next-of-kin. However, this participation, as well as the protection of the child against "arbitrary or illegal interference in his private life" is of paramount importance in preparing him to become an aware adult and a citizen with a sense of his responsibilities.

A fourth "P"

To these three "Ps" it is tempting to add a fourth: Plea. This is addressed to adults, parents, and persons concerned with children in a professional capacity, but also and perhaps especially to the associations, nongovernmental organizations, and international organizations whose task it is, under all circumstances, to plead the cause of children, particularly the cause of those who are deprived of their rights. Essential here is the role of WHO, since it is responsible for the health, and therefore the development, of the world's children. It is up to WHO to assert, at all times, the rights of the child to a family, safety, health and the conditions upon which it is dependent, social welfare, education, protection against all forms of exploitation, and harmonious development.
considerable efforts deployed by WHO since it came into being, both from the conceptual standpoint and in the field, in order to improve and promote the health of children, mothers, and families show that it has not failed to carry out its task.

From principles to implementation

However, it is necessary to go even further and it is here that the Convention can help. In a communication to the International Pediatric Congress held in Cairo in 1995, the present author, in collaboration with M. A. Belsey (then Programme Manager, Maternal and Child Health and Family Planning, WHO, Geneva), presented a model relating each stage of development to the Articles of the UNCRC affirming the rights of the child, as well as to the needs, both biomedical and physical and psychosocial, that must be satisfied in order to assure the good health and harmonious development of the child.7 Table I, which has been drawn up on the basis of an arbitrary selection of four stages from among the nine from conception to adult (periconceptual, prenatal, delivery, neonatal, post-neonatal, toddler, pre-school, school-age, and adolescence), clearly demonstrates, with reference to the relevant Articles of the UNCRC, a perfect match between the rights affirmed for these various stages of the life cycle and the corresponding needs of the developing child.

<table>
<thead>
<tr>
<th>TABLE I. HEALTH, GROWTH, AND DEVELOPMENT AND THE CONVENTION ON THE RIGHTS OF THE CHILD (UNCRC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGES OF DEVELOPMENT</td>
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<tr>
<td>------------------------</td>
</tr>
<tr>
<td>PRENATAL PERIOD</td>
</tr>
</tbody>
</table>

INTERNATIONAL DIGEST OF HEALTH LEGISLATION, 1998, 49 (1)
### TABLE I (continued)

#### DELIVERY

<table>
<thead>
<tr>
<th>Article</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:</td>
<td>the child is to be registered immediately after birth and is to have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.</td>
</tr>
<tr>
<td>24(2)(a)</td>
<td>to diminish infant and child mortality.</td>
</tr>
<tr>
<td>24(2)(b)</td>
<td>to ensure the provision of necessary medical assistance and health care in all children with emphasis on the development of primary health care.</td>
</tr>
<tr>
<td>8(1):</td>
<td>both parents have common responsibilities for the upbringing and development of the child. The best interests of the child are to be their basic concern.</td>
</tr>
<tr>
<td>18(2):</td>
<td>States Parties are to render appropriate assistance to parents and legal guardians in performance of their child-rearing responsibilities and are to ensure the development of institutions, facilities, and services for the care of children.</td>
</tr>
<tr>
<td>19(1):</td>
<td>to protect the child from all forms of physical or mental violence, injury or abuse, including sexual abuse.</td>
</tr>
<tr>
<td>24(2)(d)</td>
<td>see supra.</td>
</tr>
</tbody>
</table>

| Clean, traumatic delivery. | Social support in labour and delivery, including father. |
| Warm control. | Breast-feeding. |

#### NEONATAL PERIOD (0-27 days)

<table>
<thead>
<tr>
<th>Article</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:</td>
<td>see supra.</td>
</tr>
<tr>
<td>11:</td>
<td>combat the illicit transfer and non-return of children abroad.</td>
</tr>
<tr>
<td>18(1):</td>
<td>both parents have common responsibilities for the upbringing and development of the child. The best interests of the child are to be their basic concern.</td>
</tr>
<tr>
<td>18(2):</td>
<td>States Parties are to render appropriate assistance to parents and legal guardians in performance of their child-rearing responsibilities and are to ensure the development of institutions, facilities, and services for the care of children.</td>
</tr>
<tr>
<td>19(1):</td>
<td>to protect the child from all forms of physical or mental violence, injury or abuse, including sexual abuse.</td>
</tr>
<tr>
<td>24(2):</td>
<td>see supra.</td>
</tr>
</tbody>
</table>

| Protection from physical danger. | Breast-feeding. |
| Health care. | |

#### TODDLER (1-3 years)

<table>
<thead>
<tr>
<th>Article</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>14(1):</td>
<td>family reunification needs to be dealt with by States Parties as a priority, humanely, and expeditiously manner.</td>
</tr>
<tr>
<td>17:</td>
<td>the promotion of his or her social, spiritual, and moral well-being and physical and mental health.</td>
</tr>
<tr>
<td>17(4):</td>
<td>the production and dissemination of children’s books; Articles 18 and 19(1): see supra.</td>
</tr>
<tr>
<td>23(1):</td>
<td>a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child’s active participation in the community.</td>
</tr>
<tr>
<td>23(2):</td>
<td>States Parties are to cooperate the right of the disabled child to special care.</td>
</tr>
<tr>
<td>23(3):</td>
<td>the disabled child is to have access to education, training, health care services, rehabilitation services, preparation for employment, and recreation opportunities.</td>
</tr>
<tr>
<td>24(2)(c):</td>
<td>to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology.</td>
</tr>
<tr>
<td>39:</td>
<td>to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment, or armed conflicts.</td>
</tr>
</tbody>
</table>

| Monitoring of growth. | Acquisition of psychomotor, language, and cognitive skills, including personal hygiene, mobility, and exploration. |
| Immunization. | Feeding oneself. Gradual development of independence; learning to control own behaviour; beginning of capacity to care for oneself, daily play with a variety of objects. |
| Screenmg hearing and sight. | Definition of role and relationship in family. |
| Clean environment. | Social support. |
| Support in labour and delivery, including father. | |
The rights affirmed call for responses that go far beyond the problems of health alone. Furthermore, health can only be achieved through a genuinely multisectoral action, itself modulated in time throughout the life cycle. It is here that Table II, drawn up nearly 40 years ago by the International Children's Centre, assumes its full significance. It presents the investments to be made, at different ages and in different sectors, while assessing their relative importance. It is up to each country to adapt it according to its priorities.

### TABLE II. INVESTMENTS ACCORDING TO AGE IN THE DIFFERENT SECTORS OF ACTIVITY CONCERNING CHILDREN

<table>
<thead>
<tr>
<th>AGE GROUPS</th>
<th>SECTORS OF ACTIVITY</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health</td>
<td>Social</td>
</tr>
<tr>
<td>0-4 years</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5-9 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10-14 years</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15-19 years</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Over 20 years</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

For all those concerned with the health, development, and well-being of children — parents, private individuals, professionals, institutions, nongovernmental organizations, governments, and international organizations — the UNCRC is a precious tool. It can inspire policies, programmes, and activities, while providing them with an indisputable legal basis. WHO, whose work, in collaboration with UNICEF, has contributed to the birth and then the implementation of the various provisions of this truly international treaty, must continue to ensure that the Convention is better known and applied. In so doing, it will realize the wish of the eminent paediatrician Robert Debré, who did so much for the children of the world. Among his last words, uttered a few days before his death, he is recorded as saying: "Whichever way we turn, the fate of the child is at stake. We must determine how to direct our efforts if the situation is to be improved".
REFERENCES


Any opinions expressed in signed articles are those of the authors and do not necessarily reflect WHO's views.
1. THE INTERNATIONAL HUMAN RIGHTS REGIME

The significance of human rights for the advancement of women’s health and self-determination has gained recognition and momentum through recent United Nations (UN) conferences, particularly the 1994 International Conference on Population and Development, held in Cairo, and the 1995 Fourth World Conference on Women, held in Beijing. The Programme of Action adopted by 184 UN Member States in Cairo (the Cairo Programme) recognizes the
importance of human rights in the protection and promotion of reproductive health, which is a major factor, though by no means the only factor, in women’s health. The Declaration and Platform for Action adopted by 187 UN Member States in Beijing (the Beijing Declaration and the Beijing Platform respectively) reaffirm the Cairo Programme but advance women’s wider interests to social justice. Key to this new approach is empowering women within their families and communities, and protecting their human rights, particularly those relevant to their health.

This paper will address the application of human rights to protect and promote women’s health. It will survey some of the decisions of regional and international courts that advance women’s health, and explain monitoring mechanisms to hold governments and their agents accountable for violations of women’s rights to health protection and promotion. In conclusion, it will suggest what role WHO might play with regard to women’s health and human rights in the next 50 years, as it celebrates 50 years of documentation of health legislation through the International Digest of Health Legislation.

Human rights relevant to women’s health have become progressively defined upon the foundation established in 1948 by the Universal Declaration of Human Rights. The Declaration itself was not proposed as a legally enforceable instrument, but it has gained legal acceptance and legal enforceability through a series of international human rights conventions. The primary modern human rights treaty concerning women’s rights is the Convention on the Elimination of All Forms of Discrimination Against Women (hereinafter the Women’s Convention). This gives expression to the values implicit in the Universal Declaration of Human Rights, and reinforces the Declaration’s two initial legally-binding implementing Covenants, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Similarly derived from the Universal Declaration are regional human rights conventions of legal force, including the Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention on Human Rights), the American Convention on Human Rights, and the African Charter on Human and Peoples’ Rights.

Emerging analyses of State responsibility for violations of human rights assess governmental neglect of preventable causes of women’s mortality and morbidity as an affront to their human right to health, and as part of a larger social phenomenon of systemic unlawful discrimination against women. Laws that deny, obstruct, or condition availability of and access to health services are being challenged as violating women’s basic human rights protected by international
human rights conventions. If international human rights law is to be truly universal, it has to be applied both to require States to take effective preventive and curative measures to protect women's health and to afford women themselves the capacity, for instance, to achieve their own health and reproductive self-determination. International human rights treaties require international and domestic application in order to secure women's rights, *inter alia*:

- to be free, through their empowerment, from all forms of discrimination and oppression;
- to achieve their rights to liberty and security, including physical security against, for instance, domestic violence; and
- to have access to health care and the benefits of scientific progress, including to health information and education.

II. STATES' DUTIES TO IMPLEMENT HUMAN RIGHTS

Duties to give effect to human rights can be approached through many philosophical and legal frameworks. A useful framework has been developed under international human rights conventions that obliges States that have committed themselves to their observance to undertake three kinds of duties. These are to respect rights by not violating them, to protect rights by taking positive action against third party violators, and to fulfil rights by employing governmental means to afford individuals the full benefit of human rights. The duties affect women's rights to health and health care in a variety of ways.

A. The duty to respect rights

The duty to respect women's rights to the protection and promotion of their health obliges States and those they employ to be cautious when taking action that may restrict women's autonomous choices regarding health care. For instance, it is widely recognized that lawfully married couples must not be impaired in their decisions to conceive and bear the children they want, even when such children are likely to be disabled or reared in deprivation. Women's rights to bear children are paralleled by their rights to plan the number and spacing of their pregnancies so as to optimize their health and that of their children and families.

Women's regulation of their reproductive capacities frequently raises contentious issues of contraception, sterilization, and abortion. Human
conception and birth have long been considered in many religious traditions to be a divine mystery and gift that it is immoral for human agency to invade, reject, or appropriate. Laws restricting contraception, sterilization, and abortion are often explained and defended on moral grounds. However, courts have a tradition of holding that protection of health interests prevails over laws that seek to enforce moral imperatives. For instance, the European Court of Human Rights, established under the European Convention on Human Rights, held that compulsory sex education "conveyed in an objective, critical and pluralistic manner" did not violate the rights of parents to ensure education of their children in conformity with their religious beliefs. More recently, the same Court required the Republic of Ireland to accommodate the provision of information on access to abortion services in other countries.

State action becomes suspect when it obstructs individuals' use of their own means to satisfy their health goals, and when it intrudes on individuals' privacy. For instance, States cannot restrict women seeking health services, or clinics delivering them, because women do not have authorization of their husbands, or because they are unmarried. The Committee on the Elimination of Discrimination against Women (CEDAW), which is the body set up by the Women's Convention to monitor States' compliance, has issued a General Recommendation 21 on Equality in Marriage and Family Relations. This specifically states that "Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government".

States and their officers violate human rights to physical security and integrity, by, for example, conducting virginity tests on detainees, charged with, for example, political or criminal offences, by making such tests a condition of eligibility for admission to hospital, educational opportunities, or government employment, or by making a visit to a prisoner conditional upon vaginal inspections of his wife and daughter. Human rights to privacy are also offended by governmental misuse of individuals' identifiable health information on, inter alia, pregnancy, termination of pregnancy, and sexually transmitted diseases, including HIV/AIDS.

States do not violate human rights through action that is required or justifiable in order to preserve individuals' human rights. For instance, State action to prohibit parents and others from engaging in female genital mutilation (FGM) legitimately prioritizes children's rights over any that parents may claim. Laws setting a legal minimum age of marriage, designed to save young women from the health risks of premature childbearing, limit the right to marry but respect
transcending rights to the protection and promotion of health and survival. However, the burden falls on those employing State authority, whether through legislation, executive action, or judicial action, to ensure conformity of their action with human rights obligations concerning women’s health and other interests.

B. The duty to protect rights

The duty binding States to protect rights relating to women’s health requires their agencies and officers to take action to prevent violations of rights committed by private persons and organizations. This is an area of growing concern to human rights tribunals, at both domestic and international levels, as States downsize governmental bureaucracies by giving over State functions to private agencies. Private individuals and institutions as such are not bound by international law, except in very extreme circumstances, for example, in the case of war crimes and crimes against humanity. Thus, they are not internationally accountable for their conduct in breach of international human rights conventions. However, States and their governments are legally bound under such conventions “to organize the governmental apparatus and, in general, all the structures through which public power is exercised so that they are capable of juridically ensuring the free and full enjoyment of human rights”.

States cannot evade their human rights obligations by delegating powers to private sector agencies, or by invoking provisions of their own constitutions or laws that limit their powers of intervention for the protection of internationally accepted human rights. States whose governments leave private violations of human rights unremedied or unaddressed are in breach of their own duty under international law to protect human rights.

For example, in a case involving the rape of a mentally impaired woman, the government denied liability for her consequent physical and mental distress. The European Court of Human Rights held, however, that the State had “a degree of responsibility” for these impairments to her health, which WHO describes as “a state of complete physical, mental and social well-being”. Liability arose because no means were provided for the assailant to be prosecuted or for the victim to be compensated. The Court held that the State was required to take positive measures concerning events that occurred between private individuals where human rights had been violated. The State had failed in its legal duty to maximize protection of human rights through sanctions against individual violators and deterrence of potential violators.

States have been considered to have positive duties to provide protection not
only against deliberate killings committed by individuals, such as terrorists, but also against unintentional injury and death. The European Commission of Human Rights has considered the issue regarding a complaint that a governmental vaccination programme had resulted in damage and death to babies. In this case, it was found that appropriate and adequate measures to protect life had been taken. Had it been found that such measures had not been taken, the State would have been found in breach of its human rights duty to safeguard health and life. Data on persistently high levels of maternal mortality put States on notice that they may be in breach of their human rights obligations to protect women’s life and health. States have duties to take appropriate and adequate measures protective of women’s health, for instance by ensuring women’s access to trained birth attendants.

The protective duty of States to restrain third parties’ violations of women’s rights to protect and promote their health may require State action that may be interpreted as an element either of a State’s protective duty or of its duty to fulfil rights. For example, where a private health care facility discriminates against women in its allocation of health benefits on the basis of, for instance, sex, age, or marital status, governmental corrective action may be explained as protecting women against the human rights offence of discrimination, or as meeting the State’s duty to fulfil human rights by ensuring women’s fair access to health services.

C. The duty to fulfil rights

The duty to fulfil rights requires States to take appropriate legislative, administrative, judicial, budgetary, economic, and other measures to achieve women’s full realization of their human rights. Thus, governmental failure to address the magnitude of women’s ill-health, particularly preventable conditions, places the State in breach of its duty. WHO’s studies on reproductive ill-health (which estimate, inter alia, that nearly 600 000 women die each year from pregnancy-related complications, that 120 million couples would like to limit their family size but do not use any form of contraception, and that 85-110 million women and girls are subject to female genital mutilation) provide particularly important sources for putting governments on notice of the possible breaches of their duties with regard to women’s health.

The duties of States to employ “all the structures through which public power is exercised” to meet their responsibilities to protect women’s human rights permit them to conscript private health care practitioners for this purpose.
governments license health care practitioners, whether directly or by delegation to self-regulating professional licensing authorities, they may make it a condition of licensure that practitioners perform a portion of their licensed services under State direction, such as by serving for limited times in public hospitals or women's health care clinics.\textsuperscript{27} States are responsible for promoting fulfilment of human rights, for instance by ensuring that due diligence is exercised in the public interest not only by public hospitals and clinics, but also by authorities that license private health facilities and practitioners.\textsuperscript{28}

Discharge of the duty to fulfil women's human rights to health care sometimes requires States to balance competing human rights or to find a basis of maximum accommodation of the human rights of individuals that may be in conflict with women's rights. For instance, respect for individuals' religious convictions compels States to allow conscientious objection to participation in such procedures as artificial contraception and abortion, but human rights of women require that reasonable provision be made for their access to such services. Where, for example, local health services are available only through private facilities affiliated with a religious denomination opposed to the delivery of such services, States may be obliged to ensure their engagement and the facilitation of practitioners who do not object to such delivery. Alternatively, they may be required to make services available to women through a public clinic or another arrangement that adequately respects the individual consciences of all local practitioners.

If rights are to be balanced on a legal basis, it is essential to ensure women's access to care and acknowledge individual practitioners' rights of conscience, while recognizing that institutions such as hospitals and clinics, being non-human agencies, have no human right of religious conviction or conscience. These institutions cannot limit employment to personnel who adhere to a single religious faith by discriminatory employment practices, since such practices violate international human rights to non-discrimination in employment on grounds of religion or conscience.

III. INTERNATIONAL ENFORCEMENT OF WOMEN'S HUMAN RIGHTS

A. Mechanisms of international accountability

Governments may establish their respect for women's rights to health care through policies advocated by their political institutions that satisfy their independent national judiciaries that legal standards for compliance are being
Experience demonstrates, however, that there must be international scrutiny of States' observance of their commitments under international human rights law. Governmental action that claims to discharge duties to observe women's internationally protected human rights does not come within the exclusive jurisdiction over domestic matters that States claim as a legitimate aspect of their sovereignty and independence.

The major achievement of international human rights law in the past half-century, born of a reaction to the outrageous way that innumerable German nationals were treated by their own State before 1945, is to demonstrate that nation States are not free to treat their own citizens and residents in any way they wish, without accountability to the international community. The principle justified international concern with human rights abuses of South African nationals under apartheid, and remains a justification today for concern about the way in which many States treat women nationals. Individuals' human rights are of international and not exclusively domestic concern. Since governments are nationally and internationally accountable for their observance of the human rights of individuals and groups, attention must be paid to mechanisms for requiring responses to alleged violations and remedying violations.

The special challenge of protecting women's rights — to health care and to the pursuit of many other interests — is that subordination of women's autonomy and role as decision-makers in their own lives is often invisible in the societies and cultures in which they live. Domestic laws often deny women choice of action in ways that social, religious, and other institutions defend. Women are subordinated to the wishes of powerful institutions — whether political, social, religious, or otherwise — that are almost invariably led by men and frequently exclude women. This is seen not just as a feature of many societies, but as a condition of their functioning, stability, and virtue.

The international legal order is clearly imperfect in its capacity for scrutiny and compulsion when it comes to holding governments strictly to account for their records of protection of women's rights to health care and related interests. The challenge must be faced of improving accountability mechanisms at domestic and international levels, by political, legal, and other means. The Cairo Programme of Action was aware of prevailing inadequacies in international accountability for reproductive and sexual health. The Programme makes clear that movement beyond Cairo depends on momentum generated through the human rights regimes. Development for this purpose can be driven in part by existing national human rights institutions and international treaty systems.
For instance, through the Women’s Convention, 157 States have committed themselves to report regularly to CEDAW. States must report periodically on what they have done to:

"... take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning" (Article 12(1));

and to ensure women’s

"rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (Article 16(1)(e)).

Countries that have ratified other human rights conventions accept similar obligations to account to monitoring committees for the extent to which they have complied with their obligations. Mechanisms exist under some conventions, such as the European Convention on Human Rights and the International Covenant on Civil and Political Rights, that enable private persons from consenting States to bring individual complaints against their States for violations. Accommodation of such individual petitions is currently under consideration for the Women’s Convention. A normal condition of international tribunals receiving individuals’ petitions, however, is that such individuals have exhausted all reasonable possibilities of achieving remedies before national tribunals of the State against which the petition is presented.

Enforcement of treaty obligations depends primarily on State action, but monitoring committees, like CEDAW, are mandated to be vigilant in their scrutiny of States’ reports regarding evidence of defaults on responsibilities by States. For this purpose, CEDAW receives alternative reports or comments on State performance submitted by national and international nongovernmental organizations, which may incorporate significant findings of failures to protect and promote women’s health. Such findings may result from medical or, for instance, social science research. Studies that show high rates of wife beating have been used to put governments on notice of private violations that the State needs to prevent or remedy.

To assist countries in their reporting obligations, CEDAW has developed a series of General Recommendations. These Recommendations develop the content and meaning of human rights relating to women, and are somewhat akin
to regulations developed by administrative agencies under national statutory law. Several interesting symposia have begun to focus on the factors that might be considered in developing a General Recommendation on women's rights to health.\textsuperscript{31}

An increasingly important mechanism for developing guidelines for State accountability for observance of human rights is the publication of \textit{Concluding Observations} by treaty monitoring bodies on reports submitted by States. For example in 1996, the Human Rights Committee, established by the International Covenant on Civil and Political Rights to monitor State compliance with the Covenant, addressed the criminal abortion law of Peru. In its \textit{Concluding Observations}, the Committee expressed its concern "that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality".\textsuperscript{32} The Committee found that the criminal law subjected women to inhumane treatment contrary to Article 7 of the Covenant. Moreover, the Committee explained that this aspect of the criminal law was possibly incompatible with Article 3, on equal entitlement of men and women to the enjoyment of the rights set forth in the Covenant, and also Article 6 which protects the right to life.

The Committee recommended "that the necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the Covenant" and that "the provisions of the Civil and Penal Codes [of Peru] should be revised in the light of the obligations laid down in the Covenant", particularly Article 3 requiring that countries ensure respect of women's rights under the Covenant.\textsuperscript{33} As a result, Peru is responsible at least for requiring the medical profession to facilitate women's access to safe abortion and related health services as the law permits. Moreover, since the prevailing law, which strictly penalizes abortion, was shown to result in inhumane treatment of women and undue maternal mortality, Peru is obliged to consider law reform so that the law encourages compliance with human rights standards for women's health and dignity. A new national policy would have to be expressed in new law that more adequately balances limitations on abortion with women's rights to safe and humane preservation of life and health.

\textbf{B. Violations and remedies}

Violations of rights consist in failures to observe legally binding duties, whether due to deliberate refusal of observance, to unawareness of breach associated with lack of relevant information or, for instance, to oversight or
interpretative blindness to the implications of available data. The origin of each violation is relevant to its appropriate remedy. The findings of, inter alia, medical, community health, and social science research may bring to light violations of rights and may alternatively indicate interpretations that show States' conformity with human rights standards of protection of women's health.

Violations of human rights have been divided into three categories, which may be illustrated by reference to rights relating to women's health:

- **Category 1** violations result from direct action on the part of a State, such as coercive pregnancy, sterilization and abortion;

- **Category 2** violations relate to a State's failure to meet the minimum core obligations of human rights protection, such as by refusing or neglecting action shown capable of reducing maternal mortality rates; and

- **Category 3** violations relate to patterns of discrimination, such as persistent and gross discrepancies in access to health services that cumulatively disadvantage the health of groups, such as unmarried adolescent girls.

Violations in each of these categories can be established by arguments of principle, such as against States' maintenance of strictly prohibitive abortion laws that are shown to cause inhumane treatment of women, but also empirically by evidence from research in medicine, community health, and, for instance, the social sciences. Research can indicate, for example, the coercive conditioning of women's apparently voluntary requests for sterilization, such as when poor women can obtain employment only in toxic workplaces from which fertile women are barred under alleged fetal protection policies. Similarly, such research can show actions capable of reducing infertility or maternal mortality rates that States are required to take, and expose patterns of discrimination that women suffer on the ground of sex or gender.

Critical propositions governing modern legal systems are that rights without remedies are no rights at all, and that the duty of legal systems is to ensure that remedies are practically accessible, justly administered, and effective to afford rights their full substance. The purpose of remedies and sanctions for breaches of women's human rights, particularly at the international level, is not primarily that offenders suffer sanctions, but that violations of such rights will be prevented or deterred. Legal methods to make governments accountable are designed to expose governments in default of their legal responsibilities, to indicate by what
standards and processes governments may conform to their legal duties, and to show their compliance with the responsibilities they have assumed. The primary role of national and international human rights agencies is not punitive, but supportive of States’ intentions of compliance.

The duty to provide effective remedies for violations of women’s human rights to health care can be informed by research in a wide range of disciplines. With greater understanding of women’s perspectives in particular, legal systems will be better equipped to ensure the effectiveness of remedies required for violations of rights relating to health, of which women are more liable than men to be victims. For example, if a legal system does not take account of the social importance of confidentiality or of virginity in a rape victim’s life, the effectiveness of the remedy it orders might well be limited. Judicial processes might also deter women from resorting to them, thus depriving them of access to remedies. Examples include court proceedings that result in the public naming of victims of rape, domestic violence, or negligent infection with disease, or the denial of reproductive or other sensitive health services.

C. Evidence for enforcement

Conscientious governments concerned to discharge their human rights obligations concerning women’s health may sponsor research in order to learn of the duties they have met and of the goals they have yet to achieve. Research may be undertaken either within government departments or through independent agencies such as universities or nongovernmental or other organizations. Experience shows, however, that when evidence of governmental failure to discharge duties is produced outside governmental sponsorship, governments approach it with caution, scepticism, and, not uncommonly, hostility. Human rights organizations can come to be regarded, particularly by governments not accustomed to democratically elected opponents and nongovernmental organizations committed to different but not necessarily hostile visions of proper government, as anti-governmental. Reciprocally, if claims are supported only by governmentally sponsored evidence that women’s human rights entitlements have been satisfied, they will often be approached in much the same sceptical way by activists outside government who are committed to respect for women’s rights. Different attitudes and conclusions are often the raw material of conflict, and competition to achieve credibility in assessments made by disinterested international agencies and tribunals is often resolved by the scientific calibre of the evidence that competing parties present.
The quality of evidence is of particular significance when it is to be presented before international judicial or other fact-finding bodies whose decisions have legal and wider consequences. The conditions under which expert testimony and documents will be admitted differ among tribunals. Proceedings may follow, for instance, an adversarial model, in which advocates before reactive tribunals present opposing arguments supported by their witnesses and evidence, or an inquisitorial model, in which tribunal members are mandated proactively to conduct questioning to reach a determination of truth from witnesses and evidence produced on their request, as well as from witnesses and evidence they consider relevant offered by interested parties.

When international treaty monitoring committees, such as CEDAW, receive evidence from nongovernmental organizations, such as national medical associations and women’s rights organizations, that contradicts claims in governmental reports, governmental resources may be applied to question its credibility. Those who provide evidence for presentation before any such tribunal or committee must anticipate its rigorous, sceptical scrutiny, and prepare their findings accordingly.

In fact-gathering for human rights purposes, a distinction is sometimes drawn between events-based data and standards-based data. Events-based data record individual violations of human rights, such as a woman’s forced pregnancy, abortion or sterilization, whereas standards-based data can show State compliance with, or violation of, specific rights, for example through persistently low or high rates of maternal morbidity and mortality. Meticulously documented events-based data may show that abuses of women’s human rights are not merely individual private incidents, for which States may not be accountable, or individual aberrations, for which States may propose excuses, but systematic practices perhaps reflecting public policies of abusive action or abusive inaction in the face of known breaches of women’s human rights to health care, for which States are accountable. Carefully documented cases may direct attention beyond their specific facts to underlying conditions of abuse of women’s rights, such as led to the identification of human rights violations under Peru’s restrictive abortion law.

Standards-based data are commonly used in international human rights monitoring, where States’ obligations to maintain necessary programmes at an adequate level, for instance concerning the protection of women’s health, are a focus of scrutiny. Data on programme performance are interpretable by reference to international and other recognized standards. Disaggregation of data by sex is usually essential to prove the absence or presence of
discrimination against women and, in the case of infant mortality, against girl children. Systematic discrimination for which States bear international legal liability can also be shown by data regarding male and female employment in public facilities that offer health services, since in many cultures neither women nor men will seek necessary health services from members of the opposite sex.

IV. THE ROLE OF THE WORLD HEALTH ORGANIZATION

WHO has a significant role to play in ensuring States’ compliance with their duties to respect rights relating to women’s health. WHO-sponsored studies on the causes, consequences, and magnitude of women’s ill-health provide important measures of the extent of States’ duties to develop their laws to respect, protect, and fulfil rights relating to women’s health.

The international enforcement of human rights relating to women’s health would be far more effective through systematic technical input from WHO to advance the various international mechanisms for accountability. For example, if WHO were to provide the treaty monitoring bodies, on a systematic basis, with technical information on women’s health in reporting countries, it would significantly enhance the ability of these bodies to apply human rights to the advantage of women’s health. Article 22 of the Women’s Convention specifically states that CEDAW “may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities”, and CEDAW has repeatedly asked specialized agencies for technical information and assistance.

Strategies to end the marginalization of women’s human rights are beginning to emerge, and significant understanding of the theoretical, structural and organizational aspects of rights relating to women’s health is evolving. Nonetheless, profound and pervasive violations of rights relating to women’s health persist, and methodologies for investigation and documentation of such violations are inadequate. In order to devise effective remedies to such violations, it is essential to understand their causes and consequences from women’s perspectives. The use of WHO standards-based data, whether health status data or health service data, is one such approach. Other approaches are needed. For example, the use of social science research findings is essential to understanding the social causes of women’s ill-health and thus the structural nature of violations of rights relating to women’s health.

In celebrating 50 years of the *International Digest of Health Legislation*, WHO
can be proud of what the Digest has accomplished in documenting legislation regarding health generally. How laws and policies affecting women’s health are formulated says a great deal about the degree to which nations value women. The WHO data sadly indicate the frequent adverse consequences of laws for women’s health, and thus how little societies value women. Fifty years of documenting health legislation show that law is seldom used as a positive force to respect, protect, and fulfil rights relating to women’s health. It is to be hoped that the Digest’s next 50 years will show law creatively used to protect and promote women’s health, and that WHO has come to play a leadership role in that process.
REFERENCES


5. See *supra* ref. 4, at p. 150.

6. See *supra* ref. 4, at p. 20.

7. See *supra* ref. 4, at p. 8


17. The Women's Convention, *supra* ref. 4, at p. 150.


25. *Supra* ref. 21.


The increasing number of elderly persons in the world will confront the public authorities with one of the greatest problems of the next 40 years. One need only mention the fact that, in Europe, the ratio of retired persons to the active population, currently 25%, will rise to 51% in 2040! In the OECD countries, the number of persons of 65 years of age and over will increase from 9.4% of the total population in 1960 to 13.9% in 2000 and to 22.5% in 2030. Life expectancy will continue to increase by about five years from 1990-1995 to 2025-2030. In

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developed countries, the increase in health expenditure for the elderly, which today already represents a major part of the total health expenditure, as suggested in the table below, will lead to considerable deficits in tomorrow's social security systems.

**SHARE OF TOTAL HEALTH EXPENDITURE INTENDED FOR THE ELDERLY, 1993**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>0-64 YEARS</th>
<th>65 YEARS AND OVER</th>
<th>75 YEARS AND OVER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population (%)</td>
<td>Expenditure (%)</td>
<td>Population (%)</td>
</tr>
<tr>
<td>United States of America</td>
<td>87.3</td>
<td>62.8</td>
<td>12.7</td>
</tr>
<tr>
<td>Japan</td>
<td>86.5</td>
<td>57.1</td>
<td>13.5</td>
</tr>
<tr>
<td>Germany</td>
<td>64.9</td>
<td>67.7</td>
<td>15.1</td>
</tr>
<tr>
<td>France</td>
<td>80.4</td>
<td>38.6</td>
<td>19.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>84.4</td>
<td>56.0</td>
<td>15.5</td>
</tr>
<tr>
<td>Australia</td>
<td>88.5</td>
<td>65.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Finland</td>
<td>86.2</td>
<td>61.5</td>
<td>13.3</td>
</tr>
<tr>
<td>New Zealand</td>
<td>88.7</td>
<td>67.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>86.9</td>
<td>60.1</td>
<td>13.1</td>
</tr>
<tr>
<td>Portugal</td>
<td>86.3</td>
<td>64.1</td>
<td>13.7</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.5</td>
<td>62.2</td>
<td>17.3</td>
</tr>
<tr>
<td>Switzerland</td>
<td>85.7</td>
<td>60.1</td>
<td>14.3</td>
</tr>
</tbody>
</table>

1. Japan: 0-64 years, 65 and over, 70 and over.
2. France: 0-59 years, 60 and over, 70 and over.

The aging of the population, as reflected in these statistical data, poses particularly important problems in the field of public health. How are the health needs of the elderly to be satisfied? How are they to be provided the necessary care and resources, without the active population becoming subject to costs that exceed tolerable limits? How is the highest possible level of health to be promoted with advancing age? What role can health legislation play in this field? In order to attain these objectives in the next few decades, taking into account the development of needs that can be satisfied, health policies and health legislation...
should draw up and implement the following major programmes: I. Successful aging and active aging; II. Reduction of morbidity; III. Organization of services for the elderly; and IV. Research and training.

1. SUCCESSFUL AGING AND ACTIVE AGING

1. Increasing life expectancy and the raising of the level of health of the elderly in each age group and the carrying out of longitudinal research programmes concerning the monitoring of the aging of autonomous elderly persons have led to the concept of successful aging and the characterization of this process. Successful aging is distinguished from normal aging (the form usually observed), in which a marked regression is noted in functional capacities, and from pathological aging accelerated or aggravated by disease and/or disability. Successful aging is characterized by the conjunction of the following three elements:

- a lifetime equal to or greater than average life expectancy;
- good health despite the existence of one, or in general, several disorders, such as hypertension, which are treated or whose development is checked; and
- a feeling of well-being and of the quality of life, whatever one’s level on the quantitative scale of material assets.

This feeling of well-being brings together four factors:

- behavioural possibilities (motor, cognitive, sensory);
- psychological well-being (happiness, optimism, correspondence between projects planned and projects realized);
- a quality of life perceived and experienced by the subject (subjective evaluation of family relationships, friends, activities, work); and
- a satisfying environment (accommodation, neighbourhood, resources, work, activities ...).

Successful aging may be observed in three categories of persons:

- subjects who, at a very advanced age, retain all their physiological functions in a satisfactory state (despite the existence of pathological conditions);
- subjects who, commanding functions that are less satisfactory, improve them during the course of the aging process; and
- subjects who are characterized by being psychologically well adjusted to what they are physiologically able to do and what they would like to do.

2. Successful aging is not the prerogative of a handful of elderly persons.
Research work has shown that the majority of elderly persons can benefit from it. In other words, they may, for a good many years, command the best part of their functional capacities and thus constitute important human resources for society.

3. Given this important progress with respect to the level of health, it is unthinkable that the human resources constituted by the ever-growing number of persons who enjoy successful aging will not be utilized within the context of active aging. If this is the case, the elderly will contribute through their activities to increasing the national product. They will finance retirement systems for longer. Through using their functional capacities, they will be fitter and the cost for health systems will be modified accordingly.

It is for this reason that the OECD recommends to Member States that they "promote active aging ... it is a question of helping people to remain active, open to change, and autonomous as they get older and as they are offered a greater number of choices concerning the use of their time throughout their life. What is particularly worrying is the increase, on the one hand, in the number of persons belonging to the age groups in which the transition from working life to retirement takes place and, on the other hand, in the very elderly population where there is a concentration of chronic health care problems". 3

4. Health legislation has an essential role to play in ensuring that successful aging and active aging benefit the majority of elderly persons.

4.1. In the next few decades, health legislation should make it possible for the majority to enjoy successful aging through provisions devoted to the principal factors that promote this process. These provisions could be binding in nature or provide incentives:

- Periodic gerontological evaluation, the results of which should be entered in the medical file or health booklet of each elderly person, could be made compulsory, non-compliance resulting in the withholding of certain payments or benefits. More specifically, compared with standard medical examinations, it would permit the identification of the functional capacities of the subject in order to stabilize, compensate, or develop those for which this is possible, such as, for example, in the case of muscular mass and the locomotor, respiratory, and cerebral capacities, thereby resulting in a prescription of a preventive nature.

- Nutrition, which has the dual potential of delaying "natural" aging and improving the quality of life of the elderly subject by optimizing his physiological capacities and limiting the occurrence of certain age-linked pathological conditions, exerts a positive effect that has been demonstrated in a
good many areas, such as, for example, the prevention of osteoporosis. In other areas, the data are, although still somewhat fragmentary, extremely encouraging and point the way, through nutrition, to a genuine prevention of the diseases of aging, as emphasized by the international experts who met on the occasion of the Colloquium on “Nutrition and the Elderly”.

Health legislation should promote or place under the responsibility of territorial bodies and the major social services nutritional education programmes for the elderly:

— because nutrition can have a beneficial influence on natural aging, improve the quality of life, and even reduce the incidence of certain age-linked diseases;
— because the elderly have a greater chance of remaining in good health if their nutritional status is satisfactory, and if the risks of malnutrition are made the subject of early screening and, better still, preventive measures;
— health legislation should, by means of appropriate provisions, accord greater importance to physical exercise, the maintenance of mental dexterity, the realization of life plans, and the faculty of adaptation in health education programmes; and
— account should be taken, when equipping accommodation and during town planning, of the needs experienced during aging, especially since the improvements introduced result, for the most part, in increased levels of comfort and well-being for the younger members of the population.

4.2. Health legislation with regard to active aging should translate the consequences of successful aging into specific provisions, entailing, for those who so wish:

— a postponement of the retirement age, that is to say total or partial retention of active status with regard to the tasks previously performed;
— the possibility of performing new, lighter tasks; and
— an extension of the period of contribution to a retirement scheme corresponding to the extension of professional activity.

II. REDUCTION OF MORBIDITY

The reduction of morbidity is one of the principal aims of medicine for the elderly. It makes it possible, at one and the same time, to improve the quality of life of elderly patients and to reduce the cost of old age. For this reduction to be achieved on a large scale, essentially through prevention, it is necessary for the chronic diseases that occur later during life to be of shorter duration and for their onset to be postponed. In recent years, a marked decrease in the mortality rate due to chronic diseases has been observed in the specific age brackets concerned.
The same phenomenon is beginning to be measurable by morbidity markers for which adequate data are available; for example, the average age of the first heart attack has risen by four years in the course of the last 15 years.

Susceptibility to pathological states or external traumatisms varies in keeping with the body’s vitality. This vitality appears to be linked more to the potential length of life remaining to an individual than to his distance from birth. In other words, individual vitality is less dependent on chronological age than on the distance separating the person from death. Indeed, recent years have seen a significant reduction of the mortality rate due to chronic diseases in the case of persons over 70 years of age. The French results, for example, show an increase in the length of time that a person lives without increased life expectancy, at the age of 65 as well as at 85, being accompanied by incapacity. They indicate a relative reduction of morbidity at advanced ages. In order to reduce morbidity during the course of aging, screening tests should be recommended or imposed by health legislation, in particular those set out below.\(^5\)

I. *Clinical history and examinations*

Clinical history:
- symptoms of vascular injury
- alimentary supply
- physical activity
- alcohol consumption
- functional state

Clinical examinations:
- height and weight
- blood pressure
- visual acuity
- hearing
- examination of the breasts
- screening for glaucoma

In high-risk subjects:
- auscultation of the carotid arteries
- complete cutaneous examination
- examination of the oral cavities
- palpation of the thyroid gland

II. *Examinations and analyses*

Customary:
- total cholesterol
- urine analysis
- mammography (in women)
- TSH test (in women)
Groups at risk:
- glycaemia after fasting
- tuberculin test
- ECG
- coloscopy/sigmoidoscopy
- bone densitometry

III. Screening and monitoring of possible risks

In clinic:
- depression
- peripheric vascular pathology
- cutaneous lesions
- poor dental condition

Functional state:
- cognitive decline
- medicaments that can increase the risk of decline
- alcoholism
- ethical problems and the patient’s wishes for the future

III. ORGANIZATION OF SERVICES FOR THE ELDERLY

The adaptation of services to the development of the health needs of the elderly, as well as the facility and equality of access, will play an essential role in the health policies of the next few decades. In this domain, the objectives of health legislation should concern the following aspects: (1) the creation of new services in keeping with the evolving needs of the elderly: gerontological evaluation units; and care units for patients suffering from Alzheimer’s disease; and (2) the bringing into more general use of existing services:

- Hospital and domiciliary palliative care services — The improvement of care for the dying should be the subject of appropriate legislative provisions so that it is possible to organize, at one and the same time, the provision of care to elderly patients in the terminal stage of a disease who wish to die at home, and also the social services whose essential function will be to promote the visits and presence of the family and priests of various religions, when this is desired;

- Primary health care services — These services, which are well integrated with regard to life at district level, easily accessible to the elderly population, and open to the people of the district concerned, will be able to contribute in an essential manner to the realization, or promote the realization, of prevention programmes, including retirement preparation programmes, to the referral of elderly persons to the medical or medicosocial services corresponding to their
needs, and to the organization of domiciliary medicsosocial services;
— **Domiciliary care and home help services;**
— **Development of social support networks** — These networks are destined to play a fundamental role in the improvement of the living and health conditions of the elderly, since they are able to provide important assistance (either complementary or subsidiary) to the health and social services; a reduction of individual vulnerability in the face of disease, disability, depression, and most risk factors associated with the aging process; a development of social relations; a greater possibility of forming part of a social group and benefiting from its affective warmth and solidarity; and a raising of the level of health and safety and a greater participation in community life.

Appropriate legislative provisions should promote the development of social support networks and the availability to such networks of the necessary means, while avoiding any shift of purpose in their programmes and in their voluntary nature. Social support networks are the expression of natural forms of social solidarity.

**The family group** is the primary health and social protection structure for the following reasons: it reduces the vulnerability of the elderly person through the assistance it provides him and contributes to satisfying his need for affectivity, sensitivity, and usefulness, particularly within the context of the grandparent-grandchild relationship. For the elderly person this results in a feeling of physical, mental, and social well-being that is difficult to replace. It is essential, in order to promote this feeling, to simultaneously establish sufficient proximity and distance between parents, children, and grandchildren if the family community is to bestow its advantages without damaging the necessary autonomy of each person.

The family is a social support network by virtue of the exchange of services organized between generations: child-minding, housework, and professional assistance in families engaged in agriculture, the craft industry, or small-scale commerce. These exchanges will become all the more useful as the ratio of dependent persons in society (in relation to the working population) increases (thereby increasing the social cost of aging and entailing a risk that the budgetary resources necessary for financing gerontological services will be reduced), and as changes in the way that life is structured bring about the dehumanization of society. Appropriate legislative provisions should promote the family structure by extending it to those in the ascending line (aid for the accommodation of such persons in the neighbourhood or building inhabited by their descendants, housing benefits calculated taking into account all members of the family, that is to say...
with reference to surface area and amenities, changes in the family’s composition, allowances, social benefits, and significant tax exemptions for looking after parents or grandparents).

Professional mutual assistance schemes have their own, or complementary, systems of social welfare, medical care, and sociocultural actions that cover retired persons. Health legislation could use them where they exist, extend their tasks (objectives), and promote any financial aid likely to be accorded to them.

Throughout the history of human societies, the neighbourhood has always been a place graced with solidarity, protection, mutual aid, and the sharing of joys and sorrows, although it should not be forgotten that it has also always been the scene of rivalries, opposition, and hostility. Appropriate legislative provisions should be used to maintain or restore the social life of the neighbourhood, which is where social solidarity is born. Neighbourhood solidarities provide frequent and regular opportunities to see one another, to meet, to get to know one another, and to render services to one another, such as, for example, when an elderly person comes to look after the sick child of a neighbouring family while the father and mother are working. This avoids the economic and social costs that would result either from the absenteeism of the mother if she herself takes care of the child, or from the hospitalization of the child. On another occasion, when the elderly person is unwell, it is the family of the young child who returns the favour by carrying out various tasks.

Associations (devoted to culture, games, sports, etc.) express solidarity through affinity. They have the advantage of bringing together, through common tastes, persons who belong to different age groups. Such associations promote social activities, integration, and solidarity. Their contribution to the elderly is particularly useful. Appropriate legislative provisions should promote their creation and development and ensure that they have the support of the local authorities.

IV. RESEARCH AND TRAINING

Raising the level of health of the elderly in the near future will depend to a large extent on the gerontological knowledge of the professionals called upon to work in the service of these persons and on the general information, that is to say the basic education, provided to the population as a whole on the subject of aging. Health legislation will be required, in this domain, to play a particularly important role in four fundamental sectors: initial training, continuing education, basic education, and preparation for retirement.
Initial training

Given its importance, the aging process in the individual and in populations should be a subject taught in all initial training programmes for future professionals. More developed programmes should be adapted to the needs of different professional specialties: physicians, nurses, nursing auxiliaries (whose role in accompanying the elderly is particularly important), specialized health personnel (kinesitherapists, ergotherapists, psychotherapists, chiropodists, etc.), social workers, domiciliary support workers (home helps, health assistants, minders), and administrative and managerial personnel, particularly of the health services and social institutions, psychologists, sociologists, economists, and lawyers. Courses in gerontology should be created in universities and lead to the award of a specialist diploma.

Continuing education

The continuing education of professionals during the course of their work, that is to say their retraining, will make it possible to supplement or update previously acquired knowledge. Therefore, appropriate elements of gerontological knowledge should be incorporated in continuing education programmes specializing in gerontology — with either a medical or a social emphasis — for all professionals concerned. These courses should be decentralized as far as possible within the national territory. They should be conducted within the framework of cooperation between professional organizations and local authorities. Financial assistance should be made available to them, the justification of such assistance being all the more evident from precise evaluations, based on, *inter alia*, the cost-benefit ratio, that reveal their full utility. Institutions, services, private foundations, and undertakings could be broadly associated with the design and implementation of these programmes, to which retired professionals could also provide assistance.

Basic education

Appropriate legislative measures should be used to promote the inclusion of gerontological data in health education programmes aimed at informing the population on the following major topics: the importance of the aging process of the human being and populations; the place of the elderly person in society — respect, dignity, solidarity; knowledge of the essential elements that make it
possible to prevent the pathological conditions of aging; and knowledge of the measures to be taken with regard to social welfare (everyday hygiene, mutual aid, savings-retirement, etc.). These programmes should be offered, *inter alia*, in schools, including by means of school textbooks (civic education), in associations for the retired, clubs, and universities of the third age, etc., within the specific framework of health education services and by means of widely disseminated programmes provided with the assistance of the mass communications media.

**Retirement preparation programmes**

If retirement preparation programmes were conducted on a large scale, that is to say for a major part of the population, they would effectively contribute to raising the level of health of the elderly, as well as life expectancy at 60 or 65 years, through the adoption of forms of behaviour that are more conducive to a good state of physical, mental, or social health. A range of measures should be adopted, particularly with regard to the following points:

- the drawing up of model programmes for retirement preparation courses;
- the recommendation of different “modules” of preparation courses adapted to the needs and availability of the participants: two days, three days, a week, one day a month for 3-6 months, weekend, etc.;
- the recommendation of active and participatory teaching methods and human relations conducive to communication;
- the establishment of a European “bank” of information, documents, results of experiences, and pilot programmes, including a library of videos, films, and sound recordings and a loans service;
- close cooperation between the local, regional, and national authorities for the provision of rooms, equipment, and personnel services (public health physicians, social workers, and physical education teachers), with a view to organizing retirement preparation courses as cheaply as possible and for as many people as possible;
- the training of managerial personnel and facilitators of retirement preparation courses;
- the assistance and cooperation of the public services and private voluntary services;
- the rigorous evaluation of the costs and benefits of the retirement preparation courses conducted, in order to find the optimum cost-benefit ratio, account also being taken of ultimate behavioural changes;
- the implementation in each country of applied research programmes to
improve the cost-benefit ratio, thereby making retirement preparation available to the majority; and

— the organization and monitoring of retirement preparation courses.

Preparation for retirement should, therefore, be considered a vital element of an action concerned with preventive medicine for the elderly. As such, it belongs essentially to the field of health legislation. Various legal provisions are devoted to gerontological training in the European countries. In Belgium, for example, there are Crown Orders on the organization of training centres for assistance for the elderly in the Brussels and Walloon Regions, while in France the legal and financial arrangements for continuing education are applicable to retirement preparation.

**The development of research in gerontology**

National research programmes in gerontology should be developed through the allocation of ample resources to high-level research teams, particularly in the fields of the biology and physiology of aging, clinical gerontology and preventive medicine, and social gerontology. Multi-national research programmes should be developed within the framework of cooperation organized at different levels:

— between the States concerned, that is to say between research ministries, ministries of health, and ministries of social affairs, on the basis of agreements concluded by specialized ministers; and

— between universities or research departments.

Health legislation, in the broad sense, should therefore include a considerable number of gerontological research agreements concluded by the ministers concerned and international research contracts concluded by the universities or public or private research departments of the different countries of the Region.

The viability of each research programme should, to a greater extent than in the past, be subject to rigorous evaluation. New programmes should not be adopted, nor existing programmes extended, unless a commission independent of the research team has carried out an evaluation of the cost-benefit ratio of the programme concerned and issued a favourable opinion. Legislative provisions should make it compulsory for a statement of the anticipated cost-benefit ratio to be presented during the programme approval procedure. Applied research programmes of an experimental or pilot nature should receive priority treatment, owing to the direct, very specific, contribution that they are likely to make to the attainment of progress in the health or social fields. It should be compulsory for their results to be subjected to rigorous evaluation.
Cooperation with voluntary establishments

In addition to the numerous foundations that contribute substantially to various research programmes, a good many voluntary bodies with considerable means devote their resources to “first-line” social actions. They could participate, to a greater extent than hitherto, in applied research programmes, especially experimental pilot programmes. It is only rarely that research in gerontology has been the subject of legal provisions. In most cases, the texts concerned do no more than express the intention of promoting the development of such research. The programmes that result from this intention are dependent on the financial resources allocated to them.

In the next few decades, considerable progress may transform the problems posed by the aging of populations, whether in the case of successful aging to which the majority may aspire, or in the case of active aging by virtue of which the elderly become human resources that are directly useful to society. This progress will not take place unless health legislation is equipped, in each State, with the provisions necessary to promote such development."
REFERENCES


3. See supra ref. 1, at p. 17.


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