Global Health Governance
OVERVIEW OF THE ROLE OF INTERNATIONAL LAW IN PROTECTING
AND PROMOTING GLOBAL PUBLIC HEALTH

Professor David Fidler

May 2002

Centre on Global Change & Health
London School of Hygiene & Tropical Medicine

Dept of Health & Development
World Health Organization
Acknowledgements

This paper was written as part of a project entitled "Key Issues in Global health Governance" funded by the Department of Health and Development, World Health Organization. The author wishes to thank Kelley Lee and Nick Drager for their help and support on this paper.
Preface

WHO's work in the area of Globalization and Health focuses on assisting countries to assess and act on cross border risks to public health security. Recognising that domestic action alone is not sufficient to ensure health locally the work programme also supports necessary collective action to address cross border risks and improve health outcomes.

In carrying out this work there was an increasing recognition that the existing rules, institutional mechanisms and forms of organization need to evolve to better respond to the emerging challenges of globalization and ensure that globalization benefits those currently left behind in the development process.

Consequently, as part of WHO's research programme on Globalization and Health, global governance for health was identified as an issue that required more detailed analysis to better inform policy makers interested in shaping the future "architecture" for global health.

Working in partnership with the Centre on Global Change and Health at the London School of Hygiene and Tropical Medicine, WHO's Department of Health and Development commissioned a series of discussion papers as a starting point to explore the different dimensions of global governance for health. The papers have been written from varying disciplinary perspectives including international relations, international law, history and public health. We hope these papers will stimulate interest in the central importance of global health governance, and encourage reflection and debate among all those concerned with building a more inclusive and "healthier" form of globalization.

Dr. Nick Drager
Department of Health and Development
World Health Organization
Author

David Fidler
Professor of Law
Indiana University School of Law

Series editor

Kelley Lee
Senior Lecturer and Co-Director
Centre on Global Change and Health
London School of Hygiene & Tropical Medicine

For more information please contact:

Melanie Batty, Secretary
Centre on Global Change and Health
London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT UK
Tel: +44(0)20 7927 2944
Fax: +44(0)20 7927 2946
Email: melanie.batty@shtm.ac.uk
ABBREVIATIONS

CIL  customary international law
DSU  Dispute Settlement Understanding
ESC rights  economic, social and cultural rights
GATS  General Agreement in Trade in Services
GATT  General Agreement on Tariffs & Trade
GHG  global health governance
IAVI  International AIDS Vaccine Initiative
ICESCR  International Covenant on Economic Social & Cultural Rights
ICJ  International Court of Justice
ICRC  International Committee of the Red Cross
IDHL  International Digest of Health Legislation
IHL  international humanitarian law
IHR  International Health Regulations
ILO  International Labour Organization
IMF  International Monetary Fund
MIM  Multilateral Initiative on Malaria
MNCs  multinational corporations
NGOs  non-governmental organizations
OIHP  Office International d'Hygiène Publique
PASB  Pan American Sanitary Bureau
TRIPS  Trade-Related Aspects of Intellectual Property Rights
UN  United Nations
UNESCO  UN Educational, Scientific & Cultural Organization
WHA  World Health Assembly
WHO  World Health Organization
WTO  World Trade Organization
GLOBAL HEALTH GOVERNANCE:
OVERVIEW OF THE ROLE OF INTERNATIONAL LAW IN PROTECTING AND
PROMOTING GLOBAL PUBLIC HEALTH

INTRODUCTION: LAW, GOVERNANCE, AND GLOBAL PUBLIC HEALTH

Public health officials and experts increasingly refer to the emerging concept of “global health governance” when thinking about how globalization affects the national and international pursuit of public health. As the diverse contributions in this series demonstrate, global health governance (GHG) is a complex, multifaceted idea whose contours are now being shaped by academic discourse and practical policy endeavours. This Discussion Paper looks at GHG through the lens of international law and provides an overview of how international law is important to the emerging discussions about GHG and the global efforts to protect and promote public health.

At every political level, governance involves many factors, forces, and actors. From a lawyer’s perspective, central to understanding governance is grasping the importance of rules to the process of governing societies. Without the existence of a system of rules, regulating the behaviour of individuals, organizations, and even governments would be impossible. Substantive and procedural rules determine and shape the nature of governance. Legal systems, thus, provide the core architecture for governance.

Evidence of the need for law in structuring strong governance can be found in recent international relations. International organizations, such as the World Bank and the International Monetary Fund, put significant emphasis on reform of national legal systems during the 1990s as part of their “good governance” policies (World Bank 1994; IMF 1997). These efforts, by and large, equated “good governance” with the establishment and implementation of the rule of law in domestic societies (Carothers 1998).

The importance of law to public health governance in states has also been part of the discourse on the globalization of public health. The necessity for a strong legal foundation for public health activities has long been understood conceptually by public health experts and public health lawyers (Tobey 1939; Grad 1990; Lhírendel and Yach 1998; Gotin 2000). The Constitution of the World Health Organization (WHO) recognizes the role of law in national public health by requiring in Article 63 that each member state communicate to WHO promptly important laws and regulations pertaining to health (WHO 1946). WHO then shares national legislation with the rest of the world through the International Digest of Health Legislation (IDHL 2001).

Despite conceptual appreciation of the role of law in supporting public health governance nationally, in practice public health law has suffered from neglect on a worldwide basis. Such neglect is part of the reason public health policies, infrastructures, and resources within low and high-income countries have suffered in the last twenty-five years. In many respects, the need for GHG arises from the manifest failures of public health governance within states. Whether GHG succeeds or fails will depend heavily on effective national public health governance.
GHG involves, however, a dimension that cannot be captured by focusing solely on national public health governance and the role law plays domestically. Just as national law is critical to public health governance within a country, international law is central to the structure and dynamics of GHG. Explaining the role of international law in protecting and promoting public health on a global basis is the objective of this Discussion Paper.

The paper’s analysis unfolds in five parts. Part 1 examines the theoretical and practical need for international law in global governance systems. Part 2 provides a brief overview of the structure and dynamics of international law, which is an area of legal theory and practice that is often unfamiliar to public health experts and policy makers. Part 3 demonstrates how deeply embedded the value of public health is in public international law today. The protection and promotion of public health can be found in a wide variety of international legal regimes that cut across virtually every area of international relations. Part 4 analyzes different kinds of global governance mechanisms and strategies that have developed in international law on public health. In Part 5, the focus is on international law’s limitations as an instrument of GHG in order to communicate the message that international law is necessary but not sufficient to create effective GHG in today’s complex world.

I. GLOBAL GOVERNANCE AND INTERNATIONAL LAW

The concept of GHG is premised on the notion that “global governance” is distinguishable from “international governance” and “national governance.” Table 1 below attempts to distinguish those three types of governance based on the actors and form of rules involved and on the scope of the applicability of the relevant rules.

### TABLE 1: GOVERNANCE TYPOLOGIES

<table>
<thead>
<tr>
<th>Governance Models</th>
<th>Actors Involved</th>
<th>Sources of Rules</th>
<th>Scope of Rule Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Governance</td>
<td>-State</td>
<td>-Constitutions</td>
<td>Applicability of rules is limited to the territorial jurisdiction of the state</td>
</tr>
<tr>
<td></td>
<td>-Non-state entities (e.g., corporations, labour unions)</td>
<td>-Statutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Individuals</td>
<td>-Administrative regulations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Common law</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Court decisions</td>
<td></td>
</tr>
<tr>
<td>International Governance</td>
<td>-States</td>
<td>-Treaties</td>
<td>Rules apply in relations between states either directly or indirectly through international organizations</td>
</tr>
<tr>
<td></td>
<td>-International organizations</td>
<td>-Customary international law</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-General principles of law</td>
<td></td>
</tr>
<tr>
<td>Global Governance</td>
<td>-States</td>
<td>-Treaties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-International organizations</td>
<td>-Customary international law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Multinational corporations</td>
<td>-General principles of law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Non-governmental organizations</td>
<td>-&quot;Soft&quot; law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Individuals</td>
<td>-Non-binding norms</td>
<td></td>
</tr>
</tbody>
</table>
GHG literature often argues that the factor that distinguishes global governance from international governance is the involvement of non-state actors, such as non-governmental organizations (NGOs) and multinational corporations (MNCs) in the governance process (Lee and Dodgson 2000, Lee, Dodgson and Drager, 2002). Thus, in global governance, NGOs and MNCs participate in the creation and modification of new rules of international law and are affected directly by international legal rules. By contrast, international governance involves only states in the making of rules, and the rules themselves applied only to inter-state behaviour.

Distinguishing characteristics of national, international, and global governance is helpful, but only up to a point. As with most attempts at categorizing complex phenomena, breaking governance into national, international, and global levels misses some of the ways each level of governance is intertwined. National governance is, for example, often influenced by the commitments a state has under international law. MNCs and NGOs have historically had impact on the formation of treaties and rules of international law governing relations between states (Charnovitz 1997). Global governance involves heavy doses of international law and thus involves international governance.

Perhaps a more helpful way to think about global governance from a legal perspective is to understand the global governance dynamic: what actually happens when states and non-state actors are confronted with international problems. Figure 1 below depicts the global governance dynamic.

**FIGURE 1: THE GLOBAL GOVERNANCE DYNAMIC**
The process begins with a global or international problem placing pressure on both states and non-state actors. A global or international problem is one caused, in whole or in part, by actors or events beyond the control of the individual state coming under pressure to respond. The state and non-state actors in question perceive that the problem cannot be effectively handled through national law and policy alone, so the process is internationalized. States engage in diplomacy with each other, but non-states actors play a role in influencing the diplomatic process by giving input to both states and the diplomatic process itself. Often the result of diplomatic negotiations are rules of international law, which have effects on both the behaviour of states and non-state actors. States frequently have to translate rules of international law into national law to implement their international legal obligations, and non-state actors influence the national law-making process as well as being affected by the national law that is produced. The combination of the international law and the national law is intended to have an impact on the global problem that sparked the process in the beginning.

From the legal perspective, Figure 1 illustrates how global governance involves both international and national governance. In addition, Figure 1 shows that state and non-state actors play roles in national and international law-making. This dynamic shows that the idea that international governance does not involve non-state actors is analytically inaccurate. Also revealed by Figure 1 is the interdependence of international and national law in state and non-state actors responding to global problems.

The global governance dynamic illustrated abstractly in Figure 1 can be concretely applied to a global public health problem—the international spread of infectious diseases in the nineteenth century. Figure 2 depicts the nature of the development of GHG on infectious diseases in the latter half of the nineteenth century.

FIGURE 2: GLOBAL HEALTH GOVERNANCE AND INFECTIOUS DISEASES IN THE NINETEENTH CENTURY
The cholera epidemics of the first half of the nineteenth century forced European states to realize that their traditional approach to the spread of disease, namely national quarantine measures, was no longer viable. European states began in 1851 a process of disease diplomacy that spawned many international sanitary conferences and a number of international sanitary treaties by the end of the nineteenth century (Goodman 1971; Howard-Jones 1975; Fidler 1999a). Very important in the internationalization of disease control was the frustration of European merchants with the economic burdens national quarantine systems imposed (Goodman 1971; Howard-Jones 1975). Non-state actors therefore played a critical role in the development of GHG on infectious disease control from the very beginning. States had to implement the international sanitary conventions by reforming national quarantine systems, and this had an impact on merchants as well. The policy objective of this GHG process was to reduce the international spread of disease and to reduce burdens on international trade from health-related measures.

Figure 2 provides not only an illustration of the general dynamic of global governance, but also a lesson that GHG is not a new phenomenon in international relations (Loughlin & Berridge 2002). While GHG today involves players and issues not seen in the nineteenth century, the development of disease diplomacy and the crafting of international treaties on the control of cholera, yellow fever, and plague contain all the basic elements of GHG that are part of the process today. The same lesson can be found in the history of international cooperation on other public health problems, such as trade in narcotic drugs and alcohol and occupational safety and health (Fidler 2001a).

Understanding the global governance dynamic and the important role that international law plays within it requires grasping the political structure of international relations. Humanity is divided politically into sovereign states that interact with each other in a condition of anarchy, or the absence of any supreme authority or power. The interaction of states in the condition of anarchy produced the conceptual and practical need for mechanisms and instruments to stabilize and regulate political and economic intercourse. States devised international law for the purpose of regulating their interactions.

International law was not, however, the only mechanism developed to bring such order and stability. Political mechanisms, such as the balance of power, were also developed and used to regulate relations between states. Governance in international relations has always been an unstable mixture of power politics and international law. The structure of international politics makes international law necessary to global governance but not sufficient to produce the kind of stability and peace associated with domestic politics. Applied to public health, these observations mean that international law is structurally and practically unavoidable as an instrument of GHG. The evidence provided in Part 3 below proves this point because it shows clearly that international law is critical to GHG.

Before digging into such evidence, it is necessary to explore the structure and dynamics of international law to understand how this important governance tool works in international relations. International law is a complicated and controversial subject. Despite its centrality in GHG, many public health experts and officials are not well versed in how international law functions. The next part
of the chapter is necessary, therefore, to give the reader a technical foundation for
the substantive analysis on international law and public health that follows.

2. **THE STRUCTURE AND DYNAMICS OF INTERNATIONAL LAW**
2.1 **Definition and Nature of International Law**

Many people not trained in international law frequently adopt a common attitude
toward the role of international law in international politics: international law is
not really law because it cannot be enforced. This simplistic perspective focuses
attention on the nature of international law: is it law, simply morality dressed in
legal clothing, or the pursuit of power politics through legal means? These
questions become critical for public health if, as this paper asserts, international
law is critical to the global public health effort.

International law can be defined briefly as the rules that govern the relations
between sovereign states. States make the rules of international law to govern
their international relations, and states are the most important subjects of the
rules of international law. As Section 2.3 below examines in more detail,
international law involves more than states; but states remain, even in the era of
globalization, the dominant players in international law.

As argued in Part 1, international law historically arose because humanity
organized itself into sovereign states that recognized no superior authority. States
needed some instrument to help organize and stabilize their relations in the
condition of anarchy. When someone argues that international law is not really
law because it cannot be enforced like domestic law, the argument misses one of
the most important features about international law—its rules apply in a political
system radically different from what exists within states. As a general matter,
within a state, citizens recognize a superior authority that has the power to
enforce laws. The condition of anarchy does not prevail in international relations,
the system of sovereign states recognizes no superior authority and has not
vested in any state or institution the power to enforce rules of international law.
International law is thus unlike domestic law because the political system from
which it emerges is radically different. As a set of rules, international law cannot
and should not be judged against what happens legally and politically within
states.

A more helpful way to look at international law involves identifying the functions
that it serves in international relations. The question of international law’s
functions is, however, controversial in international relations theory. Distinct
theoretical perspectives on the utility of international law exist, and Table 2
summarizes the four main classical positions in international relations theory on
the functions of international law.
TABLE 2: FUNCTIONS OF INTERNATIONAL LAW: CONTROVERSY IN INTERNATIONAL RELATIONS THEORY

<table>
<thead>
<tr>
<th>Category of International Relations Theory</th>
<th>Basic Description of Theoretical Category</th>
<th>Basic Description of Category's Position on International Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realism</td>
<td>Explains international relations as a struggle for power between states</td>
<td>International law exists but is merely an instrument in the game of power politics</td>
</tr>
<tr>
<td>Liberalism</td>
<td>Explains international relations by focusing on the liberty and rights of the individual</td>
<td>International law is critical to creating order and peace between states in the international system</td>
</tr>
<tr>
<td>Marxism</td>
<td>Explains international relations as a byproduct of the struggle for the control of the means of economic production</td>
<td>International law is a tool used by capitalist states to advance their interests and deepen the transnational oppression of the proletariat</td>
</tr>
<tr>
<td>Conservatism</td>
<td>Explains international relations through a focus on cultural similarities and differences between states and peoples</td>
<td>Cultural similitude gives international law a solid foundation; without such similitude, international law operates on the basis of expediency</td>
</tr>
</tbody>
</table>

The theoretical differences about the role of international law are relevant to GHG, but there is insufficient space here to analyze this debate fully. Beneath this conceptual level are more practical functions that international law serves on which this paper focuses. Perhaps the most basic function that international law serves is to set the ground rules for state interaction. These ground rules relate to determining over what territory, activities, and people a state has sovereignty, and how a state may exercise its jurisdiction outside of its territory. International law also contains rules that govern diplomatic relations, which involve principles of immunity for embassies and diplomatic personnel.

A second basic function of international law is to provide states with flexible tools to use in their interactions. These tools are the so-called sources of international law (see Section 2.2 below), the most important of which are treaties and customary international law (CIL). Through treaties and CIL, states shape and regulate their intercourse in diverse areas, providing the anarchical environment of international relations with some semblance of order and stability.

While order is the primary objective of international law in its first two basic functions, the third basic function is to provide states with ways to supplement the pursuit of order with notions of justice. The "justice function" of international law relates to both a dispute between two states over an alleged violation of an international legal rule and controversies about human justice on a global scale. International justice implicates international law because states need to determine whether rules of law have been violated and what consequences flow from such violations. International legal discourse also involves consideration about whether international law contributes to, or adversely affects, a just distribution of power, wealth, and influence in international relations.

Each of the three basic functions of international law is important for the global pursuit of public health. Discourse on GHG does not typically contemplate overthrowing the existing structure of sovereign states, so the basic functions of
international law in providing the ground rules for interstate relations are important, if not obvious, for public health. Second, as will be analyzed in greater depth below, the tools of treaties and CIL become central to efforts to protect and promote public health. Finally, concerns about inequalities in health that exist in the world today connect with the “justice function” of international law.

2.2 SOURCES OF INTERNATIONAL LAW
2.2.1 Theoretical Sources of International Law

From what sources do rules of international law come? This question can be approached from a conceptual or practical level. Conceptually, international legal discourse includes debates between positivism and natural law as the theoretical source of international law. Positivism holds that rules of international law flow from state practice, and more specifically, from states consenting to be bound by rules of international law. The international lawyer’s job is to study international relations empirically and record the rules to which states give their consent. The natural law approach posits that the rules of international law are, and should be, connected with universal maxims of right and justice that are discovered by the exercise of human reason. Thus, the practice of states is not dispositive of whether a rule of international law exists or what the substantive content of the rule is. For example, although states routinely practice torture (Amnesty International 2000), international law prohibits torture (UN 1986). The international legal prohibition against torture cannot, thus, be located solely in state practice (Weisburd 2001).

In the past two hundred years, positivism has been the dominant theoretical source of international law (Grewe 2000). The dominance of positivism can be seen in the provision most international lawyers use as the authoritative list of the practical sources of international law: Article 38(1) of the Statute of the International Court of Justice (ICJ 1945) (see Box 1). The three primary sources of international law—treaties, CIL, and general principles of law recognized by civilized nations—reflect positivism’s influence because they record expressions of state consent to be bound. Article 38(1) of the ICJ Statute does not list natural law as a source of international law, despite natural law’s importance in the development of the law of nations from its earliest days through the nineteenth century (Nussbaum 1954).

**BOX 1: ARTICLE 38(1) OF THE ICJ STATUTE**

<table>
<thead>
<tr>
<th>The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) international conventions, whether general or particular, establishing rules expressly recognized by the contesting States;</td>
</tr>
<tr>
<td>(b) international custom, as evidence of a general practice accepted as law;</td>
</tr>
<tr>
<td>(c) the general principles of law recognized by civilized nations;</td>
</tr>
<tr>
<td>(d) subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of the rules of law.</td>
</tr>
</tbody>
</table>
The discussion in the rest of this section focuses on the positivistic sources of international law in Article 38(1) of the ICJ Statute, but a few words about the resurgence of natural law thinking in international law in the twentieth century are in order. Many international legal rules developed in treaties and CIL in the twentieth century bear little resemblance to state practice. International human rights law is perhaps the best example of a significant gap between what international law provides and how states actually behave, as illustrated by the example of torture mentioned above. The development of international human rights law cannot be adequately explained from positivism because natural law thinking has significantly influenced this area of international law. Further evidence of natural law’s resurgence in international law can be found in jus cogens norms and obligations erga omnes. As I have written elsewhere:

\[\text{Jus cogens norms are rules of international law against which no derogation is permitted. Obligations erga omnes are international legal duties that a State owes to the entire international community. These ideas contain the assertion that legal obligation in international relations does not derive only from State consent but also from the opinion of the “international community” about what is right and wrong.}\]

(Fidler 2000: 46)

\[\text{Jus cogens norms and obligations erga omnes have generated controversy in international legal discourse, and discussion of this debate is beyond the scope of this paper. The important point here is that, despite the dominance of positivism in international law, natural law thinking remains influential and controversial.}\]

### 2.2.2 Practical Sources of International Law

**Treaties** The Vienna Convention on the Law of Treaties (1969) defines a treaty as “an international agreement between States in written form and governed by international law” (Article 2.1(a)). The obligations in treaties are only binding on states that expressly give their consent to be bound. States that do not join a treaty are not bound by its rules under international law. As a source of international law, treaties require express and written consent from states for binding obligations to be created. Treaties reflect a strong image of sovereignty because the need for express consent leaves the state as complete master of its international legal commitments.

**Customary International Law (CIL).** CIL constitutes the second major source of international law. Rules of CIL are unwritten rules of international law that develop from patterns of state behavior. For a rule of CIL to solidify, three elements must be shown to exist: (1) a particular pattern of state behavior is present generally in the international system (general state practice); (2) the pattern of state behavior is consistent throughout the international system (consistent state practice); and (3) states follow the pattern of behavior out of the sense that they are legally obligated to do so (\textit{opinio juris}) (Brownlie 1998). If all three elements are found, a rule of CIL exists; and the CIL rule is universally binding on all states in the international system except those states that have persistently objected to the rule’s formation (persistent objectors) (Fidler 1996).
As a source of international law, CIL differs dramatically from treaties. First, CIL rules are unwritten, whereas treaties must be in writing. This difference suggests that the methods by which binding treaty rules and rules of CIL form are radically different. Treaties are the products of formal, highly organized negotiations, while CIL rules develop from a decentralized, unorganized process through which patterns of behaviour emerge over time and solidify into rules of international law. Second, CIL rules are universally binding whereas treaty rules bind only those states that have accepted the treaty. A state may be bound by a rule of CIL even if it has not expressly given its consent. CIL contains, thus, a weaker image of sovereignty than treaties do. Third, the unwritten, ad hoc nature of the CIL process usually produces rules that have more generality and ambiguity than many treaty provisions. CIL formation is not well-suited to the development of precise rules of international law in specific areas of international relations. This aspect of CIL adversely affects its contributions to GHG [see Section 2.2.3 below].

**General Principles of Law Recognized by Civilized Nations.** This third primary source of rules of international law consists of legal principles found in domestic systems of law that are useful in regulating the interactions of states (Brownlie 1998). The phrase “recognized by civilized nations” is today an embarrassment for international lawyers (Schwarzenberger 1955), and it is usually interpreted to mean “recognized by states in the international system.” The idea behind this source of international law is that some fundamental principles of domestic legal systems can be elevated into the international realm and applied in relations between states. General principles of law have most frequently been used as a source of international law in adjudicating disputes before international tribunals, such as the ICJ (Brownlie 1998). But even in this limited context the use of this source is infrequent. General principles of law are not, therefore, a very important or robust source of international law in the contemporary international system.

**Judicial Decisions and the Writings of Publicists.** Rules of international law flowing from treaties, CIL, or general principles of law are often the subject of interpretation and analysis by national and international courts, and by international legal scholars and practitioners. Judicial decisions and the writings of publicists have become, thus, an important subsidiary means for determining the meaning of rules of international law. Judicial decisions and writings of publicists are subsidiary means because these texts interpret and analyze rules created by treaties, CIL, or general principles of law. Theoretically, judges and scholars do not create rules of international law, but only work with what has already been generated by state practice.

### 2.2.3 The Sources of International Law and Public Health

International law on public health concerns is heavily treaty-based. Compared to treaties, CIL and general principles of law play less significant roles. While CIL arguments are made in the public health context (e.g. the human right to health is a right recognized under CIL), the general dynamic is that CIL has offered an inadequate basis for addressing public health problems, which has forced states to use treaties to build regimes that attempt to promote and protect public health.
The prominence of the treaty means that GHG confronts the strong image of sovereignty contained in the treaty concept, forcing the promotion of public health into a difficult situation:

Sovereignty looms large when international legal rules require explicit State consent to the creation of binding obligations. The requirement for State consent means that States can withhold their support from a treaty until its rules are diluted or made more to their liking. Such dilution weakens the international legal regime being created in the treaty, and the end result might be a treaty that does nothing much to advance the desired objectives. This dynamic affects existing international law on public health issues, such as the International Health Regulations . . . , and threatens new international legal initiatives, such as the proposed framework treaty on tobacco control . . .

(Fidler 2000: 51)

This difficult international legal and political environment has stimulated states to create various ways to make the treaty a more flexible and effective ally in the pursuit of public health, and these innovations are analyzed in Part 4.

2.3 Subjects of International Law

The definition of international law provided in Section 2.1 focused on rules governing interstate relations. This definition implies that only states are subjects of international law. A "subject of international law" means an actor who holds rights and obligations under the rules in question. Once upon a time, states were the only subjects of international law. Today, however, international organizations and individuals have joined states as subjects of international law, the former being not a particularly radical addition because membership in international organizations is, after all, composed of states.

The more dramatic change came in the twentieth century when individuals, through the development of international human rights law and international humanitarian law, became subjects of international law. Under international human rights law, individuals now possess rights under international law that they can ostensibly hold against their governments in national and international fora. Under international humanitarian law and international human rights law, individuals also have obligations not to commit certain acts against other individuals, such as genocide, war crimes, crimes against humanity, and torture.

Current international legal discourse includes debate about whether NGOs and multinational corporations (MNCs) are or should be subjects of international law. As Figures 1 and 2 above showed, non-state actors have long been part of the global governance dynamics and GHG without having the status of formal subjects of international law. The role that non-state actors play in GHG does not depend, therefore, on whether they are subjects of international law. Many people believe that the role of NGOs (but not necessarily MNCs) should be formalized to increase the legitimacy and transparency of the creation and operation of international legal regimes. The question of whether global governance generally and GHG would be improved if NGOs and MNCs were given formal subject status is
considered in Part 4 in relation to the involvement of non-state actors in the international norm-making process.

2.4 Scope and Progress of International Law

From its origins in post-Renaissance Europe, international law has expanded enormously to cover a vast array of issues. It is difficult to identify areas of human activity that are not addressed today in some fashion by international law. As will be seen in Part 3, the international law that relates to public health constitutes an enormous body of rules that spans the entire spectrum of international relations. Whether the expanded scope of international law constitutes progress for humankind remains a difficult question to answer. In connection with public health one could argue that, as the number of treaties has increased, the inequalities in health conditions between rich and poor states have grown. As international regimes touching on public health have multiplied, so have problems that threaten human health on a global scale. These somber observations do not mean that international law is a useless instrument for GHG but rather hint at the limitations GHG faces in having to utilize international law. I explore these issues more in Part 5.

3. INTERNATIONAL LAW AND PUBLIC HEALTH: AN OVERVIEW

3.1 The Importance of the Broad Scope of Public Health

Public health experts and officials are often surprised to discover how much international law directly relates to their mission. Part of this surprise stems from the historical lack of interest in international law shown by the World Health Organization (WHO) (Taylor 1992). While important in GHG, WHO does not represent the totality of GHG, especially in connection with international law. In fact, given WHO’s historical lack of interest in international law, most of the international law important to public health is exogenous to WHO.

Figure 3 below illustrates non-exhaustively the vast array of international legal areas that directly relate to GHG. This figure illustrates not only how much international law is relevant to public health but also the broad scope of contemporary understanding of the public health mission. WHO’s Constitution contains one of the broadest definitions of the public health concept through its concept of “health” as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946: preamble). This broad conception of health supports the large number of public health fields in which WHO operates (WHO 1946: Article 2). But many of these areas, such as occupational health and safety and environmental degradation, involve other international organizations that have been more active than WHO in the creation and implementation of international law.
3.2 History of International Law on Public Health

In Part 1, I illustrated the global governance dynamic by using the example of the development of international health diplomacy and international law on communicable diseases in the mid-nineteenth century. International law on public health has a rich history that has largely been forgotten by both international lawyers and public health experts. Figure 4 below attempts to capture the historical development of international law's involvement in public health issues.
The long and complex involvement of international law in the global pursuit of public health underscores the argument made earlier that GHG is not merely a recent phenomenon. In fact, public health is subject to some of the oldest efforts by states to create multilateral regimes through international law and diplomacy to address a global problem. This long history reinforces the centrality of international law to GHG, but also suggests that GHG is an enduring challenge of the international system that has never been, and will never be, completely addressed. This permanent challenge is also dynamic in that new public health problems continue to emerge. Familiar problems, such as the control of communicable diseases, remain substantial, while new public health concerns have emerged to tax the energy, commitment, and resources of national and international public health experts and officials. The intense discourse about the "globalization of public health" that started in the 1990s serves as evidence that
GHG exists today in a turbulent, fluid, and globalizing environment (Fidler 1997; Yach and Bettcher 1998; Walt 1998).

3.3 INTERNATIONAL LAW AND DISEASE

3.3.1 Communicable Diseases

The oldest area of international law that directly relates to public health is the control of communicable disease. This public health objective dominated international health diplomacy from the mid-nineteenth century through the founding of WHO. With the rise of emerging and re-emerging infectious diseases in the late twentieth and early twenty-first centuries, international law on communicable diseases has again surfaced as a major concern of GHG.

International law on communicable diseases comprises not only specific treaty regimes created to deal with the spread of communicable disease, but also other international legal regimes, such as international human rights and international trade law, that affect how communicable disease control functions internationally and nationally. Table 3 summarizes the complex international legal situation concerning the control of communicable diseases.

**TABLE 3: SUMMARY OF INTERNATIONAL LAW AND COMMUNICABLE DISEASE**

<table>
<thead>
<tr>
<th>Area of International Law</th>
<th>Description of Relevant to Communicable Disease Control</th>
<th>Examples of International Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>International law on communicable disease control</td>
<td>Attempts to control directly the international spread of communicable diseases</td>
<td>International Sanitary Conventions (1851-1951); International Health Regulations (1951)</td>
</tr>
<tr>
<td>International trade law</td>
<td>Contains rules that (1) regulate trade-restricting health measures relating to protection of human, animal, and plant health; (2) govern intellectual property rights over pharmaceuticals</td>
<td>General Agreements on Tariffs and Trade (1994); Agreement on the Application of Sanitary and Phytosanitary Measures (1994); Agreement on Trade-Related Aspects of Intellectual Property Rights (1994)</td>
</tr>
<tr>
<td>International human rights law</td>
<td>Protects civil and political rights, which affect how individuals with contagious diseases can be treated; and contains the human right to health.</td>
<td>International Covenant on Civil and Political Rights (1966); International Covenant on Economic, Social, and Cultural Rights (1966)</td>
</tr>
<tr>
<td>International environmental law</td>
<td>Contains regimes that address international environmental problems that potentially contribute to communicable disease problems</td>
<td>Treaties on air, water, and marine pollution; treaties on ozone depletion; treaties on global warming</td>
</tr>
<tr>
<td>International humanitarian law</td>
<td>Attempts to protect health of combatants and non-combatants from communicable diseases in times of armed conflict</td>
<td>Four Geneva Conventions (1949)</td>
</tr>
<tr>
<td>International law on arms control</td>
<td>Prohibits the development, production, and use of biological weapons</td>
<td>Geneva Protocol (1925); Biological Weapons Convention (1972)</td>
</tr>
</tbody>
</table>
The remainder of this section focuses on the international law designed specifically to control the international spread of communicable diseases, which is now contained in the International Health Regulations (IHR). The IHR represent the culmination of a long period of international legal development on communicable disease control that began in 1851 because the Regulations provide a unified and universal set of rules for controlling the international spread of communicable diseases subject to them. The IHR's objective is to provide maximum protection against the international spread of disease with minimal interference with world travel and trade (IHR 1969). The IHR set international standards for disease notification and for handling infected travelers and goods that WHO member states were required to implement through national law and policy. The international standards were based on the best available scientific and public health principles. Through international law, national law and policy on communicable diseases would be harmonized across countries in a scientifically sound manner by the IHR.

The weaknesses of the IHR have been analysed elsewhere (Fidler 1999a). WHO is currently revising the IHR to modernize the regime for the challenges of the global era. This modernization process includes broadening the scope of the Regulations to include more than cholera, yellow fever and plague, which are the only communicable diseases currently subject to the IHR (IHR 1969). The latest proposed approach is to focus not on specific diseases but on "public health risks of urgent international importance," which may encompass more than infectious diseases (WHO 2001a). In addition, IHR modernization has to take into account the developments in international trade law produced by the creation of the World Trade Organization (WTO) and the adoption of new multilateral trade agreements, such as the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement 1994). Further, changes in technology, particularly the Internet and e-mail, mean that a great deal of information on infectious disease outbreaks comes from non-state sources; and WHO wants to build these non-state sources into the revised IHR (WHO 2001a). The IHR's future is, thus, very much up in the air.

3.3.2 Non-Communicable Diseases

The transboundary implications of non-communicable diseases are not as clear as those of communicable diseases. Nevertheless, public health concerns about non-communicable diseases also have to take into consideration international law. While non-communicable diseases are not transmitted from person to person across borders, substances that cause non-communicable diseases do move across national boundaries accidentally or intentionally. States have used international law historically to try to control the transboundary movements of such health-damaging substances and continue to do so today.

The non-communicable disease areas with the longest international legal histories are occupational health and safety and abuse of narcotic drugs and psychotropic substances (Fidler 2001a). Occupational health and safety are covered in Section 3.4.5 below. Environmental pollution is another important cause of non-communicable diseases, discussed in Section 3.4.3.

The creation of international treaties to control the international flow of narcotic drugs began in the first quarter of the twentieth century, and this international
legal regime has since developed in scope and complexity. Table 4 below provides a chronology of the development of international law on the control of the narcotics drugs and psychotropic substances.

**TABLE 4: INTERNATIONAL NARCOTIC DRUG CONTROL TREATIES, 1912-1988**

<table>
<thead>
<tr>
<th>Date</th>
<th>Treaty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1912</td>
<td>International Opium Convention</td>
</tr>
<tr>
<td>1925</td>
<td>Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium</td>
</tr>
<tr>
<td>1925</td>
<td>International Opium Convention</td>
</tr>
<tr>
<td>1931</td>
<td>Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs</td>
</tr>
<tr>
<td>1931</td>
<td>Agreement for the Control of Opium Smoking in the Far East</td>
</tr>
<tr>
<td>1936</td>
<td>Convention for the Suppression of I illicit Traffic in Dangerous Drugs</td>
</tr>
<tr>
<td>1946</td>
<td>Protocol amending the treaties of 1912, 1925, and 1931</td>
</tr>
<tr>
<td>1948</td>
<td>Protocol for Bringing under International Control Drugs Outside the Scope of the Convention of 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs</td>
</tr>
<tr>
<td>1953</td>
<td>Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium</td>
</tr>
<tr>
<td>1961</td>
<td>Single Convention on Narcotic Drugs</td>
</tr>
<tr>
<td>1971</td>
<td>Convention on Psychotropic Substances</td>
</tr>
<tr>
<td>1988</td>
<td>United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances</td>
</tr>
</tbody>
</table>

The dynamic in international law on narcotic drugs and psychotropic substances is similar to the one seen in the IHR. Through international law, states would harmonize their national policies and laws toward manufacture, trade, and consumption of narcotic drugs and psychotropic substances. A balance had to be struck between allowing legitimate manufacture and use of narcotic drugs, and prohibiting illicit activities. The result is a complicated framework that requires states to have sophisticated regulatory and law enforcement capabilities that are adequately staffed and funded.

While stemming the international flow in narcotic drugs and psychotropic substances is in the interest of public health nationally and internationally, public health experts have criticized the existing international legal for not paying more attention to the health aspects of substance abuse. Tomasevski argued, for example, that “if the priority attached to suppression of trafficking and production not only outweighs health issues, but also imposes a prohibitory and repressive approach to a health problem, where neither appears appropriate, and therefore cannot be effective” (Tomasevski 1995: 890).

In 1998, the United Nations General Assembly expressed concern about the worsening problem of global trade in, and the use of, illicit narcotic drugs and psychotropic substances (UN 1998). The alarms sounded in the United Nations General Assembly suggested that the international legal framework constructed during most of the twentieth century was proving inadequate to the challenge posed (Fidler 2000).

Another area in non-communicable diseases that international law affects is mental illness. WHO has long been involved in mental health as a global public
health issue, and Director-General Gro Harlem Brundtland has made mental health one of her priorities (Brundtland 1999; WHO 2001b). The international law implicated by the treatment of the mentally ill is international human rights law. The rights of the mentally ill have been addressed in UN declarations, resolutions of regional international organizations, and in cases litigated by international human rights tribunals (see Table 5 below). As part of her emphasis on mental health, Director-General Brundtland has even proposed an international convention on the rights of persons with mental disorders (WHO 1999).

**TABLE 5: INTERNATIONAL INSTRUMENTS AND RULINGS ON THE RIGHTS OF THE MENTALLY ILL**

<table>
<thead>
<tr>
<th>International Organization or Court</th>
<th>Examples of International Instruments or Ruling</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Nations</td>
<td>Declaration on the Rights of Mentally Retarded Persons (1971); Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991)</td>
</tr>
<tr>
<td>Council of Europe</td>
<td>Recommendation Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Persons (1983); Recommendation on the Protection of the Mental Health of Certain Vulnerable Groups in Society (1990)</td>
</tr>
<tr>
<td>European Court of Human Rights</td>
<td>Winterwerp v. The Netherlands (1979); X v. United Kingdom (1981)</td>
</tr>
</tbody>
</table>

In the latter half of the 1990s, WHO launched a new international legal effort in the area of non-communicable diseases—the negotiation of a framework convention on global tobacco control (WHO 2001c). While the substantive content of the proposed framework convention has not yet been finalized, this effort constitutes an unusual and high-profile effort by WHO to use international law to promote a global public health effort.

### 3.4 International Legal Regimes Affecting Public Health

As Figure 3 above illustrates, many international legal regimes play important roles in GHG. In this section, I briefly survey seven different international legal regimes that affect the global public health mission. My objective is not to provide a comprehensive presentation of each relevant area of international law but rather to communicate how each regime factors into GHG.

#### 3.4.1 International Trade Law

A number of the multilateral trade agreements of the WTO affect the global public health mission, and these are summarized in Table 6.
## Table 6: WTO Multilateral Trade Agreements Affecting Public Health

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Basic Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Agreement on Tariffs and Trade (GATT 1994)</td>
<td>Sets the fundamental rules of trade liberalization for goods</td>
</tr>
<tr>
<td>General Agreement in Trade in Services (GATS 1994)</td>
<td>Provides framework for gradual liberalization of trade in services, including services relevant to health</td>
</tr>
<tr>
<td>Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement 1994)</td>
<td>Regulates WTO member states’ use of trade-restricting health measures related to animal, plant, and human health</td>
</tr>
<tr>
<td>Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS 1994)</td>
<td>Harmonizes WTO member states’ intellectual property protections for, among other things, patents for pharmaceutical products</td>
</tr>
<tr>
<td>Agreement on Technical Barriers to Trade (TBT Agreement 1994)</td>
<td>Encourages WTO member states to adopt health-protective international standards and discourages use of technical standards for protectionist purposes</td>
</tr>
</tbody>
</table>

Underpinning the multilateral trade agreements is a dispute settlement mechanism that gives the treaties impact that is very unusual in international law. One of the historical problems with treaties and CIL has been the unwillingness of states to create dispute settlement bodies that have compulsory jurisdiction and the power to authorize enforcement against violators. The WTO Dispute Settlement Understanding provides all the mandatory multilateral trade agreements with a compulsory dispute settlement process that can produce enforcement against recalcitrant WTO member states that violate WTO rules (DSU 1994). Table 7 below compares the WTO dispute settlement mechanism to the dispute settlement procedures in the IHR to illustrate the radical difference in the two international legal regimes. Given the interconnections between multilateral trade agreements and public health, the WTO dispute settlement mechanism means that many global public health issues will be adjudicated by the WTO. Cases involving public health issues have already been adjudicated, including the Gasoline Case (1996) (interpreting GATT, Article XX(b) and (g)), Beef Hormones Case (1998) (interpreting the SPS Agreement), Canadian Patent Act Case (2000) (interpreting TRIPS), and the Asbestos Case (2001) (interpreting GATT Article XX(b) and the TBT Agreement 1994).

## Table 7. Dispute Settlement Under the WTO and IHR Compared

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>International Health Regulations</td>
<td>Yes</td>
<td>Yes, reference to Director-General for informal mediation</td>
<td>Yes, either party can submit dispute to ICS, assuming ICS has jurisdiction over both parties</td>
<td>No</td>
</tr>
<tr>
<td>World Trade Organization Dispute Settlement Understanding</td>
<td>Yes</td>
<td>Yes, reference to WTO Dispute Settlement Body for formal adjudication</td>
<td>Yes, panel decisions can be appealed to Appellate Body, which has compulsory jurisdiction</td>
<td>Yes, dispute settlement body can authorize winning party to apply trade sanctions if losing party does not change the violating law or policy</td>
</tr>
</tbody>
</table>

24
International law on public health in the first half of the twenty-first century will, in large part, be driven by the WTO and its multilateral trade agreements. The combination of the multiple interfaces between the WTO agreements and public health, combined with the revolutionary dispute settlement mechanism, put the WTO in a much more powerful international legal position than WHO with respect to global public health. From the international legal perspective, the center of power for GHQ has shifted from WHO to the WTO.

### 3.4.2 International Human Rights Law

When the late Jonathan Mann attempted to place human rights at the centre of the global campaign against HIV/AIDS (Mann 1996), the linkage between human rights and public health struck both human rights activists and public health experts as nothing short of revolutionary. The linkage between human rights and public health is, however, very old. As experts in public health law have long observed, tension between public health practices and individual rights has existed since the very beginning of modern public health policies. This tension largely involved how public health interacted with the protection of civil and political rights (Jacobson v. Massachusetts 1905). The relationship between public health and human rights deepened when the category of economic, social, and cultural rights were added to the human rights pantheon in the post-Second World War period. The most relevant right in this new category has been the human right to health.

**Civil and Political Rights.** The fundamental tension between public health and civil and political rights arises from determining when it is legitimate to restrict the enjoyment of civil and political rights to protect public health. Treaties protecting civil and political rights, such as the European Convention on Human Rights and Fundamental Freedoms (1950) and the International Covenant on Civil and Political Rights (1966) recognize that some civil and political rights can be restricted for public health purposes. These purposes are typically related to communicable disease control.

However, for governments to restrict enjoyment of civil and political rights, certain substantive and procedural requirements must be met. The restrictive measure in question must: (1) be prescribed by law; (2) be applied in a non-discriminatory manner; (3) relate to a compelling public interest in the form of a significant disease threat to the public’s health; and (4) be necessary to achieve the protection of the public, meaning that the measure must be (a) based on scientific and public health information and principles; (b) proportional in its impact on individual rights to the disease threat posed; and (c) the least restrictive measure possible to achieve protection against the disease risk (Siracusa Principles 1984; Gostin and Lazzarini 1997). Further, in non-emergency situations, the government should provide the individual(s) concerned with a fair and impartial hearing prior to the restriction of civil and political rights (Gostin and Lazzarini 1997). In emergency situations, due process of law should be accorded as quickly as possible after the restriction of civil and political rights (Gostin and Lazzarini 1997).

Most of these human rights principles for the protection of civil and political rights in a public health context were violated by governments all over the world when the HIV/AIDS epidemic emerged (Tomasevski et al 1992; Gruskin et al
Government abuses of civil and political rights helped drive the epidemic underground in many places, as persons with HIV/AIDS feared discrimination or other adverse consequences from the government and society knowing their serological status. Despite attempts by international organizations and NGOs to promote respect for human rights in HIV/AIDS policies, discrimination against persons living with HIV/AIDS remains an enormous global public health problem.

The Right to Health. Economic, social, and cultural rights (ESC rights) are also important to global public health policy, especially the right to health. ESC rights are typically distinguished from civil and political rights in the following way: civil and political rights are “negative rights” because they prevent governments from interfering with individual liberties; ESC rights are “positive rights” in that they require the government to create the conditions necessary to allow individuals to enjoy the rights. The imposition of positive duties on governments can be seen in the right to health in the International Covenant on Economic, Social, and Cultural Rights (1966) (see Box 2 below).

**BOX 2: THE RIGHT TO HEALTH IN THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS**

<table>
<thead>
<tr>
<th>Article 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;</td>
</tr>
<tr>
<td>(b) The improvement of all aspects of environmental and industrial hygiene;</td>
</tr>
<tr>
<td>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;</td>
</tr>
<tr>
<td>(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.</td>
</tr>
</tbody>
</table>

In discourse about international human rights, civil and political rights and ESC rights are proclaimed to be universal, indivisible, interdependent, and interrelated (World Conference on Human Rights 1993). The situation on the ground is, however, different. Creaven (1995: 9) argued, for example, that “the reality in practice is that economic, social, and cultural rights remain largely ignored.” Three basic problems have plagued ESC rights in international law. First, socialist and developing countries pushed ESC rights in international forums, while Western democracies emphasised civil and political rights. Thus, ESC rights (as well as civil and political rights) were caught in the vice of Cold War politics and the decolonization process.

Second, the universality of ESC rights was undermined by how they were embedded in international law. All ESC rights, including the right to health, are subject to the principle of progressive realization. This principle makes enjoyment of ESC rights dependent on the government having sufficient economic and human resources. If a government fails, for example, “to assure to all medical service and medical attention in the event of sickness” as required by Article 12(2)(d) of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), it can legitimately claim that its lack of economic resources prevents it from achieving full realization of the right to health. While experts and scholars have made arguments that try to mitigate the impact of the principle of
progressive realization (Toehes 1999), its intentional presence in the treaties and its subsequent consequences cannot be wished away.

Third, monitoring and compliance mechanisms in treaties promoting ESC rights are very weak, usually consisting of states self-reporting (ICERSC 1966). The weakness of these mechanisms, and the positive nature of these rights combined with the principle of progressive realization, lead many to believe that disputes over ESC rights between individuals and governments are not capable of judicial enforcement in international law.

The ideological, legal, and enforcement problems affect the right to health; but this right suffers more complexities that add to its fragile status in international law. Comprehensive analysis of the right to health is beyond the scope of this section and can be accessed in other works, but I would like to outline an important contribution to the right to health debate that came from the Committee on Economic, Social, and Cultural Rights (ESC Committee)—General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12) (ESC Committee 2000a).

One of the historic problems with the right to health was its rather indeterminate nature. In drafting General Comment No. 14, the ESC Committee noted that “the full realization of this right is still hampered by its lack of definition and conceptual clarity” (ESC Committee 2000b: paragraph 3). The ESC Committee attempted to provide some conceptual clarity in General Comment No. 14. Table 8 below summarizes the ESC Committee’s effort.

**TABLE 8: SUMMARY OF ESC COMMITTEE’S GENERAL COMMENT ON THE RIGHT TO HEALTH**

<table>
<thead>
<tr>
<th>Right to Health</th>
<th>Normative Content</th>
<th>Obligations</th>
<th>Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Analysis</strong></td>
<td>Right to health requires availability, accessibility, acceptability, and quality with regard to both health care and underlying conditions of health</td>
<td>Right to health imposes three obligations: to respect, to protect, and to fulfill</td>
<td>General rule: lack of available resources is a valid ground for justifying non-compliance</td>
</tr>
<tr>
<td><strong>Examples Provided in General Comment No. 14</strong></td>
<td>Availability: refers to the existence of health facilities and services Accessibility: requires that health facilities and services must be within physical reach of all parts of the population Acceptability: requires that health facilities, goods, and services be respectful of medical ethics and culturally appropriate Quality: means that health facilities and services must be scientifically and medically appropriate and of good quality</td>
<td>To respect: states should refrain from interfering directly or indirectly with the enjoyment of the right to health To protect: states should take measures to prevent third parties from interfering with the right to health To fulfill: states should adopt appropriate legislative, administrative, budgetary, judicial, and other measures toward the fulfillment of the right to health</td>
<td>Violations can take the form of acts of commission (e.g., repeal of legislation necessary for continued enjoyment of right to health) or acts of omission (e.g., failure to take appropriate steps toward full realization of the right to health)</td>
</tr>
</tbody>
</table>
General Comment No. 14 tries hard to exclude a “core content” of the right to health from the effects of the principle of progressive realization. It argues, for example, that “the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care” (ESC Committee 2000a: paragraph 43). Yet the Committee acknowledges in discussing violations that, as a general rule, states can legitimately claim a lack of available resources for not complying with their treaty obligations on the right to health (ESC Committee 2000a: paragraph 47). This general rule applies to the “core elements” of the right to health. If the “core elements” are not satisfied, General Comment No. 14 asserts that the burden is on the non-complying state to show that every effort has been made to use all available resources at its disposal to satisfy the core elements of the right to health (ESC Committee 2000a: paragraph 47).

The major problem with this approach is that it puts the ESC Committee in the position of determining if a state has made every effort and used all available resources at its disposal. This power will rarely be exercised because states would perceive such determinations as intervention into their domestic affairs, which is in violation of the fundamental international legal principle of non-intervention (UN 1945: Article 2.7). Further, it allows the ESC Committee to second guess how and why states establish and fund policy priorities. If an allocation of resources or a legal reform is made by a democratically elected legislature, then what right or authority does the ESC Committee—a body without democratic accountability—have to label that allocation or legal reform a violation of international law? (Sec Box 3 below.) Finally, the “every effort and all available resources” standard applies to each ESC right, which automatically forces a state into priority setting. The ICESCR does not give the ESC Committee the power to second guess how states parties set their national priorities with the limited resources available.

**BOX 3: THE RIGHT TO HEALTH IN SOUTH AFRICA: THE SOOBRAMONEY CASE**

*Soobramoney v. Minister of Health (Kwazulu-Natal), Constitutional Court of South Africa, November 27, 1997*

Thiagraj Soobramoney, who was suffering from chronic renal failure, brought suit against the Minister of Health of Kwazulu-Natal claiming that the Minister’s refusal to provide renal dialysis to him violated the right to health enshrined in the South African Constitution (Article 27). The Constitutional Court of South Africa held against Soobramoney, arguing that the right to health in the Constitution is expressly conditioned on available resources and that the government is under the duty to realize the right to health progressively. The Department of Health in Kwazulu-Natal argued that it could not provide Soobramoney with renal dialysis because of a shortage of resources and how it had to allocate those resources.

While not a case about the right to health in international law, the substance of the right to health in the South African Constitution is very similar to the right found in the ICESCR. The case illustrates some of the obstacles to effective monitoring and enforcement of the right to health in international law produced by the principle of progressive realization.
3.4.3 International Environmental Law

A tremendous amount of international environmental law seeks to protect the health of human populations, which makes this body of international law directly relevant to GIG. International environmental law is enormously complex because states have used it to address a diverse and wide-ranging set of problems. This section conveys some basic features of this huge body of international law.

International environmental problems directly of concern to public health fall into one of three categories. The first category involves the unsustainable exploitation of a national environmental resource that causes, or threatens to cause, public health and environmental problems in other states. The second category includes domestic activities within a state that cause or threaten to cause public health and environmental damage in another state. The third category deals with threats posed to common environmental resources from domestic activities in a number of states. Table 9 provides examples of each category and of international treaties that address the respective problems.

**TABLE 9: CATEGORIES OF INTERNATIONAL ENVIRONMENTAL PROBLEMS: EXAMPLES**

<table>
<thead>
<tr>
<th>Category of Environmental Problem</th>
<th>Some Examples of Environmental Problem</th>
<th>Some Examples of International Law Relevant to the Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsustainable development of national environmental resource</td>
<td>Desertification</td>
<td>Convention to Combat Deserification (1994)</td>
</tr>
<tr>
<td></td>
<td>Deforestation</td>
<td>Convention on Biological Diversity (1992)</td>
</tr>
<tr>
<td>Domestic activities causing public health and environmental threats to other states</td>
<td>Transboundary air pollution</td>
<td>Geneva Convention on Long-Range Transboundary Air Pollution (1979)</td>
</tr>
<tr>
<td></td>
<td>Industrial accidents</td>
<td>Convention on the Transboundary Effects of Industrial Accidents (1992)</td>
</tr>
<tr>
<td></td>
<td>Nuclear accidents</td>
<td>Convention on Nuclear Safety (1994)</td>
</tr>
<tr>
<td>Threats to global common environmental resources caused by domestic activities in multiple states</td>
<td>Depletion of the ozone layer</td>
<td>Vienna Convention for the Protection of the Ozone Layer (1985) and Montreal Protocol (1987)</td>
</tr>
<tr>
<td></td>
<td>Global climate change</td>
<td>UN Framework Convention on Climate Change (1992) and Kyoto Protocol (1997)</td>
</tr>
</tbody>
</table>

The three categories are broad, and within each are very different international environmental problems, which caution against pushing the tripartite categorization too far. In addition, each international legal regime mentioned in

---

1 This section follows Fidler (2001b).
Table 9 differs in ways that mean each should be considered on its own terms. With these caveats in mind, the broad categories used in Table 9 can be helpful in organizing the political, economic, and legal features of each kind of international environmental problems. These features then provide the keys for understanding how the specific pollution and degradation problems in each category are handled in international law. Table 10 summarizes these features for each category.

**TABLE 10: SUMMARY OF POLITICAL, ECONOMIC, AND LEGAL FEATURES OF INTERNATIONAL ENVIRONMENTAL PROBLEMS**

<table>
<thead>
<tr>
<th>Category of Environmental Problem</th>
<th>Political Features</th>
<th>Economic Features</th>
<th>Legal Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsustainable development of national environmental resource</td>
<td>The unsustainable development is usually taking place in a developing country, but the pressure to increase environmental protection comes from developed countries</td>
<td>The state with jurisdiction over the resource faces lost benefits from continued exploitation and increased costs from environmental conservation, producing a need for assistance</td>
<td>International legal principles that protect the state with jurisdiction over the resource are in tension with less well-grounded duties on sustainable development in international law. Specific treaties become the way to advance sustainable development.</td>
</tr>
<tr>
<td>Domestic activities causing public health and environmental threats to other states</td>
<td>Most often the transboundary pollution originates in developed countries that have power in international relations</td>
<td>Transboundary pollution is an economic externality, producing the need to make the polluter internalize the cost of the pollution</td>
<td>Traditional principles of state responsibility have been inadequate, forcing the need for the negotiation of treaties</td>
</tr>
<tr>
<td>Threats to global common environmental resources caused by domestic activities in multiple states</td>
<td>Both developed and developing countries contribute to such problems, but developed countries have a bigger role in the pollution</td>
<td>Dealing with these problems often confronts the &quot;free rider&quot; and &quot;holdout state&quot; problems because the incentives differ between developed and developed states</td>
<td>Traditional rules of international law do not work, creating the need to craft specific treaty regimes with differential duties for developed and developing states</td>
</tr>
</tbody>
</table>

The general global governance dynamic for international environmental issues is, thus, similar to how international law on communicable diseases developed. In both contexts, traditional rules of CIL could not handle the new global challenges, forcing states to use the treaty as the main source of international law for the development of more effective rules. The treaties in both contexts set international standards that states parties have to implement effectively in domestic law. The regimes require sophisticated domestic regulatory and scientific capabilities, and create the need for financial and technical assistance from rich to poor countries. In addition, almost exclusive reliance on the treaty has forced states to overcome the sovereignty problem through the development of new rule-making techniques. In connection with communicable diseases, the development was international regulations; in international environmental law, it has been the framework-protocol approach used in a number of international environmental regimes. These innovations are discussed in more detail in Part 4 below.
As with other areas of international law, the contributions of international environmental law to GHG are mixed. On the one hand, the enormous growth of international environmental law that addresses threats to the health of human populations reveals the necessity of international law in GHG. On the other hand, experts wonder whether this dynamic body of international law is actually reducing environmental threats to human and ecosystem health.

3.4.4 Arms Control and International Humanitarian Law

The field of public health historically has focused on population health in times of peace. Armed conflict creates, however, serious threats to public health through the kind of weaponry used and how violence is used by fighting forces (Levy and Sidel 1997). States have tried to use international law to control both the weapons used in armed conflict and how weapons are used in combat. International law on arms control and international humanitarian law both form part of the larger body of international law that relates to the protection of public health.

**Arms Control.** States have used international law to prohibit the development and use of certain kinds of weapons. The prohibitions relate to the threats the weapons pose to the health of individuals and populations. Table 11 below summarizes the treaty law that attempts to control the development and use of certain types of weapons.

**TABLE 11: INTERNATIONAL LAW AND ARMS CONTROL**

<table>
<thead>
<tr>
<th>Type of Weapon</th>
<th>Type of International Legal Controls</th>
<th>Specific Treaties or Instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Biological Weapons</em></td>
<td>International law prohibits the development, stockpiling, and use of biological weapons</td>
<td>Geneva Protocol (1925); Biological Weapons Convention (1972)</td>
</tr>
<tr>
<td><em>Chemical Weapons</em></td>
<td>International law prohibits the development, stockpiling, and use of chemical weapons</td>
<td>Geneva Protocol (1925); Chemical Weapons Convention (1993)</td>
</tr>
</tbody>
</table>

Numerous controversies exist with respect to international law on arms control summarized in Table 11 that are only mentioned briefly here. In connection with biological weapons, the massive violation of the Biological Weapons Convention (1972) by states parties such as the Soviet Union and Iraq raises serious questions about this treaty’s credibility (Christopher et al 1997). Fears of
biological weapons proliferation led states to initiate a process of negotiating a protocol to provide a compliance regime to the Biological Weapons Convention [Kadlec et al 1997]. This effort, if successful, would strengthen the international legal prohibition on biological weapons. These negotiations are currently underway and have proved controversial in many respects, as illustrated by the Bush Administration's rejection of the draft protocol text in May 2001 [Loeb 2001; Rosenberg 2001].

One of the biggest fears about chemical and biological weapons is that terrorist organizations will develop and use weapons of mass destruction [Carter et al 1998]. The treaty regimes in Table 11 address states not terrorist groups, so international law has little direct impact on such a threat. In the U.S., this situation has produced a new emphasis on what is called "homeland defense," whereby federal, state, and local governments cooperate in creating effective response capabilities in the event that biological or chemical terrorism occurs on U.S. territory [Defense Against Weapons of Mass Destruction Act 1996; Falkenrath 2000; Smithson and Levy 2000; Kayyem 2001]. In the case of biological terrorism, the front lines of homeland defense would be manned by public health and health care personnel [Kayyem 2001]; and the anthrax attacks in the United States in October 2001 proved the accuracy of this observation.

Another controversial area that affects international law on conventional, biological, and chemical weapons is the growth in military and political interest in so-called "non-lethal" weapons [Fidler 1999b]. Two factors drive the interest in "non-lethal" weapons: (1) the changing nature of military operations; and (2) advances in weapons technologies [Alexander 1999]. As military leaders discovered when peacekeeping operations increased in the 1990s, traditional military tactics, strategies, and weapons did not work well in the complex environment of peacekeeping and other military operations other than war [Dando 1996]. Soldiers could not readily use traditional "lethal" military weapons in circumstances where there are substantial civilian populations. This untenable military situation produced the deployment in Somalia, and in other peacekeeping operations, of crude "non-lethal" weapons such as sticky foam and blunt trauma weapons (e.g., bean bag grenades, rubber pellet projectiles).

But scientific advances suggested that more powerful and effective "non-lethal" weapons could be developed [Alexander 1999]. The blinding laser weapon was one such weapon that provoked specific international legal prohibition (Protocol on Blinding Laser Weapons 1995), demonstrating that the growth in interest in "non-lethal" weapons would raise international legal controversies. Other such controversies may be on the horizon, as proponents of "non-lethal" weapons argue that the international legal prohibitions on the development and use of biological and chemical weapons do not, or should not, apply to "non-lethal" biological and chemical weapons [Fidler 2001c].

Not mentioned in Table 11 are nuclear weapons, perhaps the most fearsome weapon yet created from a public health perspective. Nuclear, chemical, and biological weapons are often lumped in a category called "weapons of mass destruction." While chemical and biological weapons are subject to general prohibitions on development and use in international law, nuclear weapons
remain in a more controversial position. Many have long argued that nuclear weapons could never be used in conformity with international law because of the horrendous health effects their use would produce. Whether use of a nuclear weapon would be compatible with international law was the question the UN General Assembly presented to the International Court of Justice (ICJ) in 1996.\textsuperscript{3}

In a very controversial decision, the ICJ held that (1) neither CIL nor treaty law specifically prohibits the development or use of nuclear weapons; and (2) while the threat or use of nuclear weapons in armed conflict would generally be contrary to the rules of international humanitarian law because of their destructive power, the ICJ could not definitively conclude whether the threat or use of nuclear weapons would be lawful or unlawful in an extreme circumstance of self-defense, in which the very survival of a state would be at stake (ICJ 1996b). The ICJ decision did little to clarify the international legal controversies surrounding nuclear weapons.

\textit{International Humanitarian Law.} This body of international law attempts to regulate the actual conduct of armed conflict. International humanitarian law (IHL) was historically referred to as the “laws of war.” From a public health perspective, one of the most important principles in IHL is the prohibition of military attacks against civilian populations and targets (Green 1993). As virtually every international and civil war in the twentieth century proves, the disruption warfare inflicts on societies causes massive public health problems, especially in direct casualties suffered by civilian populations and in fueling the outbreak of communicable diseases. IHL requires that military forces use weapons, tactics, and targeting that allow for discrimination between combatants and non-combatants to shield civilians from the ravages of war (Green 1993; McCoubrey and White 1992). IHL recognizes that legitimate attacks on military targets may sometimes cause civilian casualties, but such collateral damage is accepted as long as it is unintentional, and military forces made every effort to reduce the likelihood of such civilian damage (Hoffmann 1981).

IHL also regulates in detail how armies treat wounded, sick, and captured enemy combatants (Green 1993; McCoubrey and White 1992). The rules mandate that wounded and sick enemy combatants be given proper medical care and that prisoners of war be protected against diseases and receive adequate medical care while detained. IHL attempts to protect, thus, individual and population health by prescribing humane treatment of wounded, sick, and captured military personnel (Fidler 1999a). IHL also supports public health during armed conflict by prohibiting attacks on military hospitals, medical units, and medical personnel and equipment (e.g., ambulances) (Fidler 1999a).

Identifying IHL rules that seek to protect public health during international and civil war is not difficult, but compliance with these rules during armed conflict in the twentieth century has been depressingly bad. Massive violations of IHL occurred in recent conflicts in Bosnia, Rwanda, and Kosovo. Even when efforts to comply with the rules of war are made, public health suffering can still result:

\textsuperscript{2} Bilateral and regional treaties exist that regulate the production and deployment of nuclear weapons, such as the START and the INF treaties between the United States and Russia, but this section does not explore this international law on nuclear weapons.

\textsuperscript{3} WHO also presented the ICJ with a question regarding the legality of the use of nuclear weapons in 1996, but the ICJ held that WHO did not have the competence under its Constitution to ask for an advisory opinion about the legality of the use of nuclear weapons. See ICJ (1996a).
from armed conflict. Allied destruction of Iraqi electricity-generating facilities (arguably a legitimate military target) during the 1991 Gulf War produced civilian suffering because the lack of electricity hurt hospitals and shut down water treatment facilities, leading to outbreaks of disease (Arkan 1996). Reinforced efforts to hold political and military leaders accountable for violations of IHL, such as the International War Crimes Tribunals for the Former Yugoslavia and Rwanda and the proposed permanent International Criminal Court, are seen by some as progressive moves to enforce rules of IHL and increase compliance in the future. At the moment, it is too early to determine whether such endeavours do in fact rein in the dogs of war.

3.4.5 International Labour Law

The health and safety of workers has been a concern within international law since the beginning of the twentieth century. The development of international law on occupational health and safety accelerated with the establishment of the International Labour Organization (ILO) after the First World War. The ILO has produced treaties and standards on many different international labour issues, but it has been particularly active in developing international law on occupational health and safety. ILO has adopted twenty treaties on occupational health and safety issues since 1919 (see Table 12 below). The ILO makes, therefore, a significant contribution to the protection and promotion of population health through international law.

**TABLE 12: ILO CONVENTIONS ON OCCUPATIONAL HEALTH AND SAFETY AS OF JULY 25, 2001**

<table>
<thead>
<tr>
<th>ILO Convention</th>
<th>Ratifications</th>
<th>(% as % of Total ILO Member States)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C13 White Lead (Painting) Convention (1921)</td>
<td>62</td>
<td>35.45%</td>
</tr>
<tr>
<td>C27 Marking of Weight (Package Transported by Vessels) Convention (1929)</td>
<td>65</td>
<td>37.14%</td>
</tr>
<tr>
<td>C33 Protection Against Accidents (Dockers) Convention (1932)</td>
<td>43</td>
<td>25.71%</td>
</tr>
<tr>
<td>C62 Safety Provisions (Building) Convention (1937)</td>
<td>30</td>
<td>17.14%</td>
</tr>
<tr>
<td>C110 Plantations Convention (1958)</td>
<td>12</td>
<td>6.66%</td>
</tr>
<tr>
<td>C115 Radiation Protection Convention (1960)</td>
<td>47</td>
<td>26.86%</td>
</tr>
<tr>
<td>C119 Guarding of Machinery Convention (1963)</td>
<td>49</td>
<td>28%</td>
</tr>
<tr>
<td>C120 Hygiene (Commerce and Offices) Convention (1964)</td>
<td>49</td>
<td>28%</td>
</tr>
<tr>
<td>C127 Maximum Weight Convention (1967)</td>
<td>25</td>
<td>14.29%</td>
</tr>
<tr>
<td>C133 Benzene Convention (1971)</td>
<td>36</td>
<td>20.57%</td>
</tr>
<tr>
<td>C139 Occupational Cancer Convention (1974)</td>
<td>35</td>
<td>20%</td>
</tr>
<tr>
<td>C148 Working Environment (Air Pollution, Noise and Vibration) Convention (1977)</td>
<td>41</td>
<td>23.43%</td>
</tr>
<tr>
<td>C152 Occupational Safety and Health (Dock Work) Convention (1979)</td>
<td>20</td>
<td>11.43%</td>
</tr>
<tr>
<td>C161 Occupational Health Services Convention (1985)</td>
<td>20</td>
<td>11.43%</td>
</tr>
<tr>
<td>C162 Asbestos Convention (1996)</td>
<td>26</td>
<td>14.86%</td>
</tr>
<tr>
<td>C167 Safety and Health in Construction Convention (1988)</td>
<td>14</td>
<td>8%</td>
</tr>
<tr>
<td>C170 Chemicals Convention (1990)</td>
<td>9</td>
<td>5.14%</td>
</tr>
<tr>
<td>C174 Prevention of Major Industrial Accidents Convention (1993)</td>
<td>5</td>
<td>2.86%</td>
</tr>
<tr>
<td>C176 Safety and Health in Mines Convention (1995)</td>
<td>17</td>
<td>9.71%</td>
</tr>
</tbody>
</table>

Average Number of ILO Member States Ratifying ILO Conventions on Occupational Health and Safety: 32.15% 19.37%
The contribution of international labour law to public health cannot, however, be captured by a simple list of treaties. As Table 12 also indicates, the vast majority of ILO member states do not ratify ILO treaties on occupational health and safety, so the treaties do not have a wide impact. A further problem is implementation of treaty commitments where ILO member states do accept treaties (Fidler 2000). Implementation problems thus adversely affect how deeply and effectively international labour standards are embedded in national legal systems. As the ILO noted, “[t]he worldwide incidence of occupational accidents and diseases is still unacceptably high” (ILO 1999a).

International labour law is likely to be of continued importance in future discussions about global governance. Arguments are increasingly made that international trade law needs to incorporate international labour standards to ensure that globalization does not erode conditions for working populations around the world. At present, developing countries oppose linking trade and labour in the WTO or ILO, so movement on the linkage has been slow at best (ILO 1999b). But the U.S. continued to push the issue under the Clinton Administration, and the European Union supported this effort. It is unlikely to fade from the global governance agenda in the near future.

3.4.6 International Law and Genetic Engineering


Controversy has been raging in connection with genetically modified organisms and genetically modified food products. In January 2000, the Cartagena Protocol on Biosafety (2000) was adopted that attempts to regulate international trade in genetically modified organisms. The Cartagena Protocol is a protocol to the Convention on Biological Diversity (1992), and it establishes a complicated procedure for regulating international trade in (1) “living modified organisms”, and (2) “living modified organisms intended for direct use as food, feed, or for processing” (Cartagena Protocol on Biosafety 2000). The Cartagena Protocol’s negotiations were controversial for many reasons, including the lack of scientific data that genetically modified organisms cause or threaten to cause public health or environmental damage. To deal with this problem, the Cartagena Protocol included a strong version of the “precautionary principle” that many experts believe is a progressive move for both environmental and public health protection in global governance (Cartagena Protocol on Biosafety 2000).
3.4.7 International Law and Global Pharmaceutical Research

The controversy that erupted in September 1997 over the ethics of placebo-controlled clinical trials on perinatal HIV transmission conducted in developing countries [Lurie and Wolfe 1997; Angell 1997] has raised the larger issue of the role of international law in global pharmaceutical research. Critics of the placebo-controlled trials often claim that the placebo-controlled trials, which were organized and funded largely by developed countries, violated the human rights of the clinical trial subjects (Lurie and Wolfe 1997; Armas and Grodin 1998). These human rights claims bring international law directly into the picture.

The international legal situation in connection with such global pharmaceutical research is, however, not as clear as critics of the placebo-controlled trials assert. The key documents in this controversy are non-binding ethical codes established by non-state actors, such as the Declaration of Helsinki (2000) from the World Medical Association. While these non-binding documents have affinity with parts of international human rights law, such affinity does not mean by itself that the placebo-controlled trials violated international human rights law. Closer examination of the placebo-controlled trials controversy from an international legal perspective is needed. At the very least, this ethical debate again illustrates the importance of international law to GHG.

4. GLOBAL GOVERNANCE MECHANISMS AND TECHNIQUES PRESENT IN INTERNATIONAL LAW

As Part 3 reveals, international law plays a major role in GHG. The protection of human health is a value that states have expressed widely and deeply in international law. In fact, there is so much international law on public health issues that the amount of it is almost overwhelming analytically. It is hard to contain and organize all these areas of international law to provide insights into the relationship between public health and international law.

In this part, I would like to step back from the details and focus on different mechanisms and techniques that have developed over time in using international law to promote and protect public health. While states use international law in complex and different public health areas, the machinery of international law has remained basically the same during the history of international health diplomacy. The two main sources of rules of international law are treaties and CIL. In the public health context, treaties have been much more important. Part 4.1 below focuses on how use of the treaty has developed since the mid-nineteenth century. Part 4.2 follows with a brief analysis of the role of CIL in GHG. Then I examine the importance to GHG of the (1) "soft law" approach (Part 4.3), and (2) involvement of non-state actors (Part 4.4).

4.1 Treaty-Based Mechanisms

While the treaty as an instrument of international law has not substantively changed in the last 150 years of international health diplomacy, how states have

---

4 Closer international legal scrutiny of the ethical controversy over the HIV perinatal clinical trials in developing countries can be found in Fidler (2001c).
created treated has been transformed dramatically. This part reviews briefly this transformation to provide insight into the evolution of the treaty as an instrument of GHG.

### 4.1.1 Ad Hoc Treaty Creation

When international health diplomacy began in the latter half of the nineteenth century, participating states realized that they had to create treaties to deal with the problems caused by cholera, plague, and yellow fever (Goodman, 1971). The need to rely on the treaty reflected the fact that background rules of CIL were inadequate to support international cooperation against the spread of disease. The approach taken in the latter half of the nineteenth century to treaty creation was an ad hoc approach. States would convene an international sanitary conference when action against diseases was perceived necessary, and they would debate, negotiate, and perhaps adopt a new treaty to deal with the problem before them. The convening of international sanitary conferences in the latter half of the nineteenth century usually followed on the heels of a new epidemic (Howard-Jones 1975), so the spasmodic reactions of states to new outbreaks of disease drove the ad hoc treaty approach. During this period of international health diplomacy, no international health organizations existed to provide initiative and structure to treaty negotiations. Even experts in the latter half of the nineteenth century recognized that the ad hoc treaty approach was inefficient and ineffective and called for the creation of international health organizations to centralize and coordinate the work of international health diplomacy (Goodman 1971; Fidler 1999a).

### 4.1.2 Centralized Treaty Creation and Oversight

With the creation of international health organizations in the first half of the twentieth century, treaty creation and modification became centralized in such organizations. The Pan American Sanitary Bureau (PASB) and then the Office International d’Hygiène Publique (OIH) became the focal points for international legal development on communicable diseases (Fidler 1999a). The existence of permanent institutions made the organization of treaty negotiations easier, but more importantly the international health organizations could stay on top of scientific and public health developments and recommend changes to the existing international law so that it did not become anachronistic scientifically. In addition, the international health organizations could respond more efficiently to new public health challenges that arose, as the PASB and OIH did in creating sanitary conventions on aerial navigation.

Centralized treaty creation and oversight is a strong feature of contemporary international law on public health. Not only does WHO have these responsibilities under its Constitution (WHO 1946) but so too do the ILO, the UN Environment Programme, the UN International Drug Control Programme, Council of Europe, and the WTO. Thus the global governance dynamic for public health heavily involves international organizations.
4.1.3 International Regulations

While an improvement over the ad hoc approach, centralized treaty-making and oversight created a confusing patchwork of international agreements that did not provide a unified and harmonized approach to communicable disease control. In the WHO Constitution, the founding states created a new treaty-based mechanism: international regulations. Under Article 21 of the WHO Constitution, the World Health Assembly (WHA) could adopt regulations in five specific contexts: (1) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease; (2) nomenclatures with respect to diseases, causes of death, and public health practices; (3) standards with respect to diagnostic procedures for international use; (4) standards with respect to the safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and (5) advertising and labeling of biological, pharmaceutical, and similar products moving in international commerce (WHO 1946).

From an international legal perspective, the most interesting feature of the international regulatory power in the WHO Constitution was that regulations adopted by the WHA would become binding on each WHO member state unless the member state rejected the regulations by a specified period of time (WHO 1946). Under normal treaty-making, states have to affirmatively join the treaty (Vienna Convention on the Law of Treaties 1969). If they do nothing, then the treaty cannot bind them (Vienna Convention on the Law of Treaties 1969). But, with the regulations under the WHO Constitution, WHO member states would be bound unless they contracted out of the regulations. The regulatory power of the WHA still respects state consent through the ability to opt out of regulations, so any regulations adopted under Article 21 are still technically an international agreement.

The limited number of areas in which the WHA can exercise its regulatory authority balances the novelty of the international regulatory approach. In addition, the WHA has only twice exercised its Article 21 powers, so the promise of this new international treaty-making technique has not been actively pursued by WHO. The international regulations approach is also not present in any other international legal areas analyzed above in Part 3, which means that it has not and does not have much impact on the development of international law on public health.

4.1.4 Framework-Protocol Approach

Another creative treaty-making mechanism is the “framework-protocol approach.” In this technique, states agree to a framework treaty that contains only general obligations but establishes the diplomatic machinery that will push the legal regime to more specificity and effectiveness. The states party to the framework treaty use the diplomatic machinery to negotiate and adopt protocols that contain more specific and precise obligations. Through this approach, the international legal regime evolves gradually rather than being created in one document in a single set of negotiations. The framework-protocol approach has more famously

---

3 In addition to the IHR, the WHA adopted regulations concerning nomenclature issues. See Fluss et al (1998).
and widely been used in the context of international environmental law. See Table 13 below.

**TABLE 13: USE OF THE FRAMEWORK-PROTOCOL APPROACH IN INTERNATIONAL ENVIRONMENTAL LAW: SOME EXAMPLES**

<table>
<thead>
<tr>
<th>Area of International Environmental Law</th>
<th>Framework Treaty</th>
<th>Protocol(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air pollution</td>
<td>Geneva Convention on Long-Range Transboundary Air Pollution (1979)</td>
<td>Seven protocols on sulphur (2), nitrogen oxides (1), volatile organic compounds, heavy metals (1), persistent organic pollutants (1), and multi-pollutant emissions (1)</td>
</tr>
</tbody>
</table>

The framework-protocol approach has influenced the development of international law in the context of global tobacco control. The international legal strategy on tobacco control is modeled expressly on the framework-protocol approach developed primarily in international environmental law (Taylor 1996; Taylor and Bettcher 2000). WHO is currently sponsoring intergovernmental negotiations on the creation of a framework treaty on tobacco control, which will later be supplemented by specific protocols on tobacco-control areas, such as taxation, advertising, and smuggling (WHO 2001c).

Like the international regulations mechanism, the framework-protocol approach is another attempt to find a more effective way of getting states to consent to international legal regimes that are perceived necessary for public health purposes. Whereas international regulations press sovereignty harder through the “contracting out” provision, the framework-protocol approach is more flexible because it tries to induce states to join the regime and become committed to the regime’s gradual evolution into effective global governance.

Whether the framework-protocol approach provides an adequate foundation for such international legal evolution is still open to question. A common problem seen in the use of framework conventions and their associated protocols is the “inverse triangle effect” (see Figure 5). Participation in the framework convention is typically substantial, largely because states are not accepting very onerous duties. The number of states joining protocols drops, however, because the protocols demand real sacrifices and actions from their states parties. The inverse triangle effect can hurt an international legal approach to a public health problem if state commitment remains largely at the framework treaty level, while protocols are inadequately adopted and implemented.
4.2 Customary International Law and Global Health Governance

As an international legal mechanism for GHG, CIL has not historically been important. The major reason for this is that CIL was originally developed to regulate the day-to-day interactions of states, which involved diplomatic contacts, trade, and armed conflict. Traditional CIL did not reach down deeply into how a state organized its domestic affairs. When control of diseases emerged as an issue between states in the mid-nineteenth century, CIL provided no foundation from which to address this new global problem.

CIL remains today an awkward instrument in connection with dealing with global public health concerns. While arguments from CIL are made in many of the international legal contexts examined in Part 3, the real action takes place in treaty law. For example, international environmental lawyers often argue that CIL imposes on states duties to prevent, control, and reduce transboundary pollution (Birnie and Boyle 1992). This purported rule does not, however, reflect actual state practice, which undermines its status as CIL (Bodansky 1995). Further, the rule does not impose on states any specific duties to reduce pollution. CIL usually does not generate precise rules and obligations, which makes it difficult to use in the context of public health. Finally, CIL is currently under attack as a source of international law for various theoretical and practical reasons (Ficler 1996; Goldsmith and Posner 2000; Kelly 2000). This larger debate adversely affects any notion of trying to squeeze more out of CIL for GHG purposes.

4.3 The “Soft Law” Approach

Scholars have noted WHO’s penchant for adopting non-binding recommendations and resolutions rather than exercising its international legal powers under the

---

* An exception involved CIL on how a state treated foreign investors. See Sornarajah (1994).
WHO Constitution. The use of non-binding norms to influence national and international policy and law is a common feature throughout international relations. Experts sometimes call these non-binding norms as "soft law" to contrast it with the "hardness" of binding treaty and CIL norms. The concept of "soft law" suggests that a non-binding norm has the potential to harden into binding law through its gradual acceptance by states. Also, "soft law" provides a way to try to harmonize public health policies internationally without the frictions and difficulties that plague the creation of treaty and CIL rules.

While non-binding norms permeate many areas of GHG, it is questionable whether the "soft law" approach provides an effective strategy against global public health problems. First, the influence of WHO's non-binding recommendations is mixed at best. While WHO member states sometimes base national policies and laws on WHO recommendations, often member states do not implement WHO's advice. Such attitudes toward WHO recommendations are not illegal because the recommendations are not binding, but the failure to take such advice harms national and international public health.

4.4 Involvement of Non-State Actors in the Norm-Making Process

As noted in the earlier discussion about the global governance dynamic, non-state actors have long played important roles in global governance. The history of international law and public health reveals different approaches to involving non-state actors in the process of making international legal norms.

4.4.1 Informal Involvement of Non-State Actors

The most prevalent form of non-state actor involvement in international law making has been informal participation. "Informal" means that non-state actors are not officially included in governance mechanisms but that they nevertheless attempt to influence national and international public health policies and legal norms. MNCs and NGOs have for the entire span of international health diplomacy been involved in lobbying governments, diplomats, and international health organizations about the shape and direction of international law and GHG.

However, informal involvement has drawbacks. One problem is the lack of transparency in such informal contacts and influence-peddling. Another is that the informal process may favour better-resourced and powerful organizations. The informal process can be elitist and unrepresentative of the diverse interests affected by the policy or norm in question. Powerful non-state actors often are based in developed countries, which means that the informal process of involvement is biased against actors in developing countries that do not have the resources to lobby governments and international organizations effectively.

4.4.2 Formal Involvement of Non-State Actors in Treaty-Making

While informal involvement of non-state actors remains dominant, various formal schemes for non-state actor involvement have emerged in the history of international law on public health. Perhaps the most radical example of formal non-state actor involvement in international law-making can be found in the ILO.
Under the ILO Constitution, each ILO member state is represented by two government officials, one workers' representative, and one employers' representative (ILO 1919). The non-governmental representatives have the power to vote independently from the government officials on their delegation on issues before the ILO, which includes the adoption of ILO conventions (ILO 1919). Many non-state actors attend treaty negotiations as observers, but only in the ILO are non-state actors given the power to vote on whether to adopt treaties along with states.

Another example of strong non-state actor involvement in international law-making comes from the powerful role played in the development of international humanitarian law by the International Committee of the Red Cross (ICRC). The ICRC has been a major catalyst, not only in developing but also implementing international humanitarian law since its origins in the second half of the nineteenth century. While the ICRC has no formal vote in intergovernmental treaty negotiations, its views are taken into close consideration in such negotiations.

WHO's effort to craft a framework convention on tobacco control also exhibits an effort to involve non-state actors more formally into the treaty-making process. As part of the preparatory work for the intergovernmental negotiations, WHO invited submissions from non-state actors about the proposed treaty and the global tobacco problem (WHO 2001c). WHO received more than 500 submissions from non-state actors (WHO 2001c). In October 2000, WHO held two days of public hearings on the proposed framework tobacco convention at which more than 170 non-state actors submitted oral testimony (WHO 2001c). The objective was to ensure that non-state actors had the opportunity to express their views about the treaty before the intergovernmental negotiations began. WHO has also been encouraging the formation of an international alliance of NGOs that will monitor the intergovernmental negotiations. While non-state actors will not vote on the framework treaty, WHO has sought to increase non-state actor participation in the process of making this treaty.

WHO also seeks to involve non-state actors more actively through the revised IHR. WHO proposes including in the revised IHR the recognition that the Organization may receive epidemiological and outbreak information from WHO member states and non-state actors (WHO 2001a). Under this proposal, WHO may approach WHO member states confidentially about outbreak information WHO receives from non-state actors, such as NGOs (WHO 2001a). If this proposal survives, non-state actors will become more important to GHG through the revised IHR.

Of the examples discussed in this section, only WHO's efforts with non-state actors in the context of the proposed framework convention on tobacco and the revision of the IHR appear to have the potential for widespread use in GHG. No other international organization grants NGOs anything like the power non-state actors have in the ILO. The influence of the ICRC in international humanitarian law is also unique and not something that can be easily established in other areas of international law. While not without their critics, WHO's efforts to open up the process of crafting the proposed framework convention on tobacco and revising the IHR can serve as a model for other international law-making and reform exercises involving public health.
4.4.3 "Official Relations" and Participatory Rights

Another technique that has developed to increase non-state actor participation in international health diplomacy can be found in Article 71 of the WHO Constitution (WHO 1946). This provision allows WHO to enter consultative and cooperative arrangements with NGOs. WHO subsequently adopted its Principles Governing Relations Between the World Health Organization and Nongovernmental Organizations (WHO 1987), which allow qualified NGOs to enter into "official relations" with WHO. An NGO in official relations with WHO has both privileges and responsibilities. Official relations allows an NGO to participate, without voting powers, in WHO meetings, to have access to WHO non-confidential documentation, and to submit memoranda to the Director-General (WHO 1987). NGOs in official relations with WHO have, therefore, formal rights to participate to some extent in the making of WHO policy and norms.

4.4.4 Public-Private Partnerships

A final type of involvement of non-state actors in GHG falls under the rubric of "public-private partnerships." These partnerships are efforts to combine the forces of intergovernmental organizations, such as WHO, and non-state actors, such as pharmaceutical companies, to address cooperatively global public health problems (Buse and Walt 2000). Public-private partnerships tend to be project specific, focusing often on disease problems such as malaria. While public-private partnerships are not necessarily new to international health diplomacy, efforts to promote them has been prominent in the 1990s and under Director-General Brundtland.

The impact of such partnerships on international law’s role in public health depends greatly on the subject matter of the cooperative effort. If, as is the case with the Multilateral Initiative on Malaria (MIM 2001) and the International AIDs Vaccine Initiative (IAV 2001), the focus is on the development of new drugs or vaccines, then the endeavor is primarily scientific in nature and has little effect on international law. If, however, the public-private partnership focuses on policy reform or law creation, as is the case with WHO’s efforts with NGOs on the framework convention on tobacco, then the partnership can play a role in shaping the substance of international law on public health.

In summary, the most important international legal mechanism for GHG is the treaty. Treaties constitute both the foundation for international organizations involved in public health issues and the substantive rules created in international health diplomacy to promote and protect human health in specific areas of international relations. While efforts have been made to craft new treaty approaches and to increase the involvement of non-state actors, it is important to emphasize how little the global health governance dynamic has changed since it emerged in 1851. Figure 6 illustrates that how states are addressing the global problem of tobacco fits into the global governance dynamic that applied to the efforts to control communicable diseases in the latter half of the nineteenth century. While the presence of WHO as the focal point of internationalization and the more formalized participation of non-state actors in the treaty-making process differ from what transpired in 1851, the structure and nature of the GHG dynamic is essentially the same.
The continuity of the GHG dynamic from the mid-nineteenth century until today is explained by the continuity in the structure of international relations—sovereign states interacting in a condition of anarchy. The diversity and complexity of international law that relates to public health examined in Part 3 obscure the reality that international legal mechanisms for GHG are limited essentially to the treaty, which is the source of international law that expresses the strongest recognition and respect for sovereignty.
5. CONCLUSION: LIMITATIONS OF INTERNATIONAL LAW AS AN INSTRUMENT OF GLOBAL HEALTH GOVERNANCE

The extent to which international law contains recognition of the value of protecting human health is impressive. Once the scale of the role of international law in public health is appreciated, it is difficult not to see international law as a fundamental element of GHG. The central theoretical and practical importance of international law to GHG makes WHO's historical lack of interest in international law all the more surprising.

But I caution the reader not to contract an occupational disease that often afflicts international lawyers and international legal academics—the misguided belief that international law provides an answer to human problems. The objective of public health interest and use of international law cannot be simply the creation of more international law. A prominent international relations scholar once observed that the growth of international law in the twentieth century perhaps reflected not progress, but little more than a heightened protest against the facts of international politics (Bull 1977). The substantial body of international law that relates to public health perhaps should not be celebrated as a victory for GHG but rather mourned because it reflects an ever-lengthening and worsening list of challenges to humanity's health.

Even more harshly, we can ask whether international law has played much of any role in the improvements in human health witnessed in the twentieth century. Improvements in public health in developed countries in Europe and North America in the twentieth century do not seem to have needed or relied much, if at all, on international treaties creating international health organizations and regimes on communicable disease control. Domestic public health reform perhaps best explains the dramatic gains developed countries made in the twentieth century against communicable diseases. When vaccines and antibiotics emerged, developed countries could apply these scientific advances again without needing to rely on international law. Developed countries perhaps only really required international law on communicable diseases to prevent other states from using health-related trade restrictions as a form of protectionism.

International law probably played a larger role in the story of public health in developing countries mainly because it provided the foundation for the activities of international health organizations, such as WHO. Given that WHO showed little, if any, interest in international law from its creation until the mid-1990s, international law did not feature significantly in the work WHO did with developing countries. International legal developments in other areas, such as international trade, human rights and the environment, caused a great deal of friction between developing and developed countries and cannot easily be seen as great boons to public health in developing countries during the course of the second half of the twentieth century. Analyses of the sorry state of public health in much of the developing world attests to the lack of impact international legal regimes have had on human health at the national and local level.

Understanding the difficulties states and international organizations experience with international law in the public health context needs to come to grips with the problematic interface of the global and local. The ideal public health strategy would be to construct and maintain in every state in the international system a robust domestic public health infrastructure that could handle both indigenous
and exogenous public health problems. International cooperation could help the robust national systems through information sharing (e.g., surveillance for communicable diseases; dissemination of new scientific data and approaches), but the contribution of international health diplomacy would be secondary to the domestic focus. Robert Koch argued as much in 1894 when criticizing efforts to create international sanitary conventions to control cholera. Koch asserted that the treaties being created were “quite superfluous” and that the best strategy would be for every state “to seize cholera by the throat and stamp it out” [Howard-Jones 1975: 76].

But the very unevenness in public health capabilities in the international system created the need for harmonization of national public health approaches through international health diplomacy and international law. The objective, which again is illustrated in Figure 1’s depiction of the global governance dynamic, was to create international legal standards that would then be implemented domestically through national law. The direct effect on public health locally would flow from compliance with domestic law not international law. But, domestic public health law reform often might not occur without the presence of international law. International law and national law are, thus, interdependent in global governance on public health issues. The legal interdependence also means that national and international governance are bound tightly together in the pursuit of global governance.

The global-local interface in the public health context means that GHG has two mantras: “think globally, act locally” and “think locally, act globally.” International law seems critical to making the global-local interface in public health work, but it is not sufficient by itself to make the interface effectively deal with public health problems. In addition to a strong system of domestic public health law, the global-local interface requires that national governments make public health a political, social, and financial priority. Without that fundamental commitment to public health, international law on public health problems becomes, to paraphrase Edmund Burke, little more than “papers and seals” that lack “obligations written in the heart” [Burke 1796: 315].

The challenge for global health governance in the twenty-first century is not to generate more international law, even though new treaties may be needed and old regimes modernized. The challenge is to embed public health as a value and interest in (1) sovereign states; (2) their interactions in the international system; and (3) their relationships with global civil society groups. It is sobering to conclude that the deep penetration of international law by the value of human health explored in this chapter reflects ultimately how far global health governance is from successfully addressing the threats to human health presently at large in the global village.
References

Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium (1925), S1 League of Nations Treaty Series 337.

Agreement for the Control of Opium Smoking in the Far East (1931), 177 League of Nations Treaty Series 373.


Convention on Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs (1931), 139 League of Nations Treaty Series 301.


Jacobson v. Massachusetts (1905), 197 United States 11 (1905).


Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium (1953), 486 United Nations Treaty Series 56.


Soobramoney v. Minister of Health (KwaZulu Natal), Constitutional Court of South Africa, Case CCT 32/97, November 27, 1997.


