International Public Health Law

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Not so much WHO as why, and not enough WHO and why not?

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Abstract: To state the obvious, "health matters", but health (or its equitable enjoyment) is neither simple nor easy. Public health in particular, which encompasses a broad collection of complex and multidisciplinary activities which are critical to the wellbeing and security of individuals, populations and nations, is a difficult milieu to master effectively. In fact, despite the vital importance of public health, there is a relative dearth of ethico-legal norms tailored for, and directed at, the public health sector, particularly at the international level. This is a state of affairs which is no longer tenable in the global environment. This article argues that public health promotion is a moral duty, and that international actors are key stakeholders upon whom this duty falls. In particular, the World Health Organization bears a heavy responsibility in this regard. The article claims that better health can and must be better promoted through a more robust interpretation of the WHO's role, arguing that neither the WHO nor international law have yet played their necessary part in promoting health for all.

Keywords: international public health, World Health Organization, regulation, law-making, ethics, values, norms

Introduction

Defined as the science and art of preventing disease, prolonging life and promoting health through organised efforts of society, public health activities include (1) primary healthcare including mental and maternal healthcare, (2) preventative healthcare such as vaccination and health education, (3) control of communicable diseases, (4) sanitation and clean water, (5) food and drug safety, (6) environmental conditions, (7) work safety, and (8) housing and transportation standards. In short, public health encompasses a broad collection of complex and multidisciplinary activities which are critical to the wellbeing and security of individuals, populations and nations.[1] However, despite its vital importance, there is a relative dearth of ethico-legal norms tailored for and directed at the public health sector, particularly at the international level, a state of affairs which is no longer tenable in the new global environment. This article argues that public health promotion is a moral duty, and that, although multiple actors are relevant and necessary to fulfilling this duty (and achieving "good health"), international actors are key contributors. Focussing on one such international actor – the World Health Organization (WHO)[2] – it argues that better health can and must be better promoted through a more robust interpretation of the WHO's role. More specifically, it argues that neither the WHO, as a primary protagonist of international health, nor international law, as an increasingly important

and influential social force, have yet played their necessary part in promoting "health for all".

1. The Moral Foundation of Health

To state the obvious, "health matters"; it matters a great deal. Good health, being a general state of wellbeing and not just an absence of disease, matters to both individuals and societies. It has been variously characterised (1) as a "fundamental freedom", enabling us to define our identity and to do things we value (Sen, 1999), (2) as having "special meaning" insofar as we strive to achieve good health in the face of conditions that mitigate against it (Daniels, 2008), and (3) as being a right "fundamental to the attainment of peace and security" (WHO Constitution, Preamble). Regardless of its manifold characterisations, it is obvious that good health is essential for the enjoyment and maximisation of almost all human activities, from child-bearing and child rearing, to knowledge-generation and innovation, to labour and production, and so on, and it is therefore essential to both individual and social functioning. It is trite to confirm that without reasonable levels of health, individuals would be unable to participate in valued social activities such as political action, social protection, wealth generation, and cultural manifestation/advancement, with the result that social structures would atrophy and fail, and valuable social pursuits would remain unfulfilled.[3]

The above makes clear that human *functioning* depends in large part on good health; it is an integral component and enabler of human civilisation. This, in turn, means that human *flourishing* depends on good health, and human flourishing is unquestionably both a moral value and a moral objective. As such, it stands to reason that health must be a morally charged concept and a morally grounded enabler – a moral objective and/or moral good. Indeed, it has been said that:

> … health [is] intrinsically and instrumentally valuable … . … If we value individual's capability to be healthy intrinsically and instrumentally, deprivations in health are inequalities … [which] conflict with the view that justice requires public policies to bring "people as close to good functioning as their natural circumstances permit" … . (Ruger, 2006, 999)

We can also reasonably say that:

> … health deprivations are unethical because they unnecessarily reduce one's ability to function and the capacity for human agency. Health, among all the other forms of disadvantage, is special and foundational, in that its effects on human capacities impact one's opportunities in the world and, therefore, health must be preserved to ensure equality of opportunity. (Gostin *et al.*, 2007)

All told, there is ample justification for claiming the existence of a moral responsibility in relation to health.

We might adopt a negative approach and say that this moral foundation demands that we refrain from (and have no just basis for) erecting institutions or pursuing practices which directly or indirectly deny individuals and societies good health (or deny access to the means of achieving and maintaining reasonably good

health). Such an approach is certainly consistent with Kant's imperative that we must act only on that maxim through which we can at the same time will that it should become a universal law. However, drawing on such instruments as the International Covenant on Economic, Social & Cultural Rights (1966), and the numerous other widely adopted international human rights instruments to which we assign great (rhetorical) value,[4] and equally supported by Kant's imperative, we should prefer a more positive approach and claim that health's moral foundation gives rise to a positive responsibility to safeguard – indeed to enhance – people's access to health and healthcare (a position which should not be confused with a claim to a "right to health" which cannot exist).

2. Duty-Bearers in the Health Setting

At the risk of advancing a *non sequitur*, I suggest that the existence of a "moral responsibility" gives rise to a "moral duty", and therefore to concomitant practical duties. This is an inexorable correlation insofar as we claim (and strive) to be a moral society; the identification of a morally grounded condition necessitates the articulation of an associated practical duty to realise the good condition/objective we've identified, and consequently demands action in pursuit of that duty.[5] Of course, having established a duty to promote and enhance health, we must turn our minds to the question of who bears the burden of this duty; just as no right (ie: to autonomy, to mobility, etc.) can be vindicated without a corresponding duty, no duty can be satisfied unless there can be identified a duty-bearer who has some proximity to the subject and the beneficiary of that duty.

There are at least three broad categories of duty-bearers relevant to health. The first is the individual, who has an obvious interest in, and, by virtue of proximity (or manifestation as beneficiary), the primary role in preserving his or her own health; the individual is his or her own closest and most empowered ally. Moreover, the individual is a duty-bearer not only in the context of individual health, but also in the context of public health, where s/he might be expected to undertake or refrain from actions in the interest of the community. In most cases, of course, the individual acts in the preventative sense, but when one does become ill or injured, assistance is required.

In most modern welfare states, acting in response to illness or injury falls to the second duty-bearer – the state itself. (Although private insurance schemes might also intervene here, even they rely on state infrastructure.) The state has assumed burdens related to public health as a result of the social contract between it and its subjects/citizens, and also as a result of the state's interest in its own preservation and security. This taking up of responsibility has been encouraged by the shared racial, cultural, linguistic and related connections/identities that prevail within (most) states, as well as by state-sponsored instruments like the International Convention on Economic, Social and Cultural Rights (1966), which articulates the right of populations to health and the need for signatories (states) to progressively recognise same. Nonetheless, the social contract that underpins the citizen-state relationship and the shared characteristics within states, together with internationally embraced principles such as sovereignty, are typically relied on by states to limit their health activities to within their own borders:

> … States that have the wherewithal are deeply resistant to expending the political capital and economic resources necessary to truly make a

> difference to improve health outside their borders. When rich countries do act, it is often more out of narrow self-interest or humanitarian instinct … . (Gostin *et al.*, 2007, p. 1)

And so, at least in the modern era, a third category of duty-bearer has emerged, namely the international community, within which there are several types of actors concerned with health, including entities from the private sector, non-governmental organisations, and treaty-based international agencies controlled by states. Some examples of existing actors are civil society organisations such Medicines Sans Frontieres, Greenpeace, and the Gates Foundation, community and faith-based organisations such as the YMCA/YWCA and Salvation Army, voluntary health associations and networks such as the Global Network for People Living with HIV/AIDS and the People's Health Movement, and the variety of United Nations organisations, including the Food & Agriculture Organization, UNAIDS, and, perhaps most importantly, the WHO.

One might question the role or position of this last category of duty-bearer, but at least two factors suggest that it is becoming the most important and justified in leading health promotion in the 21st century, and should therefore act as if it were. These factors are the modern social context, and the interdependent nature of health, both of which are linked by and with the phenomenon that is globalisation:

> Globalization is the process of increasing economic, political and social interdependence, and global integration that occurs as capital, traded goods, people, concepts, images, ideas and values diffuse across national boundaries. (Taylor, 2002)

With respect to the first factor, modern social contexts are more diverse, overlapping and complex than ever before, and they are increasingly characterised by their cross-jurisdictional or international nature. In addition to family and neighbourhood, they include trade/employment organisations, religious affiliations, nation and regional loyalties, and membership to particular classes, genders and ages. Many of these social contexts or societies are characterised by globalism and interdependence, meaning that the particulars ties which bind people and serve as social cohesions are both broad and tight, but also farther ranging and more complex than ever before. This reality is enhanced by the fact that people are mobile and connected, practices are cross-cultural and converging, and both economics and, increasingly, law are joint (ie: realised in cooperation with others) and international.[6] This expanded 'social embeddedness' (ie: membership in layered or overlapping groups, and status determined in part by others) means that the human wellbeing and human dignity that are similarly tied up in and dependent on the interrelationship between people and peoples is spread across a greater space (physical and social) and is influenced by incidents not immediately experienced. The appropriate social context for health promotion is therefore also global.

The second factor – health interdependence – is equally transnational. Although health conditions and pressures vary between countries, levels of health are often related to, if not completely contingent on, that in other jurisdictions, and health problems in one country can threaten other countries as sources of ill-health migrate. For example, despite opinions in the 1970s that infectious diseases would soon be conquered, there has been an upturn in their prevalence, with new, re-emerging, and persistent diseases now killing some 15 million people annually (WHO, 2006; WHO,

2007). Influenza is a good example of communicable disease re-emergence and mobility. There have been roughly three influenza pandemics every century since the 1600s. The 20th century experienced pandemics in 1918-19 (Spanish Flu: H1N1), 1957-58 (Asian Flu: H2N2), and 1968-69 (Hong Kong Flu: H3N2). Given that the 1918 pandemic killed some 70 million people, the emergence at the beginning of the 21st century of a durable, mutate-able, highly contagious, and severe form of Avian Influenza (H5N1) caused significant concern. Whereas most forms of avian flu will cause conjunctivitis and mild flu-like symptoms in humans, H5N1 can lead to pneumonia, acute respiratory distress, and various other life-threatening complications. Of the 366 human cases in 14 countries reported as of February 2008, 232 have been fatal (and tens of millions of birds in numerous countries have been destroyed as part of the management strategy). In a 'worst case scenario', it is expected that 50% of the population will be affected (Garrett, 1994; Burgess, 2006).

A second characteristic of this health interdependence is the fact that all countries are affected by the growing health inequalities within and between countries. Again, a simple example highlights the situation poignantly. Developing countries, in addition to suffering from many of the chronic illnesses common in them, also experience heavy burdens of preventable and treatable diseases such as cholera, diarrhoea, elephantiasis, malaria, measles, river blindness, and others (Lopez *et al.*, 2001). Their inability to cope with these health determinants affects whole populations, and variable levels of healthcare accessibility has led to reversals in life-expectancy trends which have stretched across whole regions (eg: sub-Saharan Africa and in various Eastern European states) (Butler, 2000; Gwatkin, 2000; Benatar, 2001).[7] In short, reversals in one country pulls down trends in neighbouring countries as health determinants (and people) cross borders.

These negative health trends are facilitated by other health-relevant phenomena such as:

- poverty and widening economic disparities (eg: the income of the richest 20% of humanity is 80 times that of the poorest 20%, and more than 2 billion people live on less than US$2 per day) (Benatar, Daar, Singer, 2003);

- rapid population growth (eg: global population has risen from 4.45 billion in 1980, to 5.28 billion in 1990, to 6.08 billion in 2000, to 6.46 billion in 2005),

- escalating habitat destruction and environmental degradation (eg: freshwater consumption has increased 6x in the last 100 years; 5 million people die annually from diarrhoea due to polluted water; 20% of the world's freshwater fish have disappeared or are endangered; some 63% of all species have been lost in the last 100 years and extinctions are occurring at increased rates; some 80% of forests have been cut worldwide and 40% of the remainder are threatened) (Stuart, 2000; Polansky, 2000; Parry *et al.*, 2004); and

- ubiquitous man-made and natural crises(eg: increasingly vicious, ethnic-based wars such as those in Yugoslavia and Rwanda, cause massive human suffering, social disruption, population displacement and loss of natural resources, with some 90% of the victims being civilians, largely women and children) (WHO, 2003; Clarke, 2001).

These phenomena and our shortcomings in dealing with them are converging to create a global human tragedy which will not be limited in its ramifications to poor countries; it will burden the health of all peoples. Of course, this has been recognised by all manner of stakeholders, and one of several responses has been a multidisciplinary panel of experts from thirteen countries articulating the Grand Challenges for modern public health research.[8]

Given the above, although individuals and states are still key actors with a pivotal role to play in public health, and although health solutions still deeply implicate states (in particular), the limits imposed on them by their own parochialism, legal principles such as sovereignty, and the international and interdependent nature of public health determinants, diminishes their leadership capacity. Only a global perspective and transnational actions will vindicate health needs and redress the inequalities that currently exemplify human health, and in bringing that perspective to bear and undertaking those broader actions, we must be prepared to expand our compassion, and recognise that our duties, or the reach of our duty-based actions, are similarly expanded:

> We do not grasp the significance of suffering … unless and until we set it in the context of a view of what it is for a human being to flourish. And we do not respond compassionately to that gap between norm and fulfilment unless we think that this is a possibility in which we too partake. Compassion requires us to say: however far these people are from us in fortune or class or race or gender [or geography], those differences are morally arbitrary and might have befallen me as well. (Nussbaum, 1992, p. 239).

In short, to close our eyes to the plight of others and to the need to expand the impact of our actions is to artificially limit our social context (or embeddedness) and to all but ensure that we will fail to meet our moral responsibilities. Given the interdependence identified above, the practical consequence of this will be the (rampant) spread of ill-health across our (porous) borders and social boundaries; social isolationism and moral disconnect will not shelter us from the consequences of our artificially limited actions.

3. WHO Should be the International Leader?

In light of the above, I suggest that international organisations, and in particular UN organisations, must take a leadership role in (international) public health, in no small part because they are best equipped to (1) take the necessary transnational/international view, (2) articulate measures capable of addressing the problems and inequalities that this view exposes, and (3) encourage, demand or deploy the appropriate measures and/or mobilise the necessary actors (international and domestic) to achieve good health. In particular, I would suggest that that leadership should come from one organisation in particular, namely the WHO, which has identified its guiding imperatives as promoting development, fostering health security, strengthening health systems, harnessing research, information and evidence, enhancing partnerships, and improving performance (WHO Agenda, 2008).

Although the WHO's actions under these imperatives are already extensive and the benefits of those actions should not be underestimated or undervalued, time and space constraints necessitate focusing on one specific area of action. As such, for

the remainder of the paper I focus on the furtherance of these imperatives through international law and the authority and role of the WHO as international law-maker. In this regard the WHO Constitution empowers the WHO as follows:

- Article 1 states that the objective given to it by its state members is the attainment by all peoples of the highest possible level of health.

- Article 2 enumerates twenty-two broad-ranging functions for realising this objective, the most important one for present purposes being clause (k) which directs the WHO to "propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective".

- Article 19 states that the WHO shall have the authority to adopt conventions or agreements with respect to any matter within the WHO's competence, which conventions or agreements shall be binding upon adoption by the Health Assembly and subsequent acceptance by members. Importantly, Article 20 directs members to take action relative to the acceptance of any convention adopted by the Health Assembly, and to notify the Director-General of the action taken or the reasons for non-acceptance.

- Article 21 gives the WHO the authority to adopt Regulations in a variety of areas. Article 22 stipulates that these Regulations shall come into force for all members after adoption by the Health Assembly.

- Article 23 states that the WHO can make Recommendations to members with respect to any matter within its competence.

The above supports the claim that the WHO has been granted extensive law-making or normative powers. Of course, international law-making is not without its weaknesses (or detractors):

> Extant legal solutions have deep structural faults. The most glaring problem … is whether international legal instruments and global institutions can effectively govern diverse State and non-State actors ... (Gostin *et al.*, 2007, p. 2).

And:

> It is important to understand that conventional international law is an inherently limited mechanism for international cooperation and that the international legislative process suffers from numerous defects – including challenges to timely commitment and implementation … (Taylor, 2002).

However, despite its limitations, international (hard) law serves multiple positive functions, from raising awareness and debate, to prompting commitments, to stimulating action, to articulating norms and standards, to constructing mechanisms for achieving identified ends and erecting structures to promote/enforce action and

compliance. Moreover, the very purpose of international law is to address serious and complex transnational issues that no single country can tackle on its own, such as those (identified above) thrown up by public health.

4. The WHO and International Law-Making

But what has the WHO done with the (broad) powers it has been given? To put it bluntly, very little, a fact which has not gone unnoticed and which has been variously attributed to its institutional culture and self-image as a scientific/technical agency, as well as to the historical weakness of international law in general.[9] In fact, the WHO's involvement in advancing international public health law has been limited to only some four instruments – the Codex Alimentarius (1963) (Codex), the International Classification of Diseases (1990) (ICD-10), the International Health Regulations (2005) (IHR), and the Framework Convention on Tobacco Control (2005) (FCTC) – each of which are either marginal or quite narrowly focused.

The Codex is a technical instrument that has evolved and expanded since its creation in 1963 as a joint effort of the WHO and the FAO under the FAO/WHO Joint Food Standards Programme. Generally, the Codex establishes food standards and guidelines with the aim of protecting the health of consumers and promoting fair trade practices in food. It has become a reference for national food control agencies, producers, processors and consumers, and has been referenced in a valued UN Resolution on consumer protection.

The ICD-10 originated from the work of a series of individuals in the 1700s, which culminated in the International List of the Causes of Death overseen by the International Statistical Institute. The WHO took over responsibility for this list in 1948 with the most recent version being adopted in 1990 and coming into force as a WHO regulation in 1994. Generally, the ICD-10 provides standard diagnostic classifications which facilitate the international comparison of morbidity and mortality data.

The IHR originated from a series of European-based sanitary conferences held in the 1800s and were directed at preventing the importation of cholera, plague and yellow fever into Europe. The WHO adopted the resultant International Sanitary Regulations in 1951 and renamed them the International Health Regulations in 1969. The recent revision of the IHR represents an attempt by the WHO to harmonise conduct in a specific area of international public health bearing in mind the realities of the modern, mobile world. In particular, the IHR are directed at the outbreak, spread and containment of disease. Article 2 states that the purpose and scope of the IHR are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade. Article 3 states that implementation must conform to the full respect of dignity, human rights and fundamental freedoms, and the UN Charter. They go on to address the key elements of dealing with infectious disease, namely surveillance, notification, consultation, verification, determination of a public health emergency, and permissible public health responses. Article 18 outlines the public health measures that might be adopted by states in the event of a public health emergency. Although widely regarded as positive, it is equally widely recognised that the IHR cannot do the work that is needed to enhance public health where it is needed most.[10]

The FCTC, in force on 27 February 2005 and having 168 signatories, represents the first WHO-initiated normative instrument. Unique insofar as it is

directed at quashing a lawful activity, it was only made possible by the reputational nadir plumbed by the tobacco industry as a result its persistent denials of the harms of smoking, its deceptive advertising, and its engineering of its products to be highly addictive. The parties, who reassert their duties (although they are conceptualised more as sovereign rights) to protect public health in the Preamble, are obliged to translate the FCTC into domestic law within three years of accession. Article 3 states the objective as protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke. Article 4 sets out guiding principles as follows:

- Information: Every person should be informed of the health consequences of tobacco consumption and exposure.

- Commitment: Political commitment at all levels (international, national, intermediate and local) and coordinated, multi-sectoral responses are necessary to ensure that effective measures are undertaken by authorities responsible for protecting people, such measures being directed at protecting people from exposure, preventing initiation and supporting cessation of smoking, and supporting those injured by smoking.

- Participation: The engagement of civil society and the consideration of local conditions are essential.

- Cooperation: International knowledge, technology and financial transfer and the joint design of tobacco control programmes are important, as is economic assistance to aid the transition of tobacco growers and workers.

- Liability: Issues of liability are an important part of tobacco control.

Although there is no technical package for tobacco control and no measurable targets set, it is suggested within the instrument that the most effective response includes a combination of (1) hard-hitting, sustained anti-tobacco advertising, (2) the establishment of smoke-free public spaces, (3) heavy taxation of tobacco products, (4) the provision of cessation services, (5) surveillance to monitor results and guide programme implementation, and (6) international capacity-building.

Three things should become apparent upon examining this list of international instruments in the context of the broader international law and international public health setting. First, they are limited in scope and application and have no chance of ameliorating the desperate inequality that characterises the modern international public health setting. Indeed, they have been described as "historically, politically and structurally inadequate to do what is needed" (Gostin *et al.*, 2007, p. 25). Second, when considered together with the plethora of other instruments that are being issued by health stakeholders including UN agencies, regional organisations, nongovernmental bodies, foundations, private enterprises (which are increasingly influential in international policy-making), and so on, it is clear that there is a growing fragmentation of governance; instruments are being developed and deployed in an uncoordinated, unplanned and inconsistent manner. Third, and perhaps most concerning, these legislative activities and their reach pale in comparison to that of other international stakeholders operating in fields influential on health, most notably the World Trade Organization (WTO).

The WTO has facilitated the proliferation of trade agreements which impact on public health, some of which are the General Agreement on Tariffs and Trade (GATT), the General Agreement on Trade in Services (GATS), the Agreement on Trade Related Aspects of Intellectual Property (TRIPS), the Agreement on the Application of Sanitary and Phytosanitary Standards (SPS), and the Agreement on Technical Barriers to Trade (ATBT). Although some of these instruments contain provisions preserving national competences to protect life and health, they are difficult to access in practice, and harmonisation is doing more to force standards down around the world than to raise them up because these instruments require uniform standards that are *least* restrictive to trade (Wallach, 2002, Drager and Vieira, 2002).

Ultimately, these instruments erode the ability of public health officials (international, national, local) to guide public health and to take measures in support of public health, a fact which is not necessarily surprising when one considers that public health stakeholders (including the WHO) rarely participate in trade negotiations or the resolution of trade disputes, even when such are linked to public health (Schafer, 2005). Similarly, the WHO has failed to engage in the governance activities in other areas related to health, including the environment, arms control and human rights. Obviously, the WHO does not have the resources to participate in every international undertaking or governance activity which impacts on health, particularly where the activity is not conceptualised in primarily health terms, but it still must be said that the WHO has not offered the strong leadership health needs.

Is it appropriate that international public health should be steered in this haphazard and trade-dominated manner? Is it not pure folly to leave public health direction to the interests that direct the WTO?[11] Who is best positioned to make and enforce norms in the interest of advancing public health and the wellbeing of the people, particularly the poor, of the world? WHO indeed.

5. Realising the Unfulfilled Remit – A Call to Action

The above demonstrates that the fragmentation and leaderlessness that characterises (international) public health has caused its governance to devolve to a host of organisations whose primary concerns and objectives are not health. In its defence, as the list of WHO-related instruments suggests, the WHO has recently become more alive to its normative duties. Indeed, the WHO now claims as a core activity "setting, promoting and monitoring ethical and evidence-based norms and standards" (WHO Agenda, 2008). How might the WHO do this?

A start might be to take seriously the interconnectedness of health with other global issues/concerns, and therefore to take seriously – and take part in – the normative activities of other organisations whose remit overlaps with that of health. It has been claimed that:

> As a consequence of "issue linkage" international health law is increasingly understood to be central to other traditional legal realms, including human rights, trade, environmental law, international labour law and arms control. As a consequence, health is emerging as a central issue of multilateralism (Taylor, 2002).

The WHO needs to demonstrate that it understands this reality, and it must position itself according to the importance of the remit that has been given to it. That means

defending (our) health vigorously by insinuating itself into the law-making activities of others (as the WTO has done).

Additionally, and perhaps most importantly, the WHO might undertake to craft a framework convention for public health and prove the truth of the following claim:

> As nations at all levels of development increasingly recognize the need for frameworks for coordinated action on increasingly complex, intersectoral and interrelated global health problems, international health development in the twenty-first century will be likely to include the expanded use of international law (Taylor, 2002).

A Framework Convention on International Public Health could dramatically advance international consideration of, and cooperation around, some of the most intractable public health problems of the modern era, facilitating consensus and priorisation, and the apparent early success of the FCTC should offer some comfort to the WHO that it would be time and political capital well spent.[12] Certainly the WHO is uniquely placed to do this by virtue of (1) its already existing presence in many countries and its regional networks, (2) its access to and indeed generation of global health information/statistics, and (3) its potential to wield (perhaps bluntly) the resources it has as a means of encouraging (cajoling?) the support of others in such an endeavour.

Such a Framework Convention might reasonably rely on human rights, the basic characteristics of which are that (1) they are inherent in people by virtue of their being human, (2) they are universal so all people are rights-holders, and (3) they are the responsibility of states to vindicate, and in doing so might win the WHO some important and influential allies (eg: various UN organs, international civil society organisations and even some nations which have fashioned their public policy around human rights). Modern public health is evolving against a backdrop of strong human rights awareness and language, and, as a paradigm, human rights has something to say about healthcare and access to (safe) medicine, food and water, sanitation, education, housing, clean environments and medical treatment (Braveman and Gruskin, 2003). Unfortunately, despite their frequent deployment, human rights have done little to truly enhance public health, and the ideals of instruments such as the Universal Declaration of Human Rights (1948) and the International Convention on Economic, Social and Cultural Rights (1966) remain unrealised:

> … [T]he legal complexities of health and human rights principles, and poorly formulated evidence in advancing the cause of global health, have reduced human rights arguments to lofty ideals that are widely quoted … but seldom implemented (Sing *et al.*, 2007, p. 1).[13]

A Framework Convention on International Public Health might, as a preliminary matter, explicitly articulate the moral/social values that must inform all activities that touch on public health in the 21st century (which, at the outset, would set it apart from its older human rights predecessors). A good starting point might be draw on and define human dignity, solidarity, equity, compassion, personal responsibility, efficacy, and cost-effectiveness in the international public health context. It has been noted that there are not enough considerations of the values which (should) underlie and drive public health structures and actions (Vetter, 2003), and given the nature of values –

broadly held concepts about what is deemed to be good (or bad) by society as derived by human experience over time – they need to be stated explicitly.

Importantly, such a Framework Convention on International Public Health might pull together the existing array of health-related human rights, including the vacuous "right to health",[14] offering concrete directions as to their content, how to comply with them and who has responsibilities for them. It might also set priorities (which could guide international assistance), contain mechanisms for monitoring and evaluating progress in implementing it, as well as mechanisms for enforcing it and for settling or adjudicating disputes that arise under it (between individuals and states as well as between states). Other key issues it might address are health systems structure, stakeholder engagement, transnational activity coordination, and capacity-building with respect to all of the above.

Of course, it must be conceded that the WHO faces no shortage of challenges in taking up a true leadership role, or in driving the process of adopting an international convention. First, its resources are not infinite, and they are, to some extent, dependent on its more affluent members, many of whom have demonstrated a chilling indifference to healthcare beyond (or even within) their borders. Second, it has to negotiate through the strong countervailing interests of both its more powerful members and its (potential) international partners such as the WTO and the World Bank (which has financed health systems in different parts of the world).[15] Third, it must overcome the inertia engendered by its own bureaucratic structure and many intimate stakeholders (and bosses). Fourth, it must foster closer and more regular associations with institutions and governmental departments (like Finance Ministries) which do not form part of its normal constituencies (ie: policy dialogue and assistance by the World Bank might currently be more effective in achieving health policy space in national budgets at the country level).

Given these constraints, one might argue that the WHO is justified in choosing its actions carefully and limiting them appropriately. Certainly being realistic in its potential is necessary to preserving its existing efficacy and legitimacy, but given the WHO's guiding principles and stated aims, it must surely adjust itself and its priorities to the demands of health being a hub for so many modern issues.

Conclusion

Although some gains have been achieved in literacy, information-sharing, food production and diffusion of medical technologies at the international level, international health is still in critical condition. This despite health being a morally-grounded objective and its promotion being a morally-grounded duty, not only of individuals and states, but also – in light of the new social and health context, both of which are global – of international actors.

The WHO is best positioned to comprehend the fantastically complex relationship between health and other interests/activities vital to human and state wellbeing (eg: political, economic, security). As such, despite the limitations noted above, the WHO must become a more active, a more robust, and a more imaginative leader in the realisation of public health. It must imagine a world where (some level of) universal health has been achieved and take concrete steps to realise it, for it is becoming quite clear that the globalisation of trade, commerce, economics, cultural and social practices is not improving nor has any intention of improving population or public health (McMichael and Butler, 2006, Bettcher and Lee, 2002).

Although there are a variety of avenues which the WHO might pursue, one (important) component of a renewed effort is the creation of international norms specifically directed at public health and at pulling its many facets together. Safeguarding individual and population health requires broad engagement and cooperation (Fidler, 1997), so, in pursuing its more ambitious leadership role, the WHO needs to recruit and/or influence the other key international legislators, some of whom, as noted above, might fairly be characterised as indifferent if not somewhat antagonistic to its aims (McMichael and Butler, 2006).[16] This will be a delicate matter but, presumably, not beyond the capabilities of the WHO, which ought to be able to exercise a variety of avenues of influence.

As noted above, key organisations are the WTO and World Bank. Although the WHO is leaking power to these more wealthy organisations, it is certainly not subordinate to them when it comes to moral authority or capturing the imagination of the masses. In any event, one can point to its preliminary steps toward better engagement with the WTO, which efforts have resulted in the publication of a joint study (WHO/WHO, 2002). Other key partners include those nations who have both wealth and demonstrated strengths in the (public) health sector. And this fact has been recognised:

> [W]ithdrawal and disengagement make no sense in this age of global markets, global pollution and climate change, changes to the role of the nation-state, of refugees, ethnic hostility, violence and mass migration, and the growing poverty and intractable disease that does not respect national borders (Strong *et al.*, 1996).

Indeed, it was recognised over twenty-five years ago:

> We are increasingly confronted … with more and more problems which affect mankind as a whole, so that the solutions to these problems are inevitably internationalised. The globalisation of dangers and challenges … calls for a domestic policy which goes beyond … national items. Yet this is happening at a snail's pace (Brandt, 1981).

And so it still does. Time for the WHO to transform from snail to … something faster than a snail.

Individuals, communities and countries need to be concerned with the health-impacting normative action that is going on, who is pursuing it, and who is not. Currently, the WHO is not; hence the title: "Not so much WHO as why, and not enough WHO and why not?" The question is not who, because obviously, it must be the WHO that takes these issues forward internationally and pushes and coordinates them nationally. The real question is why? In light of the internationalising that has gone on in other sectors, why hasn't the same happened in public health? Complexity is one reason, but it cannot be advanced as the key stumbling block because it has proven little impediment in the advancement of trade. Even recognising important efforts like its joint study with the WTO, and the formation of its Commission on the Social Determinants of Health, we have not seen enough of the WHO. Certainly the challenges identified above have tempered its ambitions and blunted its effectiveness, but now it must redouble its efforts, and we can only hope to encourage further and more effective WHO action now and in the future.

Ultimately, in addition to other actions, a transformation of norms and therefore of public policy priorities is needed (Raskin, 2002), and, despite its weaknesses, a bullish WHO is ideally placed to instigate and manage this transformation – the WHO needs to become a paradigm driver. That is the WHO's mission. Let us hope it chooses to accept it.

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Notes

[1] The Ottawa Charter (1986) states that the conditions and resources for health are peace, shelter, education, food, income, stable ecosystem, sustainable resources, and social justice and equity.

[2] The WHO is a UN organisation formed in 1948 and governed by the World Health Assembly which is comprised of delegates from each of the 193 member states. For more on the WHO, see http://www.who.int/en/.

[3] Indeed, the link between poor health and social and political instability and failure is supported by evidence (Gostin *et al.*, 2007; Kennedy *et al.*, 1998; Lewis, 2006).

[4] For example, see the Universal Declaration of Human Rights (1948), European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), the Declaration of Alma-Ata on Primary Health Care (1978), the Ottawa Charter for Health Promotion (1986), UN Convention on the Rights of the Child (1989), UN's Agenda 21 (1993), the Rio Declaration (1992), the Jakarta Declaration on Leading Health Promotion into the 21st Century (1997), UNESCO's Universal Declaration on the Human Genome and Human Rights (1997), and the Council of Europe's Convention on Human Rights and Biomedicine (1997).

[5] This reasoning is partially grounded on my interpretation of solidarity and my ranking of that value in the modern context. For example, I have argued (Harmon, 2005) that health solidarity, as an ethical value, must become a more integral aspect of out social and political actions, driving them toward responses that adopt a broad, community perspective and that have a global reach. In doing so, I draw on UNESCO (2005, p. 10), which suggests that solidarity is an ethical imperative of growing importance given ideals of collective social protection and fair opportunity and the existence of serious inequalities in access to healthcare worldwide.

[6] By way of example, the European Court of Justice has been a protagonist in empowering individuals to obtain medical treatment in member states other than where they are resident, and therefore a facilitator of social integration in the European context. For example, see *Decker v. Caisses de Maladie des Employés Privés* [1998] ECR I-1931, and *Kohll v. Union des Caisses de Maladie*

[1998] ECR I-1931, wherein the court rejected mobility limiting arguments to the effect that expenditure control was necessary and the risk of upsetting the financial balance of domestic social security systems was a danger.

[7] The WHO reports life expectancy by region as follows: Africa – 46 (M), 48 (F); Americas – 71 (M), 77 (F); South-East Asia – 61 (M), 64 (F); Europe – 68 (M), 77 (F); Eastern Mediterranean – 61 (M), 64 (F); Western Pacific – 70 (M), 74 (F). The countries with the lowest life expectancy rates and healthy life expectancy rates are African. Compared to life expectancy in the UK of 76 (M) and 81 (F), life expectancy rates in Lesotho are 35 (M) and 40 (F), Swaziland are 33 (M) and 36 (F), and Zimbabwe are 37 (M) and 36 (F). (WHO, 2005, p. 13).

[8] These Grand Challenges are listed as follows: Vaccines: (1) create effective single-dose vaccines for use shortly after birth; (2) prepare vaccines that do not require refrigeration; (3) develop need-free vaccines delivery methods; (4) devise reliable tests in model systems to evaluate vaccines; (5) design antigens for effective, protective immunity; (6) learn which immunological responses provide protective immunity; Insect Control: (7) develop genetic strategies to deplete/incapacitate disease-transmitting insects; (8) develop chemical strategies to deplete/incapacitate disease-transmitting insects; Nutrition: (9) create a full range of optimal nutrients in a single staple plant species; Infection: (10) discover drugs that minimise the occurrence of drug-resistant micro-organisms; (11) create therapies that can cure latent infections; (12) create immunological methods that can cure chronic infections; Disease/Health Measurement: (13) develop technologies that permit quantitative assessments of population health; and (14) develop technologies that permit assessment of individuals for multiple conditions/pathogens at point-of-care (see Varmus *et al.*, 2003).

[9] For more on the possible reasons for the WHO's failure to adopt a more robust law-making role in the past, see Arai-Takahashi (2001) and Magnusson (2007).

[10] Gostin *et al.* (2008) has referred to the IHR as the high-water mark for the exercise by the WHO of its normative powers.

[11] Reliance on market-driven economic policies and/or organisations to achieve social goals such as public health or even to set priorities complimentary to public health will prove unsuccessful (McMichael and Butler, 2006). Concerns about trade policies on public health have also been expressed by Labonte (2003), Checa *et al.* (2003), and others.

[12] Such a convention has been advocated by Lawrence Gostin and others (see Gostin, 2007; Gostin *et al.*, 2008; and Gostin and Taylor, 2008).

[13] By contrast, trade organisations are very adept and practical/pragmatic at norm-making and advancing the interests of their field, which is decidedly not driven by human rights or human wellbeing concerns.

[14] Some effort has been made by the Committee on Economic, Social & Cultural Rights (2000) to make this right more meaningful; also see the work of the subsequent Special Rapporteur.

[15] As both of these points suggest, the WHO is a politicised organisation that is constrained by the more powerful governments that are its members, and it is therefore sometimes constrained in ways that other international actors, whether NGOs or purely private actors, are not.

[16] The environmental sector – which is a health-related sector and which has formed the Global Legislators for a Balanced Environment, which has a remit developing a web of legal instruments aimed at protecting the environment – has been much more successful at getting its issues onto the all-important WTO policy agenda (Yach and Bettcher, 1998).