The UN and the Responsibility to Practice Public Health

DAVID P. FIDLER[*]

INTRODUCTION

Analyses of, and proposals for, reform of the United Nations (UN) frequently present the challenges facing the UN, its member states, and their respective populations as interconnected problems that all must be addressed effectively for progress to be made. For example, the UN Secretary-General's High-level Panel on Threats, Challenges, and Change (High-level Panel) stated that "[p]overty, infectious disease, environmental degradation and war feed one another in a deadly cycle."[1] The argument that poverty, infectious disease, environmental degradation, and war are interrelated problems of human governance can produce resignation that the task is impossible. Mounting scepticism about the UN's potential to contribute significantly to addressing these interdependent crises does little to temper such resignation. The outcome of the World Summit in September 2005 perhaps has, for some, deepened this pessimism.[2]

If, as the UN and UN reform strategies argue, poverty, disease, environmental degradation, and insecurity are intertwined, then a critical element of any response must involve policies that produce synergistic benefits for each of these areas of concern. This article focuses on public health as a critical synergistic strategy on which the future role of the UN in world affairs may depend. As analyzed below, overlaps between poverty, infectious disease, environmental degradation, and security point to the improvement of public health nationally and globally as a critical mission for governance in the twenty-first century. Public health is at the heart of strategies designed to advance development, tackle infectious diseases, mitigate environmental degradation, and support peace and security. Reflecting on the High-level Panel's report, the UN Secretary-General argued that "[w]e need to pay much closer attention to biological security", and he supported the High-level Panel's call "for a major initiative to rebuild global public

---

[1] *Report of the Secretary-General's High-level Panel on Threats, Challenges and Change, A More Secure World: Our Shared Responsibility*, UN GAOR, 59th Sess., Supp. No. 565, UN Doc. A/59 (2004) at para 22, online: United Nations ‹http://www.un.org/secureworld/ report.pdf› [*A More Secure World*]. For analysis of the High-level Panel's report, see Anne-Marie Slaughter, "Security, Solidarity, and Sovereignty: The Grand Themes of UN Reform" (2005) 99 A.J.I.L. 619 and Marco Odello, "Commentary on the United Nations" High-Level Panel on Threats, Challenges and Change," (2005) 10 J. Confl. & Sec. L. 231.

[2] UN General Assembly, *2005 World Summit Outcome*, GA Res 60/1, UN GAOR, 60th Sess., UN Doc. A/RES/60/1 (2005), online: United Nations ‹http://daccessdds.un.org/doc/ UNDOC/LTD/N05/511/30/PDF/N0551130.pdf?OpenElement›. [*World Summit Outcome*].

health."[3] In many ways, the UN reform agenda has at its core the strategic objective of achieving significant improvements in global public health.

The plausibility of imagining the UN dealing effectively with the interlinked crises of development, disease, environmental degradation, and security hinges, therefore, on the plausibility of the UN fostering significant improvements in global public health. Whether such improvements occur depend on the extent to which the UN can make what I call the *responsibility to practice public health* a major feature of the individual and collective behaviour of states. By connecting the strategic importance the UN and UN reform efforts have given public health in addressing problems related to development, disease, environmental degradation, and security with the attempts to promote a *responsibility to protect* as a new norm for international relations, I outline the component parts of the responsibility to practice public health, provide examples that support the reality of its formation in world politics, and consider questions that this responsibility raises. The article argues that the fate of UN contributions to international relations in the first decades of the twenty-first century will depend more on the responsibility to practice public health than on more prominent issues, including Security Council reform, international law on the use of force, peace building, and even the responsibility to protect in connection with large-scale, violent atrocities.

PUBLIC HEALTH AT THE CORE OF UN REFORM STRATEGIES

The role of the UN and the need for UN reform are not new topics in international relations; but never before has public health featured in UN reform proposals as prominently as it did in the report of the High-level Panel (December 2004)[4] and in the Secretary-General's own report *In Larger Freedom* (March 2005).[5] Neither document contains a section on "public health" because both integrate the need for public health improvements across the range of problems confronting the UN and its member states in the twenty-first century. The High-level Panel identified development, disease, and environmental degradation as critical components of what it called "comprehensive collective security",[6] and the deterioration of public health globally as a threat to comprehensive collective security and called for the rebuilding of global public health.[7] The High-level Panel also argued that, in cases of a suspicious or overwhelming outbreak of infectious disease, the Security Council should become involved to support actions of the World Health Organization

---

3   *A More Secure World, supra* note 1 at viii.

4   *Supra* note 1.

5   United Nations Secretary-General, *In Larger Freedom: Towards Development, Security and Human Rights for All—Report of the Secretary-General*, UN GAOR, 59th Sess., UN Doc. A/59/2005 (2005), online: United Nations ‹http://daccessdds.un.org/doc/UNDOC/GEN/ N05/270/78/PDF/N0527078.pdf?OpenElement› [*In Larger Freedom*].

6   *A More Secure World, supra* note 1 at 14.

7   *Ibid.* at paras. 66-70.

(WHO) and to mandate greater state compliance with multilateral efforts to control the outbreak.[8]

In terms of *In Larger Freedom*, each of the Secretary-General's objectives for UN reform—freedom from fear, freedom from want, and freedom to live in dignity—depends on progress in the area of public health. To achieve freedom from want, the Secretary-General emphasized fulfillment of the eight UN Millennium Development Goals (MDGs),[9] three of which target specific health problems (child mortality; maternal health; and the challenges of HIV/AIDS, malaria, and other diseases) and four of which seek improvement in key social determinants of health (extreme poverty and hunger; universal primary education; gender equality; and environmental sustainability).[10] The eighth MDG (develop a global partnership for development) seeks cooperation with pharmaceutical companies to provide access to affordable, essential medicines in developing countries.[11] In addition, eight of the sixteen targets set for achieving the eight MDGs and eighteen of the forty-eight indicators used to measure progress towards the MDG targets directly relate to health.[12]

The Secretary-General also asserted that ensuring access to sexual and reproductive health services, providing safe drinking water and sanitation, controlling pollution and waste disposal, assuring universal access to basic health services (including services to promote child and maternal health, to support reproductive health, and to control killer diseases), building national capacities in science, technology, and innovation, and ensuring environmental sustainability are national priorities for achieving freedom from want.[13] In addition, strengthening global infectious disease surveillance and increasing research on the special health needs of the poor are global priorities in realizing freedom from want.[14]

In terms of freedom from fear, the Secretary-General's vision for collective security included addressing threats presented by "poverty, deadly infectious disease and environmental degradation", because these threats can have equally catastrophic consequences as war, conflict, civil violence, organized crime, terrorism, and weapons of mass destruction.[15] The Secretary-General expressed particular concerns about security threats from biological weapons and biological terrorism, arguing that "[o]ur best defence against this danger lies in strengthening public health."[16]

---

8 *Ibid.* at para. 144.

9 *In Larger Freedom, supra* note 5 at paras. 28-31.

10 UN Millennium Development Goals, online: ‹ http://www.un.org/millenniumgoals/›.

11 *Ibid.*

12 World Health Organization, *Health in the Millennium Development Goals*, online: World Health Organization ‹http://www.who.int/mdg/goals/en/›.

13 *In Larger Freedom, supra* note 5 at paras. 40-41, 43-44, 46, 57.

14 *Ibid.* at paras. 63-64, 67.

15 *Ibid.* at para. 78.

16 *Ibid.* at para. 93.

Such strengthening should include bolstering WHO capabilities in the areas of disease surveillance and response.[17] The threat from infectious diseases is such that the Secretary-General stated that he was ready to call to the attention of the UN Security Council "any overwhelming outbreak of infectious disease that threatens international peace and security".[18]

The Secretary-General's conception of freedom to live in dignity also connected with public health. The Secretary-General emphasized that protecting human rights was important for fulfilling the objectives of development and security.[19] He further declared that "[t]he right to choose how they are ruled, and who rules them, must be the birthright of all people, and its universal achievement must be a central objective of an Organization devoted to the cause of larger freedom."[20] Public health supports this right and attribute of human dignity because "[e]ven if he can vote to choose his rulers, a young man with AIDS who cannot read or write and lives on the brink of starvation is not truly free."[21]

The prominence of public health in the UN reform strategies of the High-level Panel and the Secretary-General parallels efforts made in other forums to highlight public health's growing importance to development, security, human rights, and environmental protection.[22] Arguments about the centrality of public health to the process of economic development, such as those made by the Commission on Macroeconomics and Health,[23] echo public health's profile in the MDGs. The rise of infectious disease threats, both naturally occurring and intentionally caused, has made public health a frequent topic in debates about national and international security.[24] The relationship between public health and

---

[17]   *Ibid.*

[18]   *Ibid.* at para. 105.

[19]   *Ibid.* at para. 140.

[20]   *Ibid.* at para. 148.

[21]   *Ibid.* at para. 15.

[22]   See, e.g., *Empowering People at Risk: Human Security Priorities for the 21st Century* (Working Paper for the Helsinki Process on Globalization and Democracy Report of the Track on "Human Security") (2005) (making health a priority for the human security agenda), online: Human Security Gateway ‹http://www.humansecuritygateway.com/data/item907994828/view›.

[23]   Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: World Health Organization, 2001).

[24]   See, e.g., Chemical and Biological Arms Control Institute (CBACI) & Center for Strategic and International Studies International Security Program, *Contagion and Conflict: Health as a Global Security Challenge* (Washington, D.C.: CBACI, 2000); Jonathan Ban, *Health, Security, and U.S. Global Leadership* (Washington, D.C.: CBACI, 2001); Andrew T. Price-Smith, *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (Cambridge, MA: MIT Press, 2002); Jennifer Brower and

human rights—both civil and political rights and economic, social, and cultural rights—has been a feature of human rights and public health discourse over the past decade.[25] Analyses of the emergence and re-emergence of infectious diseases identify environmental degradation as an underlying cause of the appearance and spread of pathogenic microbes.[26] In addition, much of the body of international environmental law was developed to protect, directly or indirectly, human health from the harmful effects of pollution and other forms of environmental degradation.[27]

The argument that public health is a core element of leading UN reform strategies does not claim that public health is the only element of such strategies or constitutes the "magic bullet" for all global problems. UN reform and the issues it attempts to address are too complex for reductionist analysis. The argument does claim, however, that public health represents a critical public good that UN reform proposals integrated into thinking about development, disease control, security, human rights, and environmental degradation. Strategies that cut across these areas are badly needed. The High-level Panel complained, for example, that "[i]nternational institutions and States have not organized themselves to address the problems of development in a coherent, integrated way, and instead continue to

Peter Chalk, *The Global Threat of New and Reemerging Infectious Diseases: Reconciling U.S. National Security and Public Health Policy* (Santa Monica: RAND, 2003).

[25]   The importance of civil and political rights to health has arisen with respect to strategies to fight discrimination created by the HIV/AIDS pandemic (see L. O. Gostin, *The AIDS Pandemic: Complacency, Injustice, and Unfulfilled Expectations* (Chapel Hill: University of North Carolina Press, 2004), at 61-87 (analyzing human rights and public health in the HIV/AIDS pandemic)) and to the use of quarantine and isolation to deal with contagious disease threats, whether intentionally caused or naturally occurring (see, e.g., M.A. Rothstein et al., *Quarantine and Isolation: Lessons Learned from SARS* (Report from the Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine to the Centers for Disease Control and Prevention, 2003)). In terms of economic, social, and cultural rights, renewed attention has developed in the past five years with respect to the right to health, as evidenced by the issuance of a General Comment on the right to health (see Committee on Economic, Social, and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN CECSROR, 22nd Sess., UN Doc. E/C.12/2000/4 (2000)) and the appointment of a Special Rapporteur on the Right to Health in 2002 by the Commission on Human Rights (see Office of the UN High Commissioner for Human Rights, Special Rapporteur of the Commission on Human Rights on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, online: Office of the UN High Commissioner for Human Rights ‹http://www.ohchr.org/english/issues/health/right/›).

[26]   Institute of Medicine Committee on Microbial Threats to Health in the 21st Century, *Microbial Threats to Health: Emergence, Detection and Response* (Washington, D.C.: National Academies Press, 2003), at 75-77.

[27]   D. P. Fidler, "Challenges to Humanity's Health: The Contributions of International Environmental Law to National and Global Public Health" (2001) 31 Environmental Law Reporter 10048.

treat poverty, infectious disease and environmental degradation as stand-alone threats."[28]

Public health is a strategic "best buy" for national and UN policies because it constitutes an integrated public good that benefits the fight against poverty, diseases, environmental degradation, and insecurity. I have argued elsewhere that the rise of public health's importance in national and international politics means that public health itself is becoming an independent marker of good governance.[29] The High-level Panel captured the essence of this argument when it concluded that improving global disease monitoring capabilities was important for not only fighting emerging infectious diseases and defending against biological terrorism but also "building effective, responsible States".[30] Public health's importance to development, disease control, environmental protection, and security gives it governance importance obscured by the traditional "stove piping" of policy areas and by conventional categorization of public health as an activity belonging in the "low politics" of international affairs.

This conclusion concerning the strategic importance of public health necessitates coming to grips with the assertions in the reports of the High-level Panel and the Secretary-General that the global public health system is, presently, inadequate for the important role it must play in the areas of development, disease control, security, human rights, and environmental protection. The High-level Panel observed that many current infectious disease problems "signify a dramatic decay in local and global public health capacity."[31] The Secretary-General argued that "[t]he overall international response to evolving pandemics has been shockingly slow and remains shamefully underresourced."[32] Understanding this state of affairs requires comprehending the historical relationship between the UN and public health.

THE UN AND PUBLIC HEALTH IN HISTORICAL PERSPECTIVE

Supporting international cooperation on health was one of the functions assigned to the UN by its Charter.[33] The WHO's establishment as the specialized UN agency with responsibility for international health enhanced the UNs institutional capabilities in this realm. The WHO Constitution's preamble expressed a vision for health in the affairs of states and peoples that resonates with public health's central

---

[28] *A More Secure World, supra* note 1 at para. 55.

[29] D.P. Fidler, "Germs, Governance, and Global Public Health in the Wake of SARS," (2004) 113 J. Clin. Invest. 799.

[30] *A More Secure World, supra* note 1 at para. 69.

[31] *Ibid.* at para. 47.

[32] *In Larger Freedom, supra* note 5 at para. 63.

[33] *Charter of the United Nations*, 26 June 1945, Article 55(b).

role in contemporary UN reform strategies.[34] The preamble linked the enjoyment of the highest attainable standard of health with international security, economic development, and human rights.[35] The WHO's main focus was on improving health conditions in developing countries, and it provided support to such countries through vertical programs (e.g. disease eradication initiatives) and horizontal strategies (e.g. improving overall health system capacities). The WHO's influence and prestige reached its peak in the late 1970s when it successfully eradicated smallpox from the planet and launched its seminal Health for All by the Year 2000 campaign, which sought to ensure that everyone would have access to primary health care services by 2000.

The 1980s and 1990s witnessed not the march towards health for all but rather a "twenty years' crisis" for the WHO and the UN system with respect to global health. Looming largest in this crisis was the emergence of HIV/AIDS into one of the worst pandemics in human history.[36] In addition to HIV/AIDS, the world experienced the resurgence of new and old infectious diseases, fuelled by a diverse array of social and economic phenomena, including globalization, antimicrobial resistance, and environmental degradation.[37] Public health experts also saw many countries beginning to bear a "double burden of disease"—a burden arising from continued infectious disease problems accompanied by growing rates of non-communicable diseases associated with, among other things, tobacco consumption.[38] The establishment of the World Trade Organization in 1995 left many public health experts thinking that health and its importance to human rights and social justice in developing nations had been subordinated to the trade and corporate interests of developed countries.[39] Making matters worse was the decline

---

[34]   Constitution of the World Health Organization, 22 July 1946, in World Health Organization, *Basic Documents*, 40th ed. (Geneva: World Health Organization, 1994) [WHO Constitution], at 1.

[35]   *Ibid.*

[36]   Joint United Nations Programme on HIV/AIDS (UNAIDS), *Report on the Global HIV/AIDS Epidemic 2002* (Geneva: UNAIDS, 2002), at 44 ("Twenty years after the world first became aware of AIDS, it is clear that humanity is facing one of the most devastating epidemics in human history.").

[37]   World Health Organization, *World Health Report 1996: Fighting Disease, Fostering Development* (Geneva: World Health Organization, 1996), at v (WHO Director-General warning that the world stands "on the brink of a global crisis in infectious diseases.").

[38]   World Health Organization, *World Health Report 1997: Conquering Suffering, Enriching Humanity* (Geneva: World Health Organization, 1997), at v (The WHO Director-General argues that "[i]n the battle for health in the 21st century, infectious diseases and chronic diseases are twin enemies that have to be fought simultaneously on a global scale.").

[39]   For analyses of the relationship between trade and health, see World Health Organization and World Trade Organization, *WTO Agreements & Public Health: A Joint Study by the WHO and the WTO Secretariat* (Geneva: World Health Organization, 2002); E.R. Shaffer, et al., "Global Trade and Public Health," (2005) 95 Amer. J. Publ. Hlth. 23.

in the WHO's effectiveness and influence precipitated by a number of factors, including leadership problems at its Geneva headquarters.[40] Topping off the twenty years' crisis was the realization that nuclear, chemical, and especially biological terrorism was a growing threat, which also highlighted the extent to which national and international public health capabilities were inadequate.[41]

This potted history of the relationship between the UN and public health until the end of the twentieth century provides some background on the discrepancy between the critical function leading UN reform strategies have given public health and the reality of public health on the ground. This discrepancy raises questions about the plausibility of the UN contributing to the significant improvements in global public health that UN reform proposals have argued are necessary. If the twenty years' crisis tells the tale of UN intergovernmentalism on public health being overwhelmed, what can we realistically expect from arguments that the international community must elevate public health as an integrated public good to support the achievement of security, development, disease control, human rights, and environmental protection?

PUBLIC HEALTH AND THE RESPONSIBILITY TO PROTECT

Assessing the prudence and feasibility of placing global public health at the heart of UN activities in the twenty-first century is a task far too complex for the space allotted to this article, but a preliminary sketch of important issues can be attempted. The prominence of public health in the leading UN reform proposals, combined with public health's rise on the agenda of world politics more generally, point conceptually to the need for a principle of individual and collective responsibility to improve national and global public health—the responsibility to practice public health. This responsibility advocates individual and collective actions that derive from public health theory and practice.

The concept of the responsibility to practice public health brings to mind the growing prominence of the emerging norm called the "responsibility to protect." Both the High-level Panel and the Secretary-General argued that the UN and its member states must embrace and act upon the responsibility to protect.[42] As elaborated by the Secretary-General, the responsibility to protect

> lies, first and foremost, with each individual State, whose primary
> raison d'être and duty is to protect its population. But if national

---

[40]   F. Godlee, "WHO in Crisis," (1994) 309 Br. Med. J. 1424, at 1427-1428 (arguing that WHO "is suffering a crisis of confidence, both internally and internationally" and is "entering a period of intense soul searching and internal upheaval.").

[41]   For example, the WHO responded to this growing threat by updating its 1970 report on the health aspects of chemical and biological weapons. See World Health Organization, *Public Health Response to Biological and Chemical Weapons: WHO Guidance* (Geneva: World Health Organization, 2004).

[42]   *A More Secure World, supra* note 1 at para. 203; *In Larger Freedom, supra* note 5 at para. 135.

authorities are unable or unwilling to protect their citizens, then the responsibility shifts to the international community to use diplomatic, humanitarian and other methods to help protect the human rights and well-being of civilian populations.[43]

The support in the UN reform strategies for the responsibility to protect continues the work done by others, most prominently the International Commission on Intervention and State Sovereignty (ICISS).[44] As elaborated by ICISS, the responsibility to protect is based on the premise that state sovereignty means that the state itself has primary responsibility for the protection of the people living in its territories.[45] When a state is unwilling or unable to stop or avert serious harm from affecting its population as a result of internal war, insurgency, repression, or state failure, then the principle of non-intervention in international law yields to the international responsibility to protect.[46] This international responsibility embraces three component responsibilities: to prevent crises that put populations at risk; to react to situations of compelling human need with appropriate measures; and to rebuild to ensure that the harms to the population do not arise again.[47] The responsibility to protect provides the legitimacy for military intervention by the international community in extreme cases when peaceful diplomatic or coercive measures, such as sanctions, have failed to stop the suffering of the population in question.[48] Support for the responsibility to protect from the High-level Panel, the Secretary-General, and the World Summit basically follows the ICISS formulation of the responsibility to protect.[49]

Neither the High-level Panel nor the Secretary-General connected the emerging norm of the responsibility to protect with their respective arguments on the critical importance of public health to twenty-first century humanity. Consistent with the approach of the ICISS, they focused the responsibility to protect on large-scale, violent atrocities, such as genocide, ethnic cleansing, and crimes against humanity.[50] The World Summit's outcome statement also focused the responsibility to protect on such atrocities.[51]

---

[43]   *In Larger Freedom, supra* note 5 at para. 135.

[44]   International Commission on Intervention and State Sovereignty, *The Responsibility to Protect* (Ottawa: International Development Research Centre, 2001) [ICISS].

[45]   *Ibid.* at paras. 2.14-2.15.

[46]   *Ibid.* at para. 4.1.

[47]   *Ibid.* at para. 2.32.

[48]   *Ibid.* at para. 4.10.

[49]   *A More Secure World, supra* note 1 at para. 203; *In Larger Freedom, supra* note 5 at para. 135; *World Summit Outcome, supra* note 2 at paras. 138-139.

[50]   *A More Secure World, supra* note 1 at para. 203; *In Larger Freedom, supra* note 5 at paras.134-135.

[51]   *World Summit Outcome, supra* note 2 at para. 139.

The relevance of the concept of individual and collective responsibility to protect to the massive human suffering associated with the global failures in public health is, however, clear.[52] The UN reform documents and other UN activities communicate the enormity of the public health threats and harms populations in both developed and developing countries face in the early twenty-first century—HIV/AIDS, tuberculosis, malaria, malnutrition, unsafe water, lack of sanitation, antimicrobial resistance, and emerging infectious diseases such as SARS and avian influenza. Large-scale atrocities involving violence are a horrific problem requiring the UN's attention; but such atrocities do not encompass all the severe suffering populations endure because of the unwillingness or incapability of governments to protect their populations from serious, foreseeable, and often preventable harms. The depressing global morbidity and mortality statistics connected to HIV/AIDS, tuberculosis, and malaria alone reveal a fundamental failure by states, individually and collectively, to protect the well-being of human populations from pathogenic threats. To these macabre statistics must be added the misery and death caused by diseases related to poverty and environmental degradation. Reflecting on the grim statistics connected with communicable diseases in connection with the High-level Panel's emphasis on human security, Slaughter asked, "If human security is our aim, why on earth should we privilege the saving of lives from violence over the saving of lives from disease?"[53]

THE ELEMENTS OF THE RESPONSIBILITY TO PRACTICE PUBLIC HEALTH

Both the logic of the High-level Panel's and the Secretary-General's reasoning on the strategic importance of global public health and the brutal realities of disease on the ground in the world today point to the need to formulate a specific responsibility to practice public health. Formulation of this responsibility borrows from thinking developed with respect to the responsibility to protect and from the basic functions of public health practice. These functions are (1) *surveillance* of disease and health trends in populations; and (2) *interventions* to address the introduction or spread of health risks in populations. Monitoring population health through surveillance provides the data that allows interventions to be made. Surveillance is, thus, critical to effective interventions. Similarly, surveillance without effective intervention does not protect public health.

Interventions come in three forms. *Prevention* interventions prevent health risks from reaching populations. Treatment of water supplies to eliminate pathogens or contaminants and disease eradication campaigns are examples of prevention

---

[52]   Odello, *supra* note 1 at 241 (This "emerging rule" concerning the responsibility to protect seems to be applicable in cases of genocide, ethnic cleansing and gross violations of human rights, but there are no clear answers when we have to deal with pandemic disease, famine, floods, etc. ...Owing to the fact that the [High-level Panel] Report deals with a wide range of new "threats," it could be considered that the responsibility to protect involves those situations as well.").

[53]   Slaughter, *supra* note 1 at 624.

interventions. *Protection* interventions protect populations from health risks that will reach human populations. The idea behind protection interventions is to "harden the target"—strengthen a population's resilience against health risks. A classical example of a protection intervention is vaccination, such as vaccination against childhood diseases or seasonal influenza. *Response* interventions are actions taken to control the impact on population health from risks that do affect people. Such interventions can involve treating sick individuals (e.g. antiretrovirals for people infected with HIV) or containing the sources of the health risks (e.g. isolation or quarantine of contagious persons or addressing the source of toxic pollutants).

The public health functions of surveillance and intervention apply whether the health context is entirely internal or affects more than one country. These functions are transarchical because they apply whether the political context is hierarchical, as prevails within states, or anarchical, as exists among states. Surveillance and intervention have this transarchical quality because they are based in epidemiology—the science of the study and control of diseases. The only epidemiological path to better national and global public health leads through surveillance and intervention.

Combining the basic principles of the responsibility to protect[54] with the basic functions of public health produces the core features of the responsibility to practice public health:

● *Basic principles of the responsibility to practice public health*

1. State sovereignty implies responsibility, and the primary responsibility for the protection and promotion of the health of the people lies with the state itself.

2. Where population health is suffering serious chronic or acute harm and the state in question is unable or unwilling to mitigate or eliminate the harm, the principle of non-intervention in international law yields to the international responsibility to practice public health.

3. The international responsibility to practice public health authorizes the international community of states and non-state actors to take extraordinary measures to address severe disease situations that involve the cross-border movement and spread of disease organisms or agents.

● *Foundations of the responsibility to practice public health*

The foundations of the responsibility to practice public health, as a requisite principle for the international community of states and non-state actors, stem from:

1. The obligations to populations inherent in the concept of sovereignty.

2. The necessity for public health, as a "public good", to be the primary responsibility of governments.

---

[54]   ICISS, *supra* note 44 at XI.

3. The obligations concerning international cooperation for health found in the *UN Charter*.

4. The responsibilities linked to human health expressed by the WHO Constitution.

5. Specific legal obligations related to the protection of human health found in international legal instruments.

6. The developing practice of states, regional organizations, the UN (especially WHO and including the Security Council), and international non-governmental organizations with respect to health promotion and protection.

● *Elements of the responsibility to practice public health*

The national and international responsibility to practice public health encompasses four specific responsibilities:

1. The responsibility to monitor: to conduct surveillance of population health and determinants of health to determine the sources of disease threats and the nature of specific disease harms.

2. The responsibility to prevent: to intervene to prevent disease organisms or agents from adversely affecting population health.

3. The responsibility to protect: to intervene to protect populations from disease organisms or agents present in societies.

4. The responsibility to respond: to intervene to react to situations in which disease organisms or agents cause outbreaks or epidemics of diseases in populations.

RESPONSIBILITY PRINCIPLES AND THE SOCIAL CONTRACT CHALLENGE TO WESTPHALIANISM

As with the responsibility to protect, the responsibility to practice public health is a norm that overrides the principles of sovereignty and non-intervention when the state fails to live up to its responsibilities. These "responsibility principles" reject Westphalian assumptions and practices grounded in the idea of sovereignty as supreme control over territory and the people and activities in it. As the ICISS stated, the responsibility to protect involves re-characterizing sovereignty by moving "from *sovereignty as control* to *sovereignty as responsibility* in both internal functions and external duties."[55] Westphalianism created two levels of society with little interaction between them: (1) domestic society subject to sovereignty and off-limits to other states under international law; and (2) international society, or the society of states created by their interactions with each other in the context of anarchy (including interactions in diplomacy, trade, and war). Responsibility principles reject this bifurcation and conceive of world politics along the lines of a

---

[55]   ICISS, *supra* note 44 at para. 2.14.

social contract with dynamics more reminiscent of federal governance systems than anarchical Westphalianism.

The social contract nature of the responsibility to practice public health can be illustrated through an analogy to public health in federal systems, such as the United States. Under the US Constitution, the states of the Union have primary responsibility (that is, they have sovereignty) over public health.[56] When health threats escape the borders of a state, or the state is unwilling or unable to address a serious health problem, the federal government's responsibility in the area of public health is triggered. The federal government's role derives part of its scope from the capabilities of the state governments on public health. The weaker or more vulnerable those state-level capabilities are, the more involved the federal government must become. Developments in the last twenty to thirty years have produced a federalization of public health power in the United States because state-level capabilities increasingly have to be supported and led by the federal government exercising its constitutional authority.[57]

The same dynamic operates in international relations and helps explain the rise of public health as a political issue in world politics in the last ten to fifteen years. Globalization and other developments have increasingly stressed the ability of individual states to handle threats to population health, especially in the area of infectious diseases. The nature, speed, and scope of many health threats has placed more demands on states' foreign policies, the capabilities of international organizations, and the resources of NGOs and multinational corporations than ever before in history.[58] As an epidemiological matter, the basic functions of public health cannot operate in this day and age under the old Westphalian framework, particularly its strong principle of non-intervention, which rendered sovereignty virtually sacrosanct. The world confronts the need to adjust to the globalization of public health governance.

At the same time as the responsibility to practice public health pierces the Westphalian veil of sovereignty, it demands that the "international community" better organize itself to shoulder effectively the globalization of public health governance. The twenty years' crisis revealed that the UN and its intergovernmental public health capabilities proved a poor match for the challenges that emerged after the halcyon days of the late 1970s, when WHO basked in the triumph of smallpox's eradication and the launch of the Health for All campaign. The principle of the responsibility to protect reflects exactly the same dynamic: the principle demands that the international community be ready, willing, and able to intervene, by

---

[56]   L. O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2001), at 25-59 (analyzing how federalism structures public health governance in the United States).

[57]   D. P. Fidler, "Constitutional Outlines of Public Health's "New World Order" (2004) 77 Temple L. Rev. 247, at 250-257 (analyzing the federalization of public health in U.S. constitutional governance).

[58]   *Ibid.* at 257-272 (analyzing the globalization of public health governance).

military force if necessary, to stop large-scale, violent atrocities. Social contract politics in the context of anarchy is expensive, not only in terms of sovereignty costs but also in the material capabilities that must be built nationally, internationally, and globally to address globalized forces and threats effectively.

EVIDENCE OF THE EMERGING RESPONSIBILITY TO PRACTICE PUBLIC HEALTH

The responsibility to protect remains dogged by scepticism about the reality behind the rhetoric. No doubt some readers understood the conceptual framing of the responsibility to practice public health but wondered whether, in light of what happened to the UN and the WHO during the twenty years' crisis, this responsibility is merely a figment of my imagination. In this section, I argue that evidence exists to support the claim that the responsibility to practice public health is an emerging feature of twenty-first century international relations.

The Millennium Development Goals

As already indicated, the MDGs comprise a central objective in UN thinking about global politics in the early twenty-first century; but they also embody more specifically key aspects of the responsibility to practice public health. The MDGs operate on the basis of population surveillance that provides the epidemiological data necessary to assess the adequacy of prevention, protection, and response interventions. Progress towards each of the MDGs' health-related goals, targets, and indicators can only be assessed by empirically monitoring the health of populations around the world. The health-related targets of the MDGs are assessed by collecting information on specific health indicators. The data collected allows experts to develop a picture for what kind of interventions are needed and what interventions may not be working. As the WHO commented, "MDG monitoring has for the first time made available a reliable and comparable set of country health statistics—information which is useful for both policy-making and advocacy purposes."[59] The MDG process is, in fact, a grand epidemiological project both horizontally across the world's regions and vertically within individual countries for both direct public health problems (for example, child mortality, maternal health, and infectious diseases) and key social determinants of health (for example, poverty, hunger, education, gender equality, and environmental sustainability).

Revitalization of WHO

Part of the twenty years' crisis for UN activities on global public health related to problems the WHO experienced during the 1980s and 1990s that limited its effectiveness and lessened its influence. The last ten years have seen, however, efforts made to revitalize the WHO so that it can better fulfill its mandate as the specialized agency of the UN for public health. This revitalization process is too

---

[59]   World Health Organization, *Health and the Millennium Development Goals* (Geneva: World Health Organization, 2005), at 14.

complex to try to capture comprehensively here, but it involves strategies to make the WHO more responsive to the problems the globalization of public health presents to its member states concerning both communicable and non-communicable diseases. Indications of this revitalization can be found, for example, in the manner in which the WHO (1) supported the MDGs;[60] (2) reshaped its approach to global surveillance and response to infectious diseases, the potential of which was demonstrated in the successful WHO-led effort to control the dangerous global outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003;[61] (3) provided leadership on combating the globalization of non-communicable diseases, especially the WHO-led efforts to adopt the Framework Convention on Tobacco Control[62] and to develop a global strategy for fighting the spread of obesity-related diseases;[63] and (4) recognized the need to create partnerships with other international organizations (e.g. World Bank) and non-state actors (e.g. Gates Foundation) on a range of global health problems.[64]

The New International Health Regulations

The new International Health Regulations adopted in May 2005 by the WHO (IHR 2005)[65] constitute particularly compelling evidence of the emergence of the responsibility to practice public health. For many reasons, the IHR 2005 constitute a historic development in the use of international law for public health purposes; and I explore this seminal international legal regime in detail elsewhere.[66] In terms of this article, the IHR 2005 are important because they embody, in an international legal agreement that will become binding on consenting states parties in 2007, the responsibility to practice public health in a manner never before seen in the long history of public health's relationship with international law.

---

[60]   *Supra* note 12.

[61]   See D. P. Fidler, *SARS, Governance, and the Globalization of Disease* (Basingstoke: Palgrave Macmillan, 2004).

[62]   World Health Organization, *Framework Convention on Tobacco Control* (2005) online: World Health Organization ‹http://www.who.int/tobacco/framework/fctc_en.pdf›.

[63]   World Health Organization, *Global Strategy on Diet, Physical Activity, and Health: Obesity and Overweight* (2004) online: World Health Organization ‹http://www.who.int/dietphysicalactivity/publications/facts/obesity/en/›.

[64]   See e.g. World Health Organization, *The Civil Society Initiative*, online: World Health Organization ‹http://www.who.int/civilsociety/en/index.html›.

[65]   World Health Assembly, *Revision of the International Health Regulations*, WHA58.3, 23 (2005) [IHR 2005].

[66]   D. P. Fidler, "From International Sanitary Conventions to Global Health Security: The New International Health Regulations" (2005) 4 Chinese J.I.L. 325.

Starting in the latter half of the nineteenth century, states began to use international law to facilitate cooperation on infectious disease control.[67] The approach crafted for the early international sanitary conventions of the late nineteenth and first half of the twentieth century was, however, very limited in terms of the diseases to which the treaties applied and the positive obligations of states within their own territories. This Westphalian approach prevailed because the major purpose of these treaties was to minimize the impact of national quarantine regulations on flows of international trade. The international sanitary conventions were as much or more trade agreements as they were instruments focused on public health. The WHO continued this approach when it adopted the International Sanitary Regulations in 1951,[68] which the WHO later renamed the International Health Regulations in 1969 (IHR 1969).[69]

The twenty years' crisis demonstrated, beyond any doubt, how bankrupt the approach embodied in the IHR 1969 was in the context of global public health in the last decades of the twentieth century. State parties routinely violated the IHR 1969, and the IHR 1969 did not even apply to the emergence and re-emergence of many infectious diseases worrying global public health experts in the 1980s and 1990s.[70] The WHO began the process of revising and updating the IHR 1969 in 1995;[71] and the outbreak and containment of SARS accelerated the revision process, eventually producing a radically different international legal regime for global public health in the form of the IHR 2005.

The IHR 2005 contain a host of provisions that connect directly to the responsibility to practice public health. First, the scope of the IHR 2005 covers both communicable and non-communicable diseases regardless of origin or source.[72] The IHR 1969 and its predecessor regimes never ventured beyond a short list of naturally occurring communicable diseases, the spread of which was associated with international trade and travel. The IHR 2005's comprehensive disease scope means that the obligations on surveillance and intervention in this regime are now driven by global public health needs, not the trade interests of the great powers.

---

[67]   For an overview of the use of international law on infectious disease control during this historical period, see D. P. Fidler, *International Law and Infectious Diseases* (Oxford: Clarendon Press, 1999), at 21-57.

[68]   International Sanitary Regulations, 25 May 1951, 175 UNTS 214.

[69]   World Health Organization, *International Health Regulations* (1969) (3rd ann. ed.) (Geneva: World Health Organization, 1983) [IHR 1969].

[70]   For analysis of the failure of the IHR 1969, see Fidler, *supra* note 67 at 65-71.

[71]   World Health Assembly, *Revision and Updating of the International Health Regulations*, WHA48.7 (1995).

[72]   IHR 2005, *supra* note 65 at Article 1.1 (defining "disease" to mean "an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans").

Second, the IHR 2005 require all state parties to develop core public health capacities within their respective territories within a set period of time in order to engage in surveillance and to undertake appropriate interventions with respect to serious disease events within their own territories or the territories of other states.[73] Nothing in the long history of international law on public health approaches these obligations to build and maintain core surveillance and intervention capabilities at the state level. The IHR 1969 only mandated, for example, the maintenance of minimal public health capabilities at ports of entry and exit for trade and travel.

Third, the IHR 2005 require state parties to notify the WHO of all disease events that may constitute a public health emergency of international concern.[74] This notification duty functions as part of the global surveillance system the IHR 2005 supports, and the duty goes far beyond the IHR 1969's requirement for state parties to report outbreaks of less than a handful of infectious diseases. The IHR 2005 also breaks significantly with the IHR 1969 by empowering the WHO to collect and utilize surveillance information obtained from NGOs and other non-state sources, such as the media.[75] This provision feeds into the WHO's Global Outbreak Alert and Response Network (GOARN),[76] through which WHO harnesses the power of information technologies to state and non-state actor participation in global public health to create a more comprehensive, rapid, and effective surveillance system than anything seen before in the history of international health cooperation. The IHR 2005 also permits the WHO to seek verification from a state party about information it has received from sources other the state party in question, and the IHR 2005 requires state parties to respond to WHO verification requests.[77] This surveillance system drastically reduces the incentives and the possibilities states formerly had to cover-up serious outbreaks of diseases in their territories.

Fourth, the IHR 2005 grant the WHO the authority to declare whether a disease event actually constitutes a public health emergency of international concern.[78] This important decision, which could carry serious political and economic consequences for states, is not left in the hands of sovereign states. If the WHO declares a public health emergency of international concern, it is empowered to promulgate temporary recommendations on how state parties should respond to such an emergency.[79] These recommendations would pinpoint what constitute sound public health interventions vis-à-vis the public health emergency of

---

[73]   *Ibid.* at Articles 5.1, 13.1, and Annex 1.

[74]   *Ibid.* at Article 6.1.

[75]   *Ibid.* at Article 9.1.

[76]   World Health Organization, *Global Outbreak Alert and Response Network*, online: World Health Organization ‹http://www.who.int/csr/outbreaknetwork/en/›.

[77]   IHR 2005, *supra* note 65 at Articles 10.1-10.2.

[78]   *Ibid.* at Article 12.

[79]   *Ibid.* at Article 15.

international concern. State parties deviating from WHO recommendations or other provisions in the IHR 2005 on appropriate interventions must justify their actions by providing relevant information to the WHO.[80] Each of these new WHO authorities reflects the logic of the globalization of public health governance because they acknowledge the need to shift some governance authority and responsibilities from the national to the international level.

Fifth, the IHR 2005 requires that all public health interventions taken to deal with disease events and public health emergencies of international concern be not more restrictive of trade and not more intrusive for individuals than is necessary to achieve the level of health protection sought.[81] These obligations seek to ensure that trade interests and human rights are respected as much as possible when states and the WHO address serious international disease threats and mirror the principle in the responsibility to protect that action "should always involve less intrusive and coercive measures being considered before more coercive and intrusive ones are applied."[82]

This description of the IHR 2005 should help make clear why the Secretary-General and the World Summit supported either the revision of the IHR or the IHR 2005 itself.[83] The IHR 2005 expresses the necessity for the individual and collective responsibility to practice public health as clearly as the MDGs. The new Regulations represent a milestone for the UN system in advancing global public health in international law. The acceptance by states of the IHR 2005's (1) much more demanding surveillance and intervention obligations at the national level; (2) empowerment of the WHO in terms of surveillance and intervention; and (3) involvement of non-state actors in governance of global public health, all in binding international law, reveals a level of consensus about the importance of collective action on global public health that surpasses any previous treaty or non-binding instrument concerning public health.

Security Council Involvement in Global Public Health

Another indicator of the emergence of a responsibility to practice public health can be found in the Security Council's involvement in global public health issues. The Security Council has, twice in the past five years (2000 and 2005), convened to address the threat HIV/AIDS poses to international peace and security.[84] Before the first Security Council meeting on HIV/AIDS in 2000, the Council had never before

---

[80]   *Ibid.* at Article 43.

[81]   *Ibid.* at Articles 17(d), 31.2, and 43.1.

[82]   ICISS, *supra* note 44 at XI.

[83]   *In Larger Freedom*, *supra* note 5 at para. 64; *World Summit Outcome*, *supra* note 2 at para. 57.

[84]   See UNSC Res 1308 (2000), UN Doc. S/Res/1308 (2000); and *Security Council Presidential Statement Recognizes "Significant Progress" Addressing HIV/AIDS Among Peacekeepers, But Says Many Challenges Remain*, SC/8450 Press Release, 18 July 2005, online: United Nations <http://www.un.org/News/Press/docs/2005/sc8450.doc.htm>.

become seized of a matter pertaining to the threat diseases pose to international peace and security. These meetings have set a precedent that the Security Council's mandate to maintain international peace and security encompasses severe disease threats that appear to be escaping the control of sovereign states to the serious detriment of international relations.

Both the High-level Panel and the Secretary-General took this precedent one step further by advocating for Security Council involvement in situations involving overwhelming outbreaks of infectious diseases.[85] These proposals are the public health equivalent of the arguments under the responsibility to protect that the Security Council should intervene in connection with large-scale, violent atrocities relevant states appear unable or unwilling to address. The proposals also complete the logic of the globalization of public health governance by invoking the power of the international body with the most comprehensive governance authority found in international law.

QUESTIONS ABOUT THE RESPONSIBILITY TO PRACTICE PUBLIC HEALTH

Identifying the responsibility to practice public health as a strategic principle conceptually in UN reform analyses and developments in global public health underscores the importance of this responsibility to the UN, its member states, and non-state actors in contemporary world politics. The strategic importance of global public health to the future of the UN and its role in world politics invites closer scrutiny of the responsibility to practice public health. A comprehensive critique is beyond the scope of this article, but a few words are needed to emphasize that this responsibility confronts conceptual, political, and practical challenges that render it suspect, fragile, and incomplete. This section briefly mentions critical questions the emergence of the responsibility to practice public health raises.

To begin, one could ask whether the responsibility to practice public health adds anything conceptually to the generally recognized (but often ignored) responsibilities already connected with development, disease control, and environmental degradation. The Secretary-General observed that "[e]ach developing country has primary responsibility for its own development," which responsibility developed countries support with undertakings on "development assistance, a more development-oriented trade system and wider and deeper debt relief."[86] The preamble of the WHO Constitution contains propositions on the responsibilities of states for the health of their peoples.[87] No end of documents support the principle that states must be environmentally responsible and make progress toward sustainable development.

---

[85]   *A More Secure World, supra* note 1 at para. 144; *In Larger Freedom, supra* note 5 at para. 105.

[86]   *In Larger Freedom, supra* note 5 at para. 32.

[87]   WHO Constitution, *supra* note 34 at 1 ("Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures.").

More sharply, questions could be raised about the traction such general responsibilities concerning development, public health, and environmental protection create in international relations. The Secretary-General followed his description of the development responsibilities of developing and developed countries by soberly stating that, "All of this has been promised but not delivered. That failure is measured in the rolls of the dead—and on it are written millions of new names each year."[88] The need for UN reform plans to identify public health as a strategic, cross-cutting approach suggests that the WHO Constitution's sentiments on public health responsibilities have not historically taken deep root in the international system. In terms of responsibilities associated with sustainable development, the Secretary-General expressed his concerns for development efforts "if environmental degradation and natural resource depletion continue unabated."[89]

Scepticism about the responsibility to practice public health may also underscore the continuing failure of national governments and the "international community" to allocate the resources needed to facilitate the kind of surveillance and intervention capabilities required by the globalization of public health governance. The UN reform strategies" emphasis on development, disease control, and environmental degradation produced no new commitments of resources at the World Summit to fund a cross-cutting approach based on global public health (or any other approach for that matter). Even the remarkable governance changes made in the IHR 2005 are tarnished because the Regulations provide neither resources nor even a strategy for funding the building and maintenance of the national and international surveillance and response capabilities at the heart of this new regime.

The manner in which the responsibility to practice public health is unfolding may also draw concerns from public health theory and practice. From a public health perspective, the contrast between the global governance breakthrough in the new IHR and the perceived insufficient progress made on health-related MDGs reveals dynamics that may privilege *reactive* policies concerning mobile and dangerous cross-border disease events to which developed countries are vulnerable (for example, SARS, avian influenza, pandemic influenza) over *preventive* and *protective* governance for threats that kill millions in developing countries but do not necessarily threaten the territories or interests of the rich countries (for example, childhood mortality from malnutrition, diarrhoeal diseases, and lack of access to vaccines for childhood diseases; maternal mortality caused by inadequate access to reproductive health services; and sickness and death related to local water and air pollution).

This kind of skewed trajectory for global health governance is not sustainable because continued failure to prevent and protect (as the MDGs attempt to do) feeds the deadly cycle that exists between poverty, disease, environmental degradation, and insecurity. Governance mechanisms that are merely reactive and

---

[88]   *In Larger Freedom, supra* note 5 at para. 32.

[89]   *Ibid.* at para. 57.

attempt only to manage crisis after crisis spawned by this deadly cycle are not resilient. The globalization of public health governance needs the responsibility to practice public health to generate as much governance resiliency as possible nationally and globally.

CONCLUSION

The plausibility of the UN contributing to the interlinked crises of development, disease, environmental degradation, and insecurity depends on the effectiveness of the UN's future efforts to strengthen global public health. The UN's challenge is to embed the emerging principle of the responsibility to practice public health more deeply into the individual and collective behaviour of states, international organizations, and non-state actors. The UN has a better chance focusing on this challenge than on many other, more high-profile features of UN reform debate, such as increasing the size and composition of the Security Council, the need to change the international law on the use of force, and the responsibility to protect triggered by large-scale, violent atrocities.[90] Each of these reform areas derives from the UN's mission to help save present and succeeding generations from the scourge of war; but the prospects for increasing the UN's contributions to international relations in the twenty-first century are dimmest with respect to making the Security Council both more legitimate and effective by increasing its size, achieving genuine consensus on the international law on the use of force, and advancing a consistent application of the responsibility to protect.

The World Summit basically, if in a rather uninspiring way, accepted the vision of the UN reform documents that makes global public health improvements critical to mitigating and perhaps reversing the deadly cycle produced by the interdependence of poverty, disease, environmental degradation, and insecurity. Underpinning this vision is the emerging norm of the responsibility to practice public health. Visions and norms are necessary but not sufficient to achieve the governance resiliency required in the face of these mutually reinforcing threats to human well-being. Despite stressing how critical improving global public health will be for advancing humanity's values and interests in the twenty-first century, oddly neither the High-level Panel nor the Secretary-General made any recommendations or proposals for making the existing institutions that work on global public health more effective. The closest proposal was the Secretary-General's argument that an initiative on streamlining governance of the global environment was needed.[91] Along the lines of a Peacebuilding Commission or integrating global environmental governance, an important contribution could have been made by establishing a Healthbuilding Commission or a global health governance initiative to transform the responsibility to practice public health from a fragile, emerging norm

---

90   Slaughter, *supra* note 1 at 624 (comparing the task of preventing threats from violence and threats from disease and arguing that "preventing disease is likely to be the easier challenge").

91   *In Larger Freedom, supra* note 5 at para. 212.

into a living principle of human governance. This transformation remains the UN's burden and opportunity.