# 3
# Public Health and the Westphalian System of International Politics

## Introduction

The political pathology of SARS tells a tale of transition for governance on infectious disease threats. This chapter focuses on the beginning of this journey in order to explain the traditional governance structure and dynamics that determined how and why infectious disease threats were handled internationally. I do not provide a comprehensive and detailed history of international cooperation on infectious diseases; such histories have already been written (Howard-Jones, 1975; Goodman, 1971). Rather, this chapter has a conceptual orientation designed to provide a simple yet accurate picture of public health governance within the Westphalian system of international politics. The case study on the International Health Regulations (IHR) helps put the conceptual analysis into a more concrete form.

## The world according to Westphalia

As Chapter 1 mentioned, international relations scholars often identify the Peace of Westphalia of 1648 as the birth of the modern international political system. Jan Aart Scholte (2001, p. 20) argues that the Peace of Westphalia 'contains an early official statement of the core principles that came to dominate world affairs during the subsequent three centuries.' Although what we recognize as territorial nation-states began to develop before the seventeenth century, this emerging political reality suffered for not having an overarching set of principles to give the nascent structure solid grounding. The Thirty Years' War in Europe at the beginning of the seventeenth century reflected the absence of an agreed political framework. This bloody conflict flowed from the explosive



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mixture of power politics and religious zealotry as Catholic and Protestant powers battled for temporal and spiritual supremacy in Europe.

The Peace of Westphalia is famous for not only ending the Thirty Years' War but also how this settlement established a political structure for international politics that has endured for over three centuries. I describe the basic structure, principles, and dynamics of the world Westphalia created. After laying out the main characteristics of the Westphalian system of international politics, I analyze how public health arose as an issue in this system.

## The Westphalian system

A 'system' is a group of interacting elements that form a collective entity. The Westphalian system comprises independent, territorial states interacting in a condition of anarchy (Harding and Lim, 1999, pp. 5–6). International relations scholars often refer to the Westphalian configuration as an 'international system,' defined by Hedley Bull (1977, pp. 9–10) as forming 'when two or more states have sufficient contact between them, and have sufficient impact on one another's decisions, to cause them to behave – at least in some measure – as parts of a whole.' States dominate the Westphalian structure and determine the nature of anarchy in which they interact (Scholte, 2001, p. 20). The Westphalian system constructs anarchy as 'international anarchy' because of the central ordering role states play.

In the Westphalian system, 'anarchy' does not mean political confusion, disorder, or chaos. Anarchy means that the units of the system – the states – do not share or recognize a common, supreme authority (Dunne and Schmidt, 2001, p. 143). The Westphalian structure deliberately fragments political authority and power among the states, rendering any kind of world government impossible. The choice of a structure based on the anarchical interactions of independent states made at the Peace of Westphalia and sustained thereafter reflects not only political facts on the ground but also the determination that other ways of structuring international politics, such as some form of world government, were less palatable because of their potential to produce war and disorder, as the continent had experienced in the religiously motivated war among Catholic and Protestant powers. Philosophers as distinct as Jean-Jacques Rousseau and Immanuel Kant in the eighteenth century dismissed notions of a central, supreme government for European states as both illusory and dangerous to human well-being (Rousseau, 1756; Kant, 1795).

## Westphalian governance principles

The fragmentation of political authority among a group of states interacting in a condition of anarchy created the need for principles to guide governance of such anarchical relations. The Westphalian system itself represents a rejection of government in the form of a common, supreme authority; but it is not a rejection of governance. In fact, the Peace of Westphalia established a system of governance for international anarchy. Westphalian governance is based on some fundamental principles.

The central governance principle of the Westphalian system is sovereignty – the states reign supreme over their territories and peoples (Brownlie, 1998, p. 289; Scholte, 2001, p. 20). Sovereignty provides the governance anchor for Westphalian politics because it demarcates the boundaries for the exercise of political authority. Sovereignty does not mean that a state's exercise of sovereignty is unaffected by the actions of other states. After all, Westphalian politics constitute a system based on the assumption that the units interact and that such interactions influence the behavior of the units.

The principle of sovereignty does, however, establish the preconditions for the legitimacy of the exercise of political authority in the Westphalian system. Flowing from the principle of sovereignty is the second fundamental tenet of Westphalian governance – the principle of non-intervention. Because sovereignty means supreme power over territory and people, Westphalian governance frowns upon one state intervening into the domestic affairs of other states (Brownlie, 1998, pp. 293–4; Jackson, 2001, p. 43).

The United Nations Charter (1945, Article 2.7) contains the principle of non-intervention when it declares that '[n]othing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any State or shall require the Members to submit such matters to settlement under the present Charter'. Deriving much of its power from the sovereignty principle, the rule on non-intervention means that a state is free to determine its own political, economic, religious, and cultural systems. The Declaration on Principles of International Law Concerning Friendly Relations and Cooperation Among States (1970, p. 42) states, for example, that '[e]very state has an inalienable right to choose its political, economic, social, and cultural systems, without interference in any form by another State.' The principle of non-intervention excludes a great deal of sovereign behavior from being the subject matter of state interaction.

With governance within states rendered off limits by the sovereignty and non-intervention principles, Westphalian governance involved managing state interactions in anarchy. International law plays a central role in this task of anarchical management. Because no supreme, central government or law-making body exists in the Westphalian system, rules to govern the interaction of sovereign states arise from the states themselves. International law is a Westphalian governance process through which the states create, and consent to be bound by, certain rules of behavior in connection with their anarchical interactions.

The nature of the governance process means that a state is free to exercise its sovereignty as it sees fit unless that state had consented to be bound by a rule of international law that regulated its behavior in the relevant context (Brownlie, 1998, p. 289). The *SS Lotus* case decided by the Permanent Court of International Justice (PCIJ) in 1927 famously expressed this dynamic of Westphalian governance (*SS Lotus*, 1927). This case involved a dispute between France and Turkey over Turkey's exercise of criminal jurisdiction over a French national. The Frenchman was the captain of a French vessel that ran into a Turkish ship on the high seas. The collision sank the Turkish ship, killing eight Turkish nationals. When the French vessel docked at Constantinople, Turkey instituted criminal proceedings against the French captain for his actions on the high seas that led to the collision with the Turkish vessel.

France complained about the Turkish assertion of jurisdiction over the French national, arguing that Turkey could exercise its jurisdiction in this case only if a rule of international law expressly permitted such exercise. Turkey countered that it could exercise its jurisdiction in the case unless a rule of international law expressly prohibited Turkey from doing so. The PCIJ agreed with the Turkish position that no rule of international law prevented Turkey from exercising criminal jurisdiction over the captain of the French vessel. In explaining its reasoning in the case, the PCIJ stated:

> International law governs relations between independent States. The rules of law binding upon States therefore emanate from their own free will as expressed in conventions or by usages generally accepted as expressing principles of law and established in order to regulate the relations between co-existing independent communities or with a view to the achievement of common aims. Restrictions upon the independence of States cannot therefore be presumed. (*SS Lotus*, 1927, pp. 69–70).

Ever since, the *SS Lotus* case has served as a classical illustration of how international law functions in Westphalian governance. As the holding in the *SS Lotus* case demonstrates, sovereignty remains unfettered unless states themselves have created rules of international law to regulate the exercise of their sovereignty in their mutual relations.

The combination of the principles of sovereignty, non-intervention, and consent-based international law gives Westphalian governance a particular structure and subject matter. First, only states are involved in governance. This situation does not mean that non-state actors, such as companies and merchants, had no influence on the development of inter-state relations. After all, key modes of state interaction are trade and commerce, which have always involved private enterprises and entrepreneurs. How such trade and commerce is managed is, however, determined by states under the Westphalian template.

Second, Westphalian governance predominantly addressed the mechanics of state interactions, such as diplomacy, war, and trade. Even traditional rules that involved the treatment of individuals, such as international law on minimum standards of treatment of foreign nationals, connected to the interactions of states. The principles of sovereignty and non-intervention mean that Westphalian governance does not penetrate sovereignty to address how a government treats its people or rules over its territory. Governance in the Westphalian system is, thus, horizontal in nature because it occurs only between states and addresses issues raised by the interactions of states in the condition of anarchy (see Figure 3.1).

## The politics of Westphalian governance

The structure and principles of Westphalian governance exhibit political characteristics that are important to describe. Under international law,

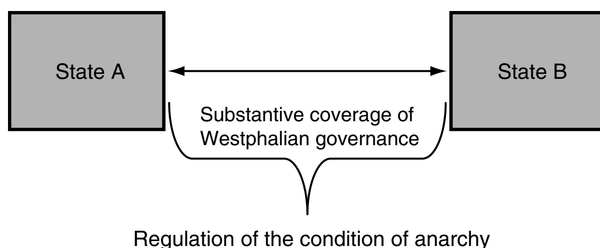


*Figure 3.1* Horizontal governance

all sovereign states have equal standing in the formal functioning of the international legal system. As Brownlie (1998, p. 289) commented, '[t]he sovereignty and equality of states represent the basic constitutional doctrine of the law of nations, which governs a community consisting primarily of states having a uniform legal personality.' The United Nations Charter (1945, Article 2.1) reflects this doctrine in proclaiming that '[t]he Organization is based on the principle of the sovereign equality of all its Members.' The politics of Westphalian governance are not, however, egalitarian. The great powers have historically dominated and controlled the politics of the Westphalian system.

The leading role that great powers have played in the functioning of the international system has long been the subject of historical and theoretical analysis for international relations scholars. Histories of the development of international relations often focus on the machinations of the great powers because these states have initiated and shaped change in the system (e.g., Hinsley, 1963). The dominance of realism in international relations theory (Frankel, 1996, p. ix; Dunne and Schmidt, 2001, p. 145) also reflects the leading role of the great powers in Westphalian politics because realism focuses on the importance of possessing and exercising material power in the condition of anarchy that exists among states (Waltz, 1979, p. 131; Legro and Moravcsik, 1999, p. 18).

The old adage that power abhors a vacuum resonates in the Westphalian system. The anarchical environment in which sovereign states interact has historically placed a premium on having and using material capabilities, predominantly military and economic power, to ensure survival and the protection of national interests in the face of competition from other states. The states possessing the most power – the great powers – by and large have determined and controlled the substance and process of Westphalian governance, as illustrated by the dominant role the great powers had in the development of the modern system of international law (Nussbaum, 1954; Grewe, 2000).

## Westphalian public health

The Westphalian structure and principles for international politics had been in place for two centuries before the cross-border spread of infectious diseases became a subject for international governance in the mid-nineteenth century. As Chapter 2 indicated, pathogens have been crossing borders since the beginning of human civilization; and they crossed borders established by the Westphalian system from the beginnings of this system in the mid-seventeenth century. The Westphalian system

created, however, a particular governance structure and process through which states would address the international spread of infectious diseases.

Prior to the mid-nineteenth century, states in the international system handled infectious disease threats predominantly as a national issue and without systemic cooperation with other states. For example, European states adopted and implemented national quarantine measures in an effort to keep diseases from entering their territories from foreign lands. The practice of quarantines began in Italian city-states in the fifteenth century (Slack, 1992, p. 15); and, by the nineteenth century, 'nearly all civilized countries of the world adopted some form of quarantine control' (Goodman, 1971, p. 31).

Quarantine practices demonstrated that infectious diseases caused problems for the international system through state interactions fostered by trade and travel. In addition, the practice of requiring ships to acquire bills of health in order to avoid the application of quarantine measures illustrates the systemic impact of infectious diseases. A state would require that a ship, leaving a foreign port bound for one of its ports, obtain a bill of health stating that the ship's last port of call was free of epidemic diseases (e.g., plague, cholera, and yellow fever). The requiring state's diplomatic representative resident in the foreign country often had to certify bills of health to ensure their accuracy and legitimacy. Use of bills of health by states became widespread by the latter half of the seventeenth century (Goodman, 1971, p. 31).

Thus, diplomats were engaging in infectious disease control efforts long before the mid-nineteenth century. Yet, until the mid-nineteenth century, states attempted to handle the systemic effects of infectious disease transmission through the uncoordinated and unregulated exercise of national sovereignty. Quarantine measures and bills of health focused exclusively on preventing diseases from entering a state from foreign locations and relied exclusively on a nation's own governmental capabilities – diplomats abroad and quarantine officials at home. Westphalian governance on public health was, therefore, strictly a matter of sovereign discretion because of the absence of any international legal rules or diplomatic processes to manage the problem differently.

The growing threat of infectious diseases in the nineteenth century caused Westphalian governance on public health to change dramatically. In response to a series of damaging cholera outbreaks in the first half of the nineteenth century, states, led by the European great powers, began in 1851 to develop systemic diplomatic processes and international legal rules in order to facilitate cooperation on infectious diseases. Over the course of the next century, states constructed a specific

governance regime to address the growing problem of cross-border microbial traffic.

The governance regime crafted during this period conformed to the structure and principles of the Westphalian system. The international sanitary conventions negotiated by states in this period (see Table 3.1) reflected, for example, a horizontal governance approach to the international spread of infectious diseases. States were the units of governance, and the rules created sought to mitigate the frictions infectious

*Table 3.1* Major International Sanitary Conventions negotiated and/or adopted, 1851–1951

| *Year* | *Convention negotiated and/or adopted* |
|---|---|
| 1851 | International Sanitary Conference in Paris negotiated a Convention and Regulations on maritime traffic and control of plague, cholera, and yellow fever. Neither entered into force. |
| 1859 | International Sanitary Conference in Paris negotiated a Convention simplifying the 1851 Convention and Regulations. It never entered into force. |
| 1874 | International Sanitary Conference in Vienna negotiated a Convention to establish a permanent International Commission on Epidemics. It never entered into force. |
| 1881 | International Sanitary Conference in Washington, D.C. negotiated a Convention to establish a permanent International Sanitary Agency of Notification. It never entered into force. |
| 1892 | International Sanitary Conference in Venice adopted the International Sanitary Convention of 1892, which entered into force. |
| 1893 | International Sanitary Conference in Dresden adopted the International Sanitary Convention of 1893, which entered into force. |
| 1894 | International Sanitary Conference in Paris adopted the International Sanitary Convention of 1894, which entered into force. |
| 1897 | International Sanitary Conference in Venice adopted the International Sanitary Convention of 1897, which entered into force. |
| 1903 | International Sanitary Conference in Paris adopted the International Sanitary Convention of 1903, which replaced the International Sanitary Conventions of 1892, 1893, 1894, and 1897. |
| 1912 | International Sanitary Conference in Paris adopted the International Sanitary Convention of 1912, which entered into force. |
| 1926 | International Sanitary Conference in Paris adopted the International Sanitary Convention of 1926, which entered into force. |
| 1933 | International Sanitary Convention for Aerial Navigation adopted, which entered into force. |
| 1951 | World Health Organization adopted the International Sanitary Regulations. |

*Source*: Fidler 1999, pp. 22–3

diseases caused for state interactions, primarily trade and travel. Historians of these efforts stress that a driving force behind the development of an international governance framework for infectious diseases was the increasing drag that national quarantine measures were creating for international trade. Norman Howard-Jones (1975, p. 11) stated that quarantine in the nineteenth century 'resulted in onerous delays and expenditure occasioned by the immobilization of ships, the incarceration of their crews and passengers in lazarets, and the destruction or spoilage of their cargoes.' The burdens of national quarantine measures rose as the speed and volume of international trade increased during the nineteenth century. The rising commercial costs imposed by a system of uncoordinated, unregulated national quarantine practices meant that trade rather than health drove the development of international governance on infectious diseases. As Howard-Jones (1975, p. 11) observed, 'the first faltering steps towards international health cooperation followed trade.' In order to reduce growing frictions in state interactions produced by the convergence of national quarantine measures and growing levels of international trade, the exercise of public health sovereignty by states would need to be regulated.

Under principles of Westphalian governance, the regulation of sovereignty comes from states agreeing to limit their sovereignty through rules of international law. As Table 3.1 indicates, the period from 1851 to 1951 proved fertile for the process of making international law on infectious diseases as states concluded many treaties on infectious disease control. These agreements represented Westphalian governance attempts to balance national public health actions on infectious diseases, such as quarantine, with the desire for an efficient flow in international trade. In this sense, the problem of the cross-border transmission of infectious diseases was slotted directly into the structure and principles of Westphalian governance.

The development of international governance on infectious diseases also reflected the non-intervention principle of the Westphalian system. The regime's focus was on the management of state interactions – trade and travel – not on the public health conditions and problems that existed within the sovereign territories of states. The rules did not penetrate the state to require improvements with respect to national infectious disease control. How a state organized and implemented public health in its own territory was not the subject of infectious disease diplomacy or international law on infectious disease control.

This non-interventionary approach held even when governments knew that the trade frictions created by germs could be mitigated by

reducing infectious disease problems *before* the pathogens spread to other countries. For example, the international regimes for infectious disease control crafted in the last half of the nineteenth century and the first half of the twentieth century never required states to improve national sanitation and water systems despite knowledge that such improvements would decrease cholera outbreaks and thus their cross-border spread. The famous nineteenth-century German epidemiologist, Robert Koch, expressed his frustration at the diplomatic activity on infectious disease control by calling the international sanitary conventions 'quite superfluous' and arguing that the international spread of cholera would be stopped if each state seized cholera by the throat and stamped it out (Howard-Jones, 1975, p. 76).

International health organizations created during the first century of international health diplomacy (see Table 3.2) did work with member states to improve national public health capabilities. For example, the Health Organization of the League of Nations (1931, p. 30) noted the following in 1931:

> The public health authorities of all countries benefit from the work of the Epidemiological Service of the Health Organisation and from the experience of its technical committees; they can also at any time request the Health Organisation to place experts at their disposal to carry out specific tasks, and they have in fact done so. Sometimes an opinion is required on measures to cope with malaria, syphilis or an epidemic of dengue, and sometimes the request is for advice on the re-organisation of the public health administration of a whole country.

In the Westphalian system, the provision of such assistance by international health organizations depended entirely on the discretion of the sovereign state, which could ask for, or accept, assistance with national

*Table 3.2* International health organizations created between 1851 and 1951

| *Year* | *International health organization* |
|---|---|
| 1902 | Pan American Sanitary Bureau |
| 1907 | Office International d'Hygiène Publique |
| 1923 | Health Organization of the League of Nations |
| 1948 | World Health Organization |

*Source*: Fidler 1999, pp. 22–3

public health problems in the exercise of its supreme authority over its territory and people. Westphalian governance included no mandates for a sovereign state to organize its internal infectious disease control policies and programs in specific ways. As the quote from the Health Organization of the League of Nations suggests, sovereign states often did seek assistance with internal public health matters. Sufficient political and especially economic incentives existed for states to be concerned about their territories being the source of cross-border microbial traffic that international health organizations could, and did, play useful roles in Westphalian public health.

Finally, Westphalian public health bore the imprint of the great powers of the international system. The great powers of Europe began to construct a governance regime for infectious diseases in the latter half of the nineteenth century for two basic reasons. First, the European great powers felt vulnerable to the importation of infectious diseases from non-European regions, what were called the 'Asiatic diseases.' As played out in the development of international health diplomacy, fear of disease importation was 'not a wish for the general betterment of the health of the world, but the desire to protect certain favoured (especially European) nations from contamination by their less-favoured (especially Eastern) fellows' (Howard-Jones, 1950, p. 1035).

Second, as mentioned previously, the great powers' interest in facilitating increased flow of international trade created growing impatience with the trade burdens imposed by the decentralized system of national quarantine practices. Goodman (1971, p. 389) noted that '[f]ear of the spread of cholera and, later, plague and yellow fever, together with the obvious economies to trade in a uniform system of quarantine were the two motivations in international health for seventy years or so.' At the forefront of this frustration was the nineteenth century's most powerful state, Great Britain. Britain's extensive empire and global trading interests gave it a particularly strong desire to see international governance develop on infectious disease control in a manner acceptable to British economic interests.

The imprint of the great powers can also be seen in the infectious diseases selected for inclusion in the governance regime. Throughout its history, the international legal rules on infectious disease control addressed only infectious diseases for which trade and travel were considered vectors, such as plague, cholera, and yellow fever. Westphalian public health targeted germ threats considered external to Europe, hence the emphasis on 'Asiatic diseases' seen in the development of international governance on infectious diseases. Infectious diseases endemic

to Europe, such as smallpox and tuberculosis, generally did not fall within Westphalian governance for public health despite their cross-border transmissibility. Governance of such endemic diseases remained a matter of the unfettered exercise of sovereignty.

## Westphalian public health in action: The International Health Regulations

To make the conceptual overview of Westphalian public health more concrete, this section analyzes the International Health Regulations (IHR) promulgated by the World Health Organization (WHO). The structure, principles, and politics of Westphalian public health governance all appear in the IHR. The IHR also represent the 'classical regime' for international governance on infectious diseases because the IHR are the direct progeny of the approach to infectious disease cooperation developed since the mid-nineteenth century (Fidler, 2003a, pp. 285–6).

Currently, the IHR are the only set of international legal rules binding on WHO member states concerning the control of infectious diseases (WHO, 2002a, p. 63). The IHR formally began life in 1951 as the International Sanitary Regulations (WHO, 2002d, p. 2). WHO adopted the International Sanitary Regulations in 1951 in an effort to consolidate the patchwork of international sanitary conventions in effect prior to World War II into one set of universally applicable rules (Fidler, 1999, p. 59). This consolidation and harmonization effort did not involve moving the regime away from its basic substantive structure, which means that the governance approach developed before WHO's creation formed the basis for the International Sanitary Regulations. WHO changed the name from the International Sanitary Regulations to the IHR in the late 1960s (WHO, 2002d, p. 2), but this name change did not alter the fundamental continuity of the classical regime on infectious disease control. The IHR descend, therefore, directly from the very origins of Westphalian public health governance.

The form the IHR take is in keeping with the Westphalian template. The IHR are binding rules of international law created by WHO member states. Although these rules are called 'regulations,' this moniker does not affect their status as a treaty under international law (Vienna Convention on the Law of Treaties, 1969, Article 2.1(a)). The process through which WHO member states adopted the IHR differs from the normal process of concluding treaties. The IHR were adopted under Articles 21 and 22 of the WHO Constitution (WHO, 1948), under which

the World Health Assembly (composed of all WHO member states) can adopt regulations that become binding on a WHO member state unless such state expressly refuses to be bound by the regulations.

Under normal procedures for making treaties, states are not bound unless they expressly agree to be bound by treaties. International lawyers sometimes refer to the normal treaty process as one in which states can 'opt in' and accept a treaty's rules. The process created by the WHO Constitution is, however, an 'opt out' approach because a WHO member state has to declare its intention not to be bound. The WHO Constitution declares in Article 22 that '[r]egulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice.' The 'opt out' approach is merely a procedural device because, at the end of the day, the sovereign state decides whether it will be bound by the rules adopted under Article 21 of the WHO Constitution. The 'opt out' approach is just as Westphalian in this regard as the 'opt in' treaty process.

The substance of the IHR represents classical Westphalian public health governance. The IHR's objective is to ensure the maximum security against the international spread of disease with minimal interference with world traffic (IHR, 1969, Foreword). This objective reflects horizontal governance because it focuses on infectious diseases moving between states. The IHR do not address aspects of public health governance that touch on how a government prevents and controls infectious diseases within its sovereign territory. The limited governance scope of the IHR is also clear from the small number of diseases subject to its rules, currently only plague, cholera, and yellow fever (IHR, 1969, Article 1). In all these respects, the IHR comply with the principle of non-intervention by addressing only aspects of infectious disease control that relate to the intercourse among states.

The IHR's rules for achieving maximum security against the international spread of disease with minimal interference with world traffic also reflect Westphalian tenets of governance. The IHR seek to achieve maximum security against the international spread of disease through two sets of rules. First, the IHR require that WHO member states notify WHO of outbreaks of diseases subject to the Regulations (IHR, 1969, Articles 2–13). This notification requirement serves as the backbone of WHO's international surveillance activities on the diseases subject to the IHR. Surveillance is a critical public health tool for addressing infectious diseases (Institute of Medicine, 1992, p. 2; US CDC, 1994, p. 12).

Surveillance allows public health authorities to know what diseases are circulating in a population and what interventions would be most appropriate. Surveillance on the diseases subject to the IHR provides WHO member states with information that allows them to take rational public health decisions about their travel and trade with the disease-affected nations.

The second category of rules in the IHR that connect to the maximum security against international disease spread involves provisions that require WHO member states to maintain certain public health capabilities at ports and airports (IHR, 1969, Articles 14–22). Ports and airports are the gateways of Westphalian state interaction through trade and travel. To mitigate the possibility of cross-border disease spread, these gateways should not themselves be vectors of microbial traffic by harboring, for examples, rats or mosquitoes that can travel to other countries in planes and ships and spread disease. The IHR's focus on ports and airports contrasts with the absence of any other rules on national public health capabilities, which again is consistent with the principles of sovereignty and non-intervention.

The IHR seek to achieve minimum interference with world traffic by regulating the trade and travel restrictions WHO member states can take against countries suffering outbreaks subject to the Regulations. The IHR provide that the trade and travel measures prescribed for each disease subject to the Regulations are the most restrictive measures that WHO member states may take (IHR, 1969, Article 23). The IHR contain the maximum measures that a WHO member state may apply to address potential cross-border transmissions of cholera, plague, or yellow fever (IHR, 1969, Articles 23–29). The IHR have provisions that prevent the departure of infected persons by means of transportation and that limit actions taken against ships and aircraft en route between ports of departure and arrival, against persons and means of transport upon arrival, and against cargo, goods, baggage, and mail moving in international transport (IHR, 1969, Articles 30–49).

These IHR rules are designed to ensure that infectious disease control measures applied against foreign trade and travel conform to public health principles and scientific evidence. The aim is to reduce public health restrictions on trade and travel to only those that are justifiable on public health grounds. This reason explains why the IHR contain specific provisions that relate to each disease subject to the Regulations and that prescribe, for example, the incubation periods of the diseases (IHR, 1969, Articles 50, 61, and 65). This aspect of the IHR connects to the long-standing goal of Westphalian public health governance to

reduce frictions between the exercise of public health sovereignty and the flow of international trade and travel.

## The collapse of the classical regime

The IHR represent, and have since their creation in 1951 represented, the classical regime of Westphalian public health governance. The IHR constitute, however, a significant failure for Westphalian public health. This failure extends beyond routine violations of the IHR to touch upon underlying problems with the Westphalian template for infectious disease control. This section analyzes the collapse of the classical regime and its implications for the traditional Westphalian framework for public health.

The IHR failed comprehensively to achieve their objective of maximum security against international disease spread with minimum interference with world traffic. WHO member states routinely violated their IHR obligations to report outbreaks of diseases subject to the Regulations (Dorolle, 1969, p. 104; Delon, 1975, p. 24; CISET, 1995, p. 4; Garrett, 1996, p. 74). A leading reason given for the massive non-compliance with notification duties was that WHO member states did not report outbreaks out of fear of the economic costs they would suffer when countries learned of and reacted to the outbreaks (Dorolle, 1969, pp. 104–5; Delon, 1975, p. 24; CISET, 1995, p. 4; Fidler *et al.*, 1997, p. 778).

This reason for non-compliance would be unpersuasive as long as WHO member states complied with the IHR's rules on trade and travel measures. Unfortunately for the classical regime, non-compliance with these IHR provisions was also epidemic. In 1968, for example, WHO's Deputy Director-General asserted that the objective of avoiding 'excessive and unnecessary quarantine measures' had failed (Dorolle, 1969, p. 105). A 1975 WHO guide to the IHR concluded that '[i]nstances of excessive and useless measures have been numerous in the history of the application of the Regulations since 1951' (Delon, 1975, p. 24).

In essence, the classical regime imploded as WHO member states ignored their international legal obligations under the IHR. In 1969 the WHO Deputy Director-General pronounced the IHR's legal duties on both notification and maximum permissible measures to be a 'dead letter' (Dorolle, 1969, p. 105). Boris Velimirovic (1976, p. 481) asked in frustration whether there was 'much sense in the maintenance of rules if they are not observed – if they are disregarded or more or less systematically broken – without any consequences for those who deviate.'

The classical regime's collapse goes beyond this implosion of non-compliance. In a number of contexts, the IHR simply became irrelevant to infectious disease control. The IHR's focus on what were called 'the pestilential diseases of the past' (Roelsgaard, 1974, p. 267) increasingly made the classical regime irrelevant to more pressing global infectious disease problems. As a governance matter, the IHR were irrelevant to attempts to address diseases not subject to the Regulations.

The significance of the IHR's governance irrelevance became painfully clear in the 1980s. After WHO successfully eradicated smallpox in the late 1970s, in 1981 WHO revised the IHR to remove smallpox from the diseases subject to the Regulations, leaving the current list of cholera, plague, and yellow fever. When HIV/AIDS emerged as a global epidemic in the 1980s, the IHR had no application at all because HIV/AIDS was not a disease subject to the Regulations. Further, WHO never added HIV/AIDS to the IHR's list of diseases because, in part, experts concluded that the IHR's irrelevance could not be fixed by simply adding more diseases to its list (Vignes, 1989). The IHR suffered from deeper flaws.

Some efforts were made to apply the IHR to the HIV/AIDS epidemic in the mid-1980s. As the HIV/AIDS problem became more widely known, a number of countries began to require 'AIDS-free certificates' from international travelers. Some WHO member states asserted that such requirements violated Article 81 of the IHR, which provides that '[n]o health document, other than those provided for in the Regulations, shall be required in international traffic.' With respect to this issue, WHO (1985) asserted that 'no country bound by the Regulations may refuse entry into its territory to a person who fails to provide a medical certificate stating that he or she is not carrying the AIDS virus.' WHO (1986) claimed that 'to require such certificates, let alone to insist on blood tests on arrival, would be totally contrary to the International Health Regulations.'

WHO's legal interpretation of Article 81 of the IHR in connection with 'AIDS-free certificates' was dubious at best given that HIV/AIDS was not a disease subject to the Regulations. Under principles of treaty interpretation, Article 81 cannot be interpreted without reference to Article 23, which contains the general principle on the health measures allowed under the IHR. Requirements for health documents are simply a sub-set of health measures governed by Article 23. Article 23 provides: 'The health measures permitted by these Regulations are the maximum measures applicable to international traffic, which a State may require for the protection of its territory *against the diseases subject to the Regulations*' (emphasis added).

The WHO's interpretation of Article 81 essentially meant any new public health measure – even one justified by public health principles – implemented by a WHO member state to address a threat from a new disease not subject to the IHR was illegal because the measure was not expressly provided for by the Regulations. Even if WHO's legal interpretation of Article 81 had merit at the time, WHO member states continued to ignore it and require 'AIDS-free certificates' and, according to Katarina Tomasevski (1995, p. 868), 'no action has been undertaken to identify instances of noncompliance, or to promote compliance with the sole binding international instrument WHO has produced.' This episode merely underscores the IHR's irrelevance to the HIV/AIDS pandemic.

The IHR also became increasingly irrelevant to the way in which WHO's work on infectious diseases had developed since its creation. Dyna Arhin-Tenkorang and Pedro Conceição (2003, pp. 485–7) trace international health cooperation's move away from 'at the border' controls to 'meeting diseases at their sources.' After its formation in 1948, '[i]n a period of great vitality in the scientific understanding of infectious diseases and of progress in medical technology – in vaccines for prevention and drugs for treatment – the WHO added eliminating communicable diseases at their sources to its mandate of containing their spread through its more traditional functions of coordinating international health regulations and serving as an information clearinghouse' (Arhin-Tenkorang and Conceição, 2003, p. 487).

WHO's desire to attack infectious diseases at their sources within countries represented a vertical public health strategy rather than a horizontal one. Vertical strategies seek to reduce infectious disease prevalence within states (see Figure 3.2).

Vertical strategies are not primarily interested in cross-border microbial traffic, which is the *raison d'être* of the classical regime on infectious

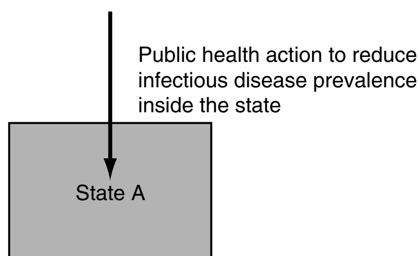


*Figure 3.2* Vertical public health strategies

disease control. Reducing infectious disease prevalence inside countries would help reduce cross-border microbial traffic as the likelihood of disease exportation is reduced. The vertical strategy is essentially what Robert Koch advocated when he criticized the international sanitary conventions as superfluous and urged nations to control and eliminate epidemic diseases inside their own borders.

WHO's growing interest in vertical as opposed to horizontal public health strategies extended beyond its activities on eradicating diseases at their sources. WHO's main strategic focus during its 50-plus years has been trying to improve public health in developing countries. Pannenborg (1979, p. 343) described this focus as WHO discarding 'in all its principal policies both the first and the second world[,] almost completely focusing on the LDC-world and enhancing the latter to a special subject of international law.' The IHR were irrelevant to this mission, as was the general Westphalian framework providing the IHR's architecture.

WHO's work with developing countries predominantly involved vertical public health strategies because WHO was more interested in improving public health conditions within poor countries than in managing the public health consequences of mechanistic state interaction for the primary benefit of the great powers. As Arhin-Tenkorang and Conceição (2003, p. 487) argued, '[a]ddressing diseases at their sources required a new type of interaction between governments and WHO. National health authorities provide most of the control of diseases at their sources. But for developing countries without the capacity or resources to control communicable diseases, the WHO helped to do so – funded by industrial countries.' In this shift, humanitarianism replaced the fear and economic concerns of the great powers as the driving force of international health activities.

This shift from horizontal to vertical strategies was also apparent in the increasing role human rights played in public health. The WHO Constitution is the first international legal instrument to state that the right to the highest attainable standard of physical and mental health was a fundamental human right (WHO, 1948, Preamble). The human right to health is radically counter-Westphalian because it makes the individual rather than the state the central governance focus. John Vincent (1986, p. 129) captured the friction between Westphalian politics and human rights when he observed:

> The society of states should and does concern itself with rights, but they are not the rights of individuals, or even nations, but of states. And one of the points about rights recognized by the society

> of states . . . was to allow political diversity, plural conceptions of rights that were to apply to individuals and groups within states. The promotion of human rights, from the point of view of the morality of states, turns this doctrine inside out.

As Vincent's argument pinpoints, the concept of human rights creates immediate tensions with the Westphalian governance principle of non-intervention because the concept invites scrutiny of how a government acts within its territory toward people subject to its sovereignty.

Comparing the Westphalian governance approach in the IHR with WHO's Health for All effort illustrates how Westphalian public health was falling out of favor by the end of the 1970s. The IHR contain no reference to the human right to health, and this right plays no role at all in the mechanics of the Regulations. By the mid-1970s, the horizontal governance failure of the IHR was apparent. The shift in WHO's priorities from horizontal to vertical governance is clear in the Health for All effort. The Health for All initiative sought to make primary health care universally accessible inside every country, which reflects a vertical public health strategy not tied to mechanistic interactions between states.

The language and contents of the Declaration of Alma Ata (1978), which launched the Health for All movement, could not be farther from what appears in the IHR. The Declaration begins with a reaffirmation of health as a fundamental human right, stresses the unacceptability of the inequality in health status of people living in developed and developing countries, connects health promotion to the economic and social objectives of the New International Economic Order, emphasizes the duty of governments to provide adequate health care for all their respective peoples, and focuses on the promotion of primary health care as the means for global health progress. The model of public health governance expressed in the Declaration of Alma Ata is not from the world Westphalia made.

The HIV/AIDS pandemic further highlights the conceptual and policy shifts taking place in public health governance. In trying to address HIV/AIDS, public health experts did not try to retrofit the IHR's Westphalian framework but rather turned to international human rights law to provide governance norms for the fight against this new plague. As Jonathan Mann (1999, p. 217) noted, WHO's emphasis in the latter half of the 1980s on stopping discrimination against those infected with HIV/AIDS represented 'the first time in history [that] preventing discrimination toward those affected by an epidemic became an integral

part of a global strategy to prevent and control an epidemic of infectious disease.' Mann and others supported the convergence of public health and human rights, asserting that '[t]he modern movement of human rights . . . provides AIDS prevention with a coherent conceptual framework for identifying and analyzing the societal root causes of vulnerability to HIV' (Mann, 1999, p. 222). Bringing international human rights law to bear on public health meant piercing the sovereign veil and scrutinizing how governments treated their citizens and their health – strategies not supported by Westphalian principles.

The emphasis on human rights in the HIV/AIDS pandemic also stimulated a growing role for non-state actors in public health governance. The human rights strategy made individuals actors in public health governance and brought non-governmental organizations (NGOs) into public health in new ways. NGOs had long played important roles in public health, especially in scientific research and delivering health care services in less affluent countries. NGO activism on health emerged more controversially in the tumultuous 1970s, as illustrated by the campaign by a coalition of NGOs against the marketing of breast-milk substitutes in developing countries by multinational corporations (Loughlin and Berridge, 2002, p. 16). The human rights–public health linkage that developed in connection with HIV/AIDS in the 1980s and 1990s brought new NGOs into public health governance issues, reinforcing the general shift underway from horizontal to vertical strategies.

A final context in which the irrelevance of the Westphalian IHR was apparent concerned the great powers. As discussed earlier, the great powers were the driving force behind the development of the classical regime. Over the course of the twentieth century, the classical regime became increasingly unimportant to the great powers. Most of the great powers succeeded in reducing infectious disease morbidity and mortality in their territories through domestic public health reforms and harnessing the potential of antibiotics and vaccines. The classical regime was irrelevant to the great powers' infectious disease achievements in the twentieth century because such achievements 'do not seem to have needed or relied much, if at all, on international treaties creating international health organizations and regimes on communicable disease control' (Fidler, 2002, p. 45).

Germs still did not recognize the borders of the great powers, but the great powers had created material public health capabilities that allowed them seemingly to cope with the increasing speed and volume of trade and travel and its implications for infectious disease spread. The need of the great powers for the kind of international cooperation embodied in

the IHR had all but vanished, leaving the regime without its traditional political engine.

As indicated earlier, the role of the great powers shifted from one of direct concern with the classical regime to one of providing funds to facilitate improvements in public health in developing countries. The politics produced by this shift reflected not only the conflict between democracy and communism but also the growing voice and demands of the developing world, epitomized by the proclamation of a New International Economic Order in 1974. As Kelly Loughlin and Virginia Berridge (2002, p. 16) observed, 'North/South (donor/recipient of aid) became a new axis of political and ideological conflict in postwar international health.'

## From Westphalian public health towards what?

The IHR's effective abandonment by the great powers, WHO member states, and WHO itself left the classical regime of Westphalian public health in a governance twilight zone. By the 1990s, the Westphalian model of infectious disease control appeared to be in serious trouble. The classical regime was a failure and, perhaps worse, an irrelevant failure. As the phenomenon of 'emerging and re-emerging infectious diseases' gathered more attention in the early 1990s, the world seemed poised to leave the Westphalian framework behind for something else. The nature of this new governance paradigm was not exactly clear. Developments in the 1970s and 1980s suggested that vertical public health strategies supported by international human rights law and influenced by NGOs would characterize the next generation of governance on infectious disease control. The next chapter continues the tale by analyzing the evolution of new governance concepts for infectious diseases in the 1990s and early 2000s.