# THE RIGHT TO HEALTH IN THE CONTEXT OF GLOBALISED PANDEMICS

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**Abstract:** COVID-19 has posed unprecedented challenges to the international public health order which could be traced to mid-nineteenth century. With the establishment of the World Health Organization (WHO) and the conclusion of international treaties relating to human rights, the right to health has been recognised as an essential component of human rights. This article will analyse the contents and characteristics of the right to health. Then it will examine the challenges of globalisation to the functions of the WHO, including interpretation of treaty obligations of reporting infectious diseases, the causes for the less effective functioning of the international public health order and improvements that may be made. This article argues that to meet the challenges, the WHO and the international community must take measures to reform the international public health order, which should include paying more attention to the experience and needs of developing countries. In the author's view, globalisation is still the grand trend today and as such, every country is easily affected by actions and inactions of other countries. This article suggests that before consensus can be reached at the multilateral level, bilateral and regional arrangements, including the Belt and Road Initiative promoted by China, should be considered as alternative forms for international cooperation in the area of public health.

**Keywords:** *right to health; public health; WHO; international law; human rights; COVID-19; pandemic; ICESCR*

## I. Introduction

COVID-19 developed in no time from a regional public health scare to an international pandemic threatening economic disaster, destabilising social order. It continues to haunt all nations and test the limits of the existing arrangements including international conventions. The current system of international public health may be said to have begun with the creation of the World Health Organization (WHO) after World War II. Until the creation of the WHO, international agreements on health were mainly concerned with the prevention of the spread of infectious diseases, such as cholera, in order to minimise disruption to international movement

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of people and goods. These international agreements, known as Sanitary Conventions, were binding only on those state parties who ratified them and there was no effective international organisation to oversee their enforcement.

As will be seen later in this article, the WHO made the following significant improvements in the scope of and structure for the promotion of international health: First, the WHO widened the scope of international health well beyond controlling the spread of infectious diseases to cover public health in a broader sense, including the recognition that health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity, that the enjoyment of the highest attainable standard of health is a fundamental right and that the health of all peoples is fundamental to the attainment of peace and security. Second, the WHO introduced a set of rules for the purpose of protecting and promoting public health, principally through controlling the spread of infectious diseases, known as the International Sanitary Regulations of 1951, later renamed International Health Regulations, and replaced by a new set of International Health Regulations in 2005, vastly enlarging the scope of the regulations. Third, the WHO provided an effective organisational structure for the implementation of the objectives of WHO.[1] These landmark innovations opened a new era in what may be aptly termed the international public health order.

This new international public health order under the leadership of the WHO has continued to improve both as responses to new challenges to public health and proactively to be well prepared for any future exigencies. It is well supported by the World Intellectual Property Organisation (WIPO) and the World Trade Organization (WTO), which are increasingly involved in public health-related issues such as trade, production and intellectual property protection of vaccines and other products. The latest development in this regard is the adoption by the Twelfth Ministerial Conference of the WTO held in June 2022 of the "Ministerial Decision on the Trips Agreement: Revision", which authorises the developing country members of the WTO to resort to the compulsory licence provisions of the TRIPS Agreement for "the production and supply of COVID-19 vaccines without the consent of the right holder to the extent necessary to address the COVID-19 pandemic".[2] WHO, WTO and WIPO have also jointly carried out projects on public health matters. There are several international treaties that deal with public health issues, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on Biological Diversity. The United Nations (UN) has adopted a number of resolutions and declarations on public health issues. The new international

1 For an instructive historical analysis, see David P Fidler, "From International Sanitary Conventions to Global Health Security: The New International Health Regulations" (2005) 4 *Chinese J Int'l L* 325.

2 The Ministerial Decision on the TRIPS Agreement, para.2; the text of the Decision is available at https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/WT/MIN22/W15R2.pdf&Open=True (visited on 17 July 2022). The Ministerial Decision revised art.28 of the TRIPS Agreement by relaxing the rights of the patent holder of their exclusive use rights of the patent. It also relaxes the conditions prescribed in art.31, which must be observed by a member state which wishes to use a patent without the authorisation of the right holder.

public health order includes these initiatives of international organisations, treaty provisions, resolutions and declarations.

The rapid spread of the current pandemic "has had far-reaching implications on the everyday lives of people in nearly all corners of the world"[3] and has had significantly impacted decision-making at national and international levels with regard to surveillance measures.[4] Not long ago, it was hoped that the development and production of vaccines would help resolve the problem. Yet with the many emerging variants of coronavirus, it seems that there is still a long way to go before the pandemic can be controlled and that unless all the countries cooperate in their fight against the pandemic by coordinating their measures, the whole mankind will continue to suffer.

Soon after the outbreak of the pandemic the UN reaffirmed its commitment to "international cooperation, multilateralism and solidarity at all levels and as the only way for the world to effectively respond to global crises such as the COVID-19 pandemic and their consequences".[5] The UN also emphasised "the key leadership role of the WHO" in the global efforts to fight the pandemic.[6] On 11 March 2020, declaring COVID-19 a pandemic, the WHO Director-General said that "we are deeply concerned both by the alarming levels of spread and severity, and by the alarming levels of inaction".[7] Even with the WHO sounding the alarm loud and clear, countries have failed to promptly adopt the Organization's recommendations and consequently, at the beginning of July 2022, there were 545,226,550 confirmed cases of COVID-19, including 6,334,728 deaths.[8] The existing international public health order obviously has not been able to effectively control COVID-19.

This article will first review the history and features of the current international public health order in relation to human rights. For this, Section II will discuss the

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3 Institute for Global Environmental Strategies, "Implications of COVID-19 for the Environment and Sustainability", 1, available at https://www.jstor.org/stable/resrep24951 (visited 29 March 2022).

4 It has been argued that "the scale of the pandemic has deepened the imperative for policy makers to expand beyond traditional public health mechanisms of surveillance to use new technologies, including global positioning systems, cell phone apps, and facial recognition to control the spread of SARS-CoV-2. These new surveillance technologies highlight longstanding tensions in public health between individual rights and collective interests". See Sharifah Sekalala, Stephanie Dagron, Lisa Forman and Benjamin Mason Meier, "Analyzing the Human Rights Impact of Increased Digital Public Health Surveillance during the COVID-19 Crisis" (2020) 22 *Health & Hum Rts* J 7, 8.

5 "Comprehensive and Coordinated Response to the Coronavirus Disease (COVID-19) Pandemic, Resolution adopted by the United Nations General Assembly (10 September 2020) Res. A/74/L.92, para.1. This General Assembly resolution affirms the plea made in an earlier Security Council resolution, where it was emphasised that "combating this pandemic requires greater national, regional and international cooperation and solidarity, and a coordinated, inclusive, comprehensive and global international response with the United Nations playing a key coordinating role". See UN (1 July 2020) S.C. Res. 2532.

6 *Ibid*.

7 World Health Organization, "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19" (11 March 2020), available at https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 (visited on 30 April 2022).

8 The WHO, "WHO Coronavirus (COVID-19) Dashboard", available at https://covid19.who.int/ (visited on 1 July 2022).

evolution of international public health order from the 1851 International Sanitary Conference to the establishment of the WHO, the adoption of ICESCR and various UN resolutions and declarations on human rights, which cover the right to health and their significance. Section III will examine the challenges that COVID-19 and its related issues have brought to the international public health order against the backdrop of globalisation; it argues that States are much interconnected and interdependent at the present than ever before and that therefore international cooperation among States is indispensable in dealing with issues like the COVID-19 pandemic, as they have economic, social and human rights dimensions; the reporting obligations of the State parties under the WHO is a case in point. Section IV will discuss the improvements needed to make the international public health order work more effectively. This article argues that the public health needs of the developing countries are far from being met and that any improvement of the international public health order must address this. Finally, Section V will discuss the possible ways to improve the existing international public health order. Measures for this purpose include: recognition that, in formulating international standards, States have a right to adopt mechanisms and norms to suit their own needs and the need to ensure that developing countries have more extensive and effective participation in the international public health order. This article will argue that, for this, the right to traditional knowledge and other rights of the third-world countries should be recognised and protected. Considering the ever-growing needs in public health area, this article argues that measures that may help the needy countries should be encouraged and no country should be discriminated against on the grounds of geopolitical and geo-economic considerations. The author believes that the Belt and Road Initiative is such a mechanism that can help improve the international public health order by meeting the needs of the developing countries.

## II. A Rights-Based International Public Health Order

The beginnings of the international public health order can be traced to as far back as the mid-nineteenth century when European countries were confronted with challenges of infectious disease. The International Sanitary Conference of 1851, the first in a series of eight international conferences between 1851 and 1894 to address the dangers of Cholera epidemics to Europe, marked the first attempt at international health cooperation in tackling diseases, particularly infectious diseases.[9] The failure of the first International Sanitary Conference to make a detailed convention

9 The first International Sanitary Conference was held on 23 July 1851. Eleven European countries, including Turkey, participated in the Conference. Each participating country was represented by two delegates, a physician and a diplomat. Norman Howard-Jones, *The Scientific Background of the International Sanitary Conferences (1851–1938)* (1975), available at https://apps.who.int/iris/bitstream/handle/10665/62873/14549_eng.pdf?sequence=1 (visited on 30 April 2022); Valeska Huber, "The Unification of the Globe by Disease? The International Sanitary Conferences on Cholera, 1851–1894" (2006) 49:2 *The Historical Journal* 453–476.

led, after several failed attempts, to the adoption in 1892 of the first International Sanitary Convention, which dealt with controlling cross-border spread of infectious diseases through quarantine policies.[10] Towards the end of the nineteenth century, several sanitary conferences were held among American countries, which led to the signing of the International Sanitary Convention of Rio de Janeiro (1887).[11] The Convention contributed to the establishment of the Pan-American Sanitary Bureau in Washington, DC in 1902.[12] Another important development was the creation of the Office International d'Hygiène Publique in Paris in 1908.[13] Both the Pan-American Sanitary Bureau and the Office International d'Hygiène Publique energetically encouraged States to share information about public health and laid a solid foundation for the development of the public health order. After almost 40 years of service, the Office International d'Hygiène Publique was dissolved in 1946 and its functions were assumed by the WHO.[14]

Shortly after World War II, the UN Economic and Social Council convened an international health conference in July 1946,[15] which adopted four final instruments, including the Constitution of the World Health Organization (WHO Constitution). The WHO Constitution came into effect on 7 April 1948, when it was ratified by 26 member states as required by art.79 of the Constitution. The preamble to the WHO Constitution[16] defines health as a "state of complete physical, mental

10 Valeska Huber, "The Unification of the Globe by Disease?" (n. 9). Norman Howard-Jones, "The Scientific Background of the International Sanitary Conferences (1851–1938)" *History of International Public Health, No 1* (Geneva: World Health Organization, 1975), available at https://apps.who.int/iris/bitstream/handle/10665/62873/14549_eng.pdf?sequence=1 (visited on 30 April 2022), 65. The 1892 convention focused on reforming the quarantine system applied to navigation through Suez Canal and modifying the regulations governing the Maritime, Sanitary and Quarantine Board of Egypt. David P Fidler, "From International Sanitary Conventions to Global Health Security" (n. 1), 331.

11 For a discussion on the history of the sanitary conferences of American countries, see Pan American Health Organization, *The Pan American Sanitary Code Toward a Hemispheric Health Policy*, available at https://www.paho.org/hq/dmdocuments/2008/code-1999.pdf (visited on 5 June 2022).

12 The Pan-American Sanitary Bureau which was later renamed "Pan-American Health Organization" (PAHO), covers North and South American countries. PAHO has its headquarters in Washington, DC and has 27 country offices and three specialised centres in the region. PAHO, "Who We Are", available at https://www.paho.org/en/who-we-are (visited on 25 April 2022).

13 Office International d'Hygiène Publique was set up on 10 November 1908. See "The Official International Sanitary Conferences and the International Office of Public Hygiences" *The Lacent* (10 July 1909), 100–102, available at https://www.sciencedirect.com/science/article/pii/S0140673601325400 (visited on 30 April 2022).

14 The Office International d'Hygiène Publique was brought to an end when on 22 July 1946 by the signatory parties to the Protocol Concerning the Office International D'hygiene Publique. Its duties and functions have been performed by the WHO. These principles include non-intervention, data sharing and operation under the authority and control of a committee formed of the delegates of the contracting government.

15 For a brief discussion of the history of international cooperation in the area of public health, see M A Palilonis, "An Introduction to Global Health and Global Health Ethics: A Brief History of Global Health", available at https://cbhs.wfu.edu/wp-content/uploads/2020/03/Topic-3-A-Brief-History-of-Global-Health.pdf (visited on 30 April 2022).

16 The Constitution of the WHO, available at https://www.who.int/about/governance/constitution (visited on 6 March 2022).

and social well-being, and not merely the absence of disease" and provides that the enjoyment of "the highest attainable standard of health is one of the fundamental rights of every human being". The objective of the WHO is the attainment by all peoples of the highest possible level of health (art.1 of the WHO Constitution). Although this definition of health has been often criticised as being "too absolute", it must be viewed in the context of post-war idealism and its emphasis on "mental and social well-being as important dimensions of health" reflects the wisdom of the founders of the WHO.[17]

The Preamble to the WHO Constitution goes on to say that achievement of the highest attainable health standard must be "without distinction of race, religion, political belief, economic or social condition". This is in line with art.12(1) of the ICESCR, which provides that the state parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The ICESCR also requires the state parties to take steps necessary "to achieve the full realization of this right", including "the prevention, treatment and control of epidemic, endemic, occupational and other diseases".[18]

The right to health as part of the obligations of the contracting parties to the ICESCR is explained in General Comment No. 14 on art.12 of the ICESCR, issued by the Committee on Economic, Social and Cultural Rights (General Comment 14).[19] The opening paragraph of General Comment 14 states as follows: "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity".[20] It reaffirms the Universal Declaration of Human Rights (UDHR) which declares that "[e]veryone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services".[21] Although General Comment 14 and UDHR may not have binding force on members of the international community, they nonetheless confirm the provisions of the ICESCR and WHO Constitution, which are international treaties. Considering that almost

17 Brigit Toebes, Lisa Forman and Giulio Bartolini, "Toward Human Rights-Consistent Responses to Health Emergencies: What Is the Overlap between Core Right to Health Obligations and Core International Health Regulation Capacities?" (2020) 22 *Health & Hum Rts J* 99, 100.

18 Article 12(2) of the International Convention on Economic, Social and Cultural Rights ("ICESCR"). Such necessary steps or measures include those necessary for: "(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness".

19 See ICESCR General Comment No. 14: "The Right to the Highest Attainable Standard of Health (Art. 12)", adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights on 11 August 2000. The General Comments are in Document E/C.12/2000/4, available at https://www.refworld.org/docid/4538838d0.html (visited on 24 June 2022).

20 General Comment 14, para.1.

21 Article 25(1) of the Universal Declaration of Human Rights. The Universal Declaration was adopted by the UN General Assembly on 10 December 1948 (General Assembly resolution 217 A). full text available at https://www.un.org/en/about-us/universal-declaration-of-human-rights (visited on 7 April 2022).

all the countries are now parties to these international instruments, it may safely be argued that the right to health as a human right reflects the current status of customary international law.

"The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable". For instance, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.[22] Paragraph 8 of General Comment 14 makes it clear that the right to health is "not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements".[23] "The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".[24] As such, the right to health is "closely related to and dependent upon the realisation of other human rights",[25] such as the rights to "food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement".[26] At the same time, "the right to health embraces a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment". These and other rights and freedoms address integral components of the right to health.[27]

Paragraph 33 of General Comment 14 states that the right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to "respect, protect and fulfil". It clarifies that the obligation to "respect" requires states "to refrain from interfering directly or indirectly with the enjoyment of the right to health;" the obligation to "protect" requires states to take measures that prevent third parties from interfering with art.12 guarantees and the obligation to "fulfil" requires states "to adopt appropriate legislative, administrative,

22 General Comment 14, para.1.

23 *Ibid.,* para.8. According to the ICESCR, the right to health is "an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health". General Comment 14, para.11.

24 General Comment 14, para.8.

25 *Ibid*., para.3.

26 *Ibid*.

27 For discussions on this issue, see General Comment 14, para.4.

budgetary, judicial, promotional and other measures towards the full realisation of the right to health".[28] Such measures must be deliberate, concrete and targeted and "without discrimination of any kind".[29] General Comment 14 also sets out some "core obligations" for the contracting parties, including: immunisation against major infectious diseases occurring in the community; taking measures to prevent, treat, and control epidemic and endemic diseases; providing education and access to information concerning the main health problems in the community and providing appropriate training for health personnel, including education on health and human rights.[30]

Paragraph 35 of General Comment 14 sets out the legal obligations of State to *protect*. These obligations include, *inter alia*, the following duties: to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatisation of health sector does not constitute a threat to availability, accessibility, acceptability and quality of health services, goods and services; to control the marketing of medical equipment and medicines by third parties and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

Paragraph 12 of General Comment 14 states that the right to health in all its forms and at all levels contain four interrelated and essential elements: availability, accessibility, acceptability and quality (AAAQ), which are considered to be an authoritative set of standards "increasingly applied across international and domestic health settings". It has been suggested that "given that these (and similar) principles are applied frequently in health settings and because their importance is underscored by governments and health authorities, this framework is emerging as a norm of customary international (health) law".[31]

The right to health cannot be fully realised without cooperation and joint efforts of all the countries. Article 2.1 of the ICESCR recognises the importance of such cooperation: "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures". General Comment 14 states as follows: "In the spirit of Article 56 of the Charter of the United Nations, the specific provisions of the [ICESCR]

28 See General Comment 14, para.33.

29 See ICESCR, art.2.2.

30 General Comment 14, paras.43 and 44.

31 Brigit Toebes *et al*., "Toward Human Rights-Consistent Responses to Health Emergencies"(n. 17), 102, where the authors go on to say that "[t]he AAAQ is also very informative in the context of COVID-19, as it pinpoints the weak spots in states' responses to this crisis. First, key problems stem from a lack of availability of health personnel, intensive care beds, drugs, masks, and gloves. Second, many problems occur in the context of accessibility. . . . Third, in terms of acceptability, COVID-19 creates many health care settings where medical ethics are under threat . . .".

(arts. 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, State parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health".[32]

Paragraph 39 of General Comment 14 states that to carry out international cooperation, state parties to the ICESCR should "respect the enjoyment of the right to health in other countries if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law, . . . facilitate access to essential health facilities, goods and services in other countries . . . ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments". Paragraph 39 goes on to say that in relation to the conclusion of other international agreements, State parties should take steps to ensure that these instruments do not adversely impact upon the right to health: specifically, State parties who are members of the International Monetary Fund, the World Bank and regional development banks, "should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions".[33]

The above discussion clearly shows that the new international public health order rests on several international instrumentalities, such as the UN Charter, ICESCR and UDHR, and that the purpose of the international public health order is to ensure the effective implementation of the right to health, a human right.

## III. Challenges to the International Public Health Order

The international public health order must aim for the highest attainable standard of health, for which purpose it is crucially important that effective measures are in place to prevent cross-border spread of infectious diseases or pandemics resulting from movement of people, goods, services and animals. For instance, the cholera pandemics which swept through Europe before the establishment of the WHO were caused by movement of people and goods,[34] though what we call globalisation was in a primitive stage. As discussed earlier, the very reason for the creation of the WHO is interdependence of the international community. With the development of

32 General Comment 14, para.38. The Alma-Ata Declaration was adopted at the International Conference on Primary Health Care, held at Alma-Ata, USSR, in September 1978, art.IX of which provides as follows: "All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country". The declaration is available at https://cdn.who.int/media/docs/default-source/primary-health-care-conference/declaration-of-alma-ata.pdf?sfvrsn=dce155ac_0&download=true

33 General Comment 14, para.39.

34 Valeska Huber, "The Unification of the Globe by Disease?" (n. 9) and Norman Howard-Jones, "The Scientific Background of the International Sanitary Conferences" (n. 10).

such interdependence into full globalisation of the world,[35] every infectious disease has the potential to become an international problem. In this context, each market is unavoidably affected by others, as ominously evidenced by COVID-19.[36] This is so because in the current circumstances, no country, however economically powerful it might be, can manage its own affairs without the assistance of other countries, enterprises or even individuals.

Globalisation undoubtedly contributed to the fast spread of COVID-19 and at the same time required all the countries to make a concerted effort to fight the pandemic.[37] If countries fail to collaborate in measures that they take to deal with COVID-19, they would be equally helpless against future pandemics. In this context, the WHO has been trying to improve its ways and means of controlling and preventing the spread of disease, one of which is the revision of the International Health Regulations (IHR) in 2005.[38] The revised IHR whose purpose and scope are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade" is founded on the following principles:

(a) The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.
(b) The implementation of these Regulations shall be guided by the Charter of the UN and the Constitution of the World Health Organization.
(c) The implementation of these Regulations shall be guided by the goal of their universal application for the protection of all people of the world from the international spread of disease.

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35 Paul Hirst and Grahame Thompson, "Globalization and the Future of the Nation State" (1995) 24 *Economy* 408; Guiguo Wang, "Globalising the Rule of Law" (2008) 48 *Indian Journal of International Law* 21.

36 Some argue that "globalization is certain to endure and could bounce back sooner than expected. The more important questions are how globalization will change and what the path to recovery could look like". See Samuel Brannen, Habiba Ahmed and Henry Newton, "Covid-19 Reshapes the Future" (2020) *CSIS* 17–18, available at https://www.jstor.org/stable/resrep25198 (visited on 29 March 2022).

37 A study has observed: "The COVID-19 crisis was caused by a combination of two related phenomena. The first is the increasingly complex and potentially harmful interaction between humans and wildlife. The harvest and sale of wild animals and plants is a constant threat to the survival of many species, as well as occasionally posing a hazard to human society through viruses, as in the current case. Indeed, research suggests that increases in human exploitation of wildlife may lead to the further possibility of virus transmission from animals to humans. The second phenomenon is the ubiquitous and accelerated movement of people and goods across borders—a feature of modern globalisation. While the former set of factors allowed for the transmission of the COVID-19 virus from animals to humans, the latter has enabled its subsequent spread to pandemic proportions. Both the scale of the market for wild species, and the volume and rapidity of human movement worldwide, underscore the immense impact of human activity on nature—and potentially vice versa". See Institute for Global Environmental Strategies, "Implications of COVID-19 for the Environment and Sustainability", p. 1; available at https://www.jstor.org/stable/resrep24951 (visited on 29 March 2022).

38 WHO, World Health Assembly Res. 58/4, at 7–63, WHA58/2005/REC/1(16–25 May 2005), available at http://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf?sequence=1.

(d) States have, in accordance with the Charter of the UN and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies. In doing so they should uphold the purpose of these Regulations.

The IHR expanded the scope of its application to cover any disease "that presents or could present significant harm to humans"[39] and vested in the Director-General the power to determine, on the basis of information received, whether an event constitutes a "public health emergency of international concern" (PHEIC).[40] In 2011, the WHO adopted the Pandemic Influenza Preparedness Framework (the PIP Framework), which was intended "to introduce greater equity and solidarity among nations when the next pandemic strikes".[41] As the WHO explained, "[T]he best defense against influenza is vaccination. However, many countries do not have the capacity to develop vaccines on their own, relying instead on products manufactured by others".[42] "Under the PIP Framework, the WHO will have real-time access to approximately 10% of global vaccine production and will be able to send life-saving doses to developing countries in need".[43] An important feature of the aforementioned measures is the obligation of WHO State parties to cooperate.

In today's highly globalised world, states may successfully deal with a severe catastrophe only through information exchange and coordination with other States. The IHR provides explicitly that "State Parties shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a PHEIC within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events".[44]

In practice, reporting a PHEIC is easier said than done. First, there is no concrete and detailed standard for determining whether an event constitutes a PHEIC. Second, a PHEIC frequently involves unknown viruses. Different cultures, traditions, governance ideologies and regulatory procedures may lead states to implement different measures and make different decisions when confronted with an unknown virus. In implementing this provision, a State has the obligation to safeguard its citizens' health and at the same time to ensure that any measures taken to

39 Foreword to IHR (2005 edition). The 2005 revised edition of the IHR is available at https://www.who.int/publications/i/item/9789241580410.

40 *Ibid.,* art.12.1. The IHR of 2005 defines public health emergency of international concern as "an extraordinary event which is determined, as provided in the regulations (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response".

41 WHO, "Pandemic Influenza Preparedness Framework" (8 March 2017), available at https://www.who.int/news-room/q-a-detail/pandemic-influenza-preparedness-framework (visited on 25 April 2022). The Pandemic Influenza Preparedness Framework is available at https://apps.who.int/iris/bitstream/handle/10665/44796/9789241503082_eng.pdf?sequence=1.

42 *Ibid*.

43 *Ibid*.

44 IHR, art.6.1.

deal with a PHEIC would not cause unnecessary panic. For instance, whether the discovery of one single case of an unknown infectious disease should be immediately reported is a judgment call. The concerned State may consider that it has no obligation to report, unless it determines that the situation may constitute a PHEIC. Making such decisions is an international obligation and is therefore subject to international law principles.[45]

The International Court of Justice in *Nicaragua v United States*, citing *Nuclear Test judgement*, stated: "One of the basic principles governing the creation and performance of legal obligations, whatever their source, is the principle of good faith. . . . Just as the very rule of *pacta sunt servanda* in the law of treaties is based on good faith, so also is the binding character of an international obligation assumed by unilateral declaration".[46] Therefore, whether a State party violated the IHR by delayed reporting is not simply a judgment call. The decision of the State party is subject to review under international law. In other words, whether a State party observed the principle of good faith in fulfilling its treaty obligations should be decided objectively, that is what a reasonable person (government) would have determined under the same circumstances, instead of with perfect hindsight.

Once a State party reports a public health event, it shall continue to report matters such as: "case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed".[47] The obligation of notification is not limited to the State party in whose territory a public health event occurs; other State parties or individuals may notify the WHO of any event that is likely to constitute a PHEIC.[48] When notified, WHO will spring into action assisting the country in need with necessary support.

The reporting requirement under the WHO lacks a mechanism for compulsory implementation. As a result, State parties may not face any sanction for non-compliance. The WHO must thus rely on the goodwill of the State parties for the effective operation of the system.

Once a PHEIC is reported, there are some matters that require regulation. For instance, at the beginning of the pandemic, China's practice with regard to the counting of coronavirus cases was that "positive cases are not counted as confirmed cases. Instead, those who test positive are isolated for 14 days and monitored by

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45 One such principle is found in art.31 of the Vienna Convention on the Law of Treaties: "A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose". In *Mesa Power*, the tribunal considered good faith to be a customary international law principle. See *Mesa Power Group LLC v Government of Canada*, PCA Case No. 2012–17, Award, 24 March 2016, para.484.

46 *Military and Paramilitary Activities in and against Nicaragua* (*Nicaragua v United States of America*), Jurisdiction of the Court and Admissibility of the Application, *I.C.J. Rep*. Vol. 392 (26 November 1984), para.60.

47 IHR, art.6.2.

48 In this regard, art.9.1 of IHR provides as follows: "WHO may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring".

health authorities. If they develop symptoms in that period, they are classified as a confirmed case".[49] China's public health officials argued that this was to "prioritize tracking sick patients who are spreading the disease", whilst some foreign experts considered this practice as "masking the epidemic's true scale".[50] This shows the extent to which even health experts may disagree with one another. Facing legal and technical difficulties, the WHO chose to adopt a tolerant approach in practice. Similarly when the Middle East respiratory syndrome-related coronavirus broke out, Saudi Arabia did not immediately notify the WHO.[51] Instead of taking any action for the delayed response, the WHO required Saudi Arabia to provide more information by composing an Emergency Committee pursuant to arts.48 and 49 of the IHR.[52] In the case of China, it was reported that whilst the WHO praised China for speedily responding to the new virus, in their private meetings with Chinese officials WHO officials complained about not releasing adequate information.[53]

Human rights-related issues also present challenges to the WHO and international public health order. A central concern is the impact on the right to privacy, which is recognised by both the UDHR and International Covenant on Civil and Political Rights (ICCPR).[54] The ICCPR requires that no one "shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation".[55] In practice, however, it is agreed that when faced with a national crisis such as COVID-19, a country may limit or suspend individual rights and freedoms, including the right to privacy. The question is how to balance the individual interests (rights) and the collective or societal interests. This is never an easy question for decision makers.[56] It has been

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49 David Cyranoski, "Scientists Question China's Decision not to Report Symptom-Free Coronavirus Cases" *Nature* (20 February 2020), available at https://www.nature.com/articles/d41586-020-00434-5 (visited on 30 April 2022).

50 *Ibid*.

51 Robert Roos, "Saudi Official Says Labs Failed to Report MERS Cases" *CIDRAP* (12 June 2014), available at https://www.cidrap.umn.edu/news-perspective/2014/06/saudi-official-says-labs-failed-report-mers-cases (visited on 30 April 2022).

52 For further information, see WHO, "MERS-CoV IHR Emergency Committee" available at https://www.who.int/groups/mers-cov-ihr-emergency-committee (visited on 25 April 2022).

53 The Associated Press, "China Delayed Releasing Coronavirus Info Frustrating WHO" (3 June 2020), available at https://apnews.com/3c061794970661042b18d5aeaaed9fae#:~:text=without%20causing%20panic.%E2%80%9D-,On%20Jan.,the%20biggest%20quarantine%20in%20history. A top Chinese public health official admitted that China needed to "improve its epidemic reporting mechanism", though he considered that "the nation's response was 'good' compared with other countries as it had to handle a 'close-book exam'". See Reuters, "China's Top Disease Control Official Accepts Criticism of Coronavirus Response" (23 May 2020), available at https://www.reuters.com/article/us-health-coronavirus-china-cdc-idUSKBN22Z0HP (visited on 30 April 2022).

54 International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), available at https://treaties.un.org/doc/Treaties/1976/03/19760323%2006-17%20AM/Ch_IV_04.pdf (visited on 8 April 2022). See Oliver Diggelmann and Maria Nicole Cleis, "How the Right to Privacy Became a Human Right" (2014) 14 *Hum Rts L Rev* 441.

55 ICCPR, art.17.

56 Emilie M Hafner-Burton, Laurence R Helfer and Christopher J Fariss, "Emergency and Escape: Explaining Derogations from Human Rights Treaties" (2011) 65 *Int'l Org* 673, 673–707.

suggested that individual rights may be restricted where the following conditions are met: the restrictions are (1) applied as a last resort; (2) prescribed by law (ie not imposed arbitrarily); (3) related to a compelling public interest (eg the protection of public health) and (4) necessary, proportional to the public interest, and without less intrusive or restrictive measures being available.[57]

When a State takes measures relating to public health surveillance, it must not go beyond what is necessary and proportionate to the desired objective. The question is how to measure what is necessary and what is proportionate. It has been suggested that "adequate safeguards be put in place to ensure that such surveillance mechanisms, whether they are digital or traditional, do not illegitimately restrict the human rights to health, life, or privacy, and are not abused for the purposes of state control".[58] This is also reflected in the guidelines of the WHO on international surveillance during the COVID-19 pandemic, according to which the objective of surveillance should be restricted to monitoring the trends in COVID-19 disease at national and global levels, detecting new cases in countries where the virus is not circulating, providing epidemiological information to conduct risk assessments and guiding the preparedness and response measures.[59]

Contact tracing, which is an essential public health measure, necessarily impacts on right to privacy. As WHO observed: "In response to the COVID-19 pandemic, many digital tools have been developed to assist with contact tracing and case identification. These tools include outbreak response, proximity tracing, and symptom tracking tools, which can be combined into one instrument or used as stand-alone tools".[60] It may be argued that with the availability and use of digital-related tools, protection of human rights at a time of pandemics has become very challenging. [61] In this regard, the efficacy of digital tools for global health surveillance (because they are still in the experimental phase), and third-party involvement in creating, using and storing data (because of personal data so collected may be exploited) are also of particular concern.[62]

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57 It is known as the proportionality test. Sharifah Sekalala *et al*., "Analyzing the Human Rights Impact of Increased Digital Public Health Surveillance" (n. 4), 10; Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, UN Doc. E/CN.4/1985/4 (1984), part.I, paras.1–14.

58 Sharifah Sekalala *et al*., "Analyzing the Human Rights Impact of Increased Digital Public Health Surveillance" (n. 4).

59 WHO, "Global Surveillance for COVID-19 Caused by Human Infection with COVID-19 Virus: Interim Guidance" (20 March 2020), 1, available at https://apps.who.int/iris/handle/10665/331506 (visited on 8 April 2022).

60 WHO, "Digital Tools for COVID-19 Contact Tracing: Annex: Contact Tracing in the Context of COVID-19" (2 June 2020), 1, available at https://www.who.int/publications/i/item/WHO-2019-nCoV-Contact_Tracing-Tools_Annex-2020.1 (visited on 8 April 2022).

61 See Sharifah Sekalala *et al*., "Analyzing the Human Rights Impact of Increased Digital Public Health Surveillance" (n. 4).

62 *Ibid*., 11.

The protection of the right to privacy is a fundamental principle of international human rights law.[63] Yet the acquisition of information about a person's health condition and travel history is equally important for the prevention and control of infectious diseases. In that context a crucial consideration will be how to balance personal data/information protection and protection of public health. In this regard, the IHR, on the one hand, recognises a sovereign state's right to collect or receive "health information . . . which refers to an identified or identifiable person"[64] and, on the other hand, requires that this information "be kept confidential and processed anonymously as required by [the] national law" of a State party.[65] In other words, a WHO State party has the duty to legislate and incorporate such provisions for protecting confidential information of individuals.

The IHR further provides:

> . . . State Parties, in accordance with national law, and WHO must ensure that the personal data are:
>
> (a) processed fairly and lawfully, and not further processed in a way incompatible with that purpose;
> (b) adequate, relevant and not excessive in relation to that purpose;
> (c) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that data which are inaccurate or incomplete are erased or rectified; and
> (d) not kept longer than necessary.[66]

Under the IHR, an individual has the right to request a State party to provide or correct his/her personal data. This provision mainly addresses the situation where the information collected by a State party is inaccurate and/or incomplete and provides that the affected person has a right to know for instance: (1) what personal data have been collected; (2) how their data will be used and (3) how long their data will be stored. In order to live up to these standards, all WHO State parties are duty-bound to safeguard acquired data. It could be argued that the non-incorporation of these provisions into national law should not be a defence for a State party not to observe this obligation. In addition, when all State parties incorporate these standards into their national laws, they will become the minimum international standards. WHO does not provide any remedy or sanction if a State party fails to adequately protect such information. The WHO can only require its members to

63 For example, art.12 of the Universal Declaration of Human Rights provides: "No one shall be subjected to arbitrary interference with his privacy".
64 IHR, art.45.1.
65 *Ibid*.
66 *Ibid*., art.45.2.

stipulate these provisions in national law. This presents another challenge to the existing international public health order.

The WHO's inability to force the State parties to legislate is exacerbated by the IHR provision that "States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies".[67] Thus, State parties' obligation to observe the goals of the WHO has become voluntary in nature, notwithstanding its positive requirement to "observe" rather than to passively not violate. At best, State parties may voluntarily adopt measures to fulfil their obligations under the IHR. This feature of the WHO makes it lag behind the instrumentalities in the field of trade and investment to say the least.[68]

Spread of disease and pandemics pose a serious threat to national security,[69] as illustrated by the Black Death in the fourteenth century, Spanish Flu in early twentieth century and the more recent Ebola Virus.[70] With ever-increasing globalisation, every pandemic may cause cross-border concerns relating to economic, social and cultural aspects, for the reason that the speed, frequency and quantity of international flow of people, goods, information and data are far more advanced than ever before. Such flows expose all countries to tremendous risks and threaten national security, a challenge to the existing international public health order.

In this context, COVID-19 is different from any previous pandemic in the sense that it has created the most serious risks by far to the functioning of all countries and the way of life everywhere, including severe restrictions on the movement of people, goods and services, investment opportunities and, above all, on economic performance and health conditions. Yet, in order to deal with this infectious virus, every country needs virus preventive materials such as face masks, medicines and raw materials for vaccines from other countries. Without the assistance of foreign countries and international organisations, no country could successfully fight against this infectious disease.

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67 *Ibid*., art.3.4.

68 Allyn L Taylor, "Global Governance, International Health Law and WHO: Looking Towards the Future" (2002) 80 *Bulletin of the World Health Organization* 975, 976–977.

69 For instance, the then Secretary-General of WHO, Margaret Chan, wrote that "[p]andemics, emerging diseases and bioterrorism are readily understood as direct threats to national and global security". Margaret Chan, Jonas Gahr Støre and Bernard Kouchner, "Foreign Policy and Global Public Health: Working Together towards Common Goals" (2008) 86:7 *Bull World Health Organ* 498, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647489/ (visited on 6 June 2022). Bouskill and Smith, after studying the US practice, concluded that "the U.S. National Intelligence Council warned that infectious diseases will 'complicate US and global security' by endangering U.S. citizens and armed forces and by inducing instability in foreign settings . . . . This had the effect of raising the profile of infectious diseases—as opposed to other major drivers of morbidity and mortality, including the burgeoning burden of chronic and noncommunicable diseases—as national security concerns". See Kathryn E Bouskill and Elta Smith, "Global Health and Security: Threats and Opportunities" (2019) *RAND Corporation* 6, available at http://www.jstor.com/stable/resrep19904 (visited on 7 June 2022).

70 See Thierry Tardy "COVID-19: Shaping Future Threats and Security Policies" in Tieerry Tardy (ed), *COVID-19: NATO in the Age of Pandemics* (Nato Defense College, 2020), 13–20, 14.

There is, however, one thing in common between COVID-19 and previous pandemics, that is that they all have adverse impacts on the international community, though the current pandemic has had much more serious consequences. At the same time, no matter how bad a pandemic is, it has to be dealt with by the countries concerned individually. In today's globalised world, measures taken by one country will unavoidably affect the effectiveness of efforts of other countries. In these circumstances, international cooperation is more crucial than ever before. High among the much-needed international efforts are the development of and access to vaccines and medicines and the overcoming of the economic crisis caused by COVID-19.[71] Promoting and sustaining international cooperation and identifying what obstacles must be overcome are the key challenges that the international public health order faces.

There is consensus that, as COVID-19 pandemic is of international concern and requires an international, concerted effort, vaccines and medicines to combat the virus are international public goods.[72] It has been suggested that being public goods, vaccines and medicines should be made available to everyone everywhere and not be market-driven. In this context, motivation for developing vaccines and medicines as well as raising necessary funds is crucial. Another crucial issue relates to intellectual property rights. Today, it is mostly transnational pharmaceutical corporations that play a key role in research and development of vaccines and medicines. Without an effective mechanism, it will be very difficult, if not impossible, to persuade the pharmaceutical industry to manufacture vaccines and medicines without being primarily profit-driven. That is why the initiatives introduced by the WHO and others were criticised as merely paying lip service in the absence of any binding commitments.[73]

The different ways in which the South and North responded to the pandemic is another concern. In the South, differences in economic development and social cultural considerations led to a lack of accessibility to medicines and a lack of adequate knowledge and data on confirmed cases. Because of these differences, some measures taken by international organisations have not achieved the desired result.[74]

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71 See Wolfgang Hein and Anne Paschke, "Access to COVID-19 Vaccines and Medicines – a Global Public Good" (2020) *GIGA* 9, available at https://www.jstor.org/stable/resrep25695 (visited 29 March 2022).

72 For instance, the UN Secretary-General António Guterres and the former German Chancellor Angela Merkel considered the COVID-19-related vaccines and medicines clear examples of "global public goods". See Wolfgang Hein and Anne Paschke, "Access to COVID-19 Vaccines and Medicines" (n. 71), 4–5.

73 *Ibid*., 8.

74 Examples in this regard include the pandemic relieve programmes by the International Monetary Fund, the World Bank and regional Development Banks. Some scholars consider such funding programmes can hardly help the African countries which are "already suffering from increasing debt services". They argue that by using the credits of the above institutions, these countries' "foreign debt situation could become even more severe in the medium term". See Wolfgang Hein and Anne Paschke, "Access to COVID-19 Vaccines and Medicines" (n. 71), 3.

The earlier discussion clearly shows that the existing international public health order has proved less effective in dealing with pandemics like COVID-19 and raises the following question: What changes or improvements are needed in the international public health order to fight pandemics?

## IV. The International Public Health Order in Need of Improvement

Faced with an unprecedented global crisis, the international public health order, with WHO as its central pillar, must reform fundamentally and improve itself. In this highly digitalised era, the WHO has effectively engaged its teams of experts on the acquisition and use of information, enabling them to impact the behaviour of its State parties. For instance, where a communicable disease is discovered in an area and the State party has not issued an immediate notification, any individual may directly report it to the WHO. On receiving and verifying the report, the WHO may send an alert via the Global Outbreak and Alert Response Network. Since the WHO is equipped with a team of world-leading experts, the information it releases is undoubtedly authoritative. As any information released by the WHO can rapidly spread around the world, the State party involved would face considerable pressure from the international community to take immediate and effective action.

Once the WHO, in accordance with the Global Outbreak and Alert Response Network, declares an outbreak of disease, the effect on the concerned State party could be very destructive. Trade, tourism and service industries are amongst those suffering the most direct and immediate impact, which could consequently lead to rippling effects that cause long-term damage to the State party—for who on earth would want to have economic transactions or exchanges with States designated as "infected areas", let alone those who may, additionally, have failed to fulfil their obligations to report? Nevertheless, if the State party experiencing an infectious disease outbreak cooperates with the WHO, this will provide the WHO with an opportunity to scientifically analyse the situation and provide policy recommendations, including whether or not to impose restrictions on tourism. Thus, whether in its self-interest, for the common good or to protect its public image, it is far better for a State party to voluntarily abide by the reporting obligation and to cooperate with the WHO.

A State party's willingness to comply with WHO rules affects the attitude of the WHO: The WHO, who has the duty to monitor, can help shape a State party's status and image in the international community through measures such as releasing information concerning it. In the absence of any effective enforcement powers, these indirect means provide some informal methods of achieving good standards of public health. The phenomenon echoes what Confucius said, "'[T]he decree

indeed may not always rest on us;' that is, goodness obtains the decree, and the want of goodness loses it".[75] This theoretical analysis, however, may not work all the time, such as in serious circumstances like the COVID-19 pandemic and when powerful countries are involved.

When COVID-19 broke out first in China and then in Asia, the WHO played an important part. Its officials made a regular presence on media expressing their views and offering advice. After the WHO declaration of COVID-19 as a pandemic and especially after the US government suspended entry of persons from Europe,[76] the world's attention immediately shifted to the actions and inactions of the United States and Europe. European countries criticised the decision of the United States to impose travel restrictions on the ground that they had been entirely blindsided in the decision-making process. Ironically, when COVID-19 first occurred in Wuhan, the United States and some European countries almost immediately prohibited entry to their countries of residents of Mainland China and persons who had been in China during the preceding 14 days. Surprisingly nobody questioned such non-entry orders.

According to the IHR, "A State Party implementing additional health measures . . . which significantly interfere with international traffic shall provide to WHO the public health rationale and relevant scientific information for it. WHO shall share this information with other State Parties and shall share information regarding the enforced health measures. For the purpose of this Article, significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than 24 hours".[77] Confronted with a once-in-a-century pandemic that is devastating human life and health, it is understandable that State parties implemented measures to suspend entry of foreign nationals. Nevertheless, there is no evidence to suggest that any State party had reported their adopted measures to the WHO. Moreover, after declaring COVID-19 a pandemic, the WHO seemed muted. Everyone was more concerned about what the US President had said or what the EU and British leaders had done.[78] However, the time when COVID-19 was declared a pandemic was exactly the time when the international community should have coordinated and taken joint actions to tackle the virus, with the WHO playing the leading role.

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75 *The Four Books: The Confucian Analects: The Great Learning, The Doctrine of the Mean, and The Works of Mencius*, translated by James Legge (Culture Book Co., 1997), 339.

76 The Director-General of the WHO declared COVID-19 a global pandemic on 11 March 2020. Later in the same day President Donald Trump announced the suspension of entry into United States from Europe. Kevin Liptak and Maegan Vazquez, "Trump Says He's Suspending Travel from Europe to US, though Citizens and others are Exempt" *CNN* (12 March 2020), available at https://edition.cnn.com/2020/03/11/politics/donald-trump-coronavirus-statement/index.html (visited on 30 April 2022).

77 IHR, art.43.3.

78 The WHO acted differently when COVID-19 broke out initially in Wuhan, China. During that period, the WHO kept commenting on the spread of coronavirus, proposing recommendations, and sent experts to China for inspections in which they exchanged opinions with Chinese experts.

The WHO's failure to play the leading role indicates that there are gaps in the global governance of public health.

In order to understand this situation, one must remember that the WHO was established at a time of "optimism and belief in a better and healthier world" and that medicine was considered "one of the pillars of peace".[79] Similar to other international organisations, the WHO was created chiefly in accordance with the values of Western countries, in particular the United States. Since then, there has been a gradual shift of power brought about by globalisation. "In a newly multipolar political climate, power blocs from the global South—led by states such as Brazil, China, India, and South Africa—provide a counterpoint to the traditional powers, which historically reserved their strongest global health efforts for issues that impacted their own security. For these rapidly emerging states, global health justice and economic development are more natural drivers of their political ambitions".[80] Although these developments have made the WHO more representative, the views, cultures, values, traditions of these emerging powers and the role that they should play are not effectively reflected in the existing international public health order.

In recent times, Europe and America have been the sole providers of disease-control methods and technology, who have been advising Asian countries through the WHO. In the face of the COVID-19 pandemic, the United States and some European countries apparently ignored the Asian experience in preventing and controlling epidemics. Evidently, this cultural and conventional prejudice, among other factors, contributed to the widespread outbreak of the virus in Western countries. In fact, they not only failed to appreciate the Asian achievements in controlling the pandemic but criticised the WHO for working closely with China.[81] In order to improve the international public health order, it is crucially important to underline the mutual recognition of and respect for Eastern and Western cultures, values and systems and to learn from one another without bias.

Article 3 of the IHR stipulates that the implementation of the IHR "shall be with full respect for the dignity, human rights and fundamental freedoms of persons" and shall be guided by the UN Charter and the WHO Constitution, whilst art.23 (health measures on arrival and departure), 32 (treatment of travellers) and 45 (treatment of personal data) require State parties to observe the above principles when taking health measures. While IHR does not specifically mention the right to health, its reference to the WHO Constitution, which clearly makes the right to health a human right, makes it clear that the IHR recognises the right to health as a human right. In fact, the IHR states that its implementation is guided by the

79 See Brigit Toebes *et al*., "Toward Human Rights-Consistent Responses to Health Emergencies" (n. 17), 100.

80 Lawrence O Gostin, *Global Health Law* (Harvard University Press, 2014), 61.

81 On numerous occasions, President Donald Trump accused the WHO of mismanaging the coronavirus pandemic, whilst he himself was criticised by many for not effectively controlling the spread of COVID-19. See BBC News, "Coronavirus: Trump Accuses WHO of Being a 'Puppet of China'" (19 May 2020), available at https://www.bbc.com/news/health-52679329 (visited on 30 April 2022).

"universal application for the protection of all people of the world from the international spread of disease" (art.32), a duty similar to that under art.12 of ICESCR. Accordingly, the IHR's overall goal is "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks".[82] To achieve this goal, the IHR sets out a series of obligations for the State parties. including those relating to developing, strengthening and maintaining "the capacity to detect, assess, notify and report events"[83] and "the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern".[84] More specific obligations concerning capacity-building are stipulated in Annex 1 of the IHR, which are required to be implemented at the local community, intermediate and national levels.[85]

To have obligations stated in an international treaty is one thing, fulfilling those obligations is another. Evidence shows that the absence of provision for imposing sanctions is a major reason for non-compliance. Although State parties "were required to comply with them by 2016, based on self-assessments provided by states in 2018, about two-thirds of states have poor or modest levels of preparedness", and "many countries lack the financial resources to meet the core capacities, while high-income countries have offered little financial support. . . . There is [even] limited knowledge on how countries should achieve the core capacities domestically".[86] Yet the non-implementation by the State parties to the IHR has attracted no sanction.

Capacity-building requires international cooperation. Yet the obligations set out in the IHR are not backed adequately by any operational arrangement. The most recent example is the ineffectiveness of the WHO's vaccine equity initiative which in September 2021 set a target for 70 per cent global vaccination coverage by mid-2022. By March 2022, the "overall number of vaccines administered has risen dramatically, but so has the inequality of the distribution: of the more than 10 billion doses given out worldwide, only one per cent have been administered in low-income countries" and "just over three per cent of people in low-income countries had been vaccinated with at least one dose, compared to 60.18 per cent in high-income countries".[87]

The Director General of the WHO recommended in a report in 2005 that the WHO should improve its monitoring system by moving "from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary

82 IHR, art.2.
83 *Ibid*., art.5.1.
84 *Ibid*., art.13.1.
85 See IHR, Annex 1 A. "Core Capacity Requirements for Surveillance and Response".
86 Brigit Toebes *et al*., "Toward Human Rights-Consistent Responses to Health Emergencies" (n. 17), 105–106.
87 See "UN Analysis Shows Link between Lack of Vaccine Equity and Widening Poverty Gap", available at https://news.un.org/en/story/2022/03/1114762 (visited on 16 April 2022).

external evaluations".[88] The Director-General observed that the "Ebola virus disease (EVD) outbreak has underscored the importance of having strong national and local capacities in place to rapidly detect, respond and take preventative measures to contain a serious public health threat. The report highlighted the fragile nature of health systems in some countries, as well as the importance of a multi-sectoral approach. It is therefore of concern that only approximately one-third of State Parties have indicated that they have met the minimum core capacity requirements".[89] It is unthinkable that a system that failed against Ebola would succeed against COVID-19. According to a study, more than 100 countries had been evaluated in accordance with the earlier-mentioned process: yet "no follow-up on reports is expected" and, in the absence of any system of sanctions for non-compliance, the evaluation process is purely voluntary in nature.[90]

The above suggests that the current international public health order fully equipped to keep pace with the fast-moving world. For instance, it does not fully reflect the cultures and values of the developing countries, whose interests have not been adequately addressed during this COVID-19 pandemic. Such shortcomings cannot be overcome without recognising the special needs, cultures and values of the developing countries and there is no consensus for resolving this at the multilateral level. In the circumstance, alternatives should be explored at bilateral and regional levels.

## V. The Way Forward

The right to health, which is well established as a fundamental human right and which features prominently in several international instruments, is yet to be fully realised at international level. The adoption of the 2019 UN Political Declaration on Universal Health Coverage, reaffirming the human right to health, highlights the need for effective protection and promotion of this right. Importantly, the Political Declaration expressed the commitment of the Heads of State and Government and representatives of States and Governments present at the UN Assembly to "increase global awareness, international solidarity, international cooperation and action towards the achievement of universal health coverage by promoting national, regional and global collaborative frameworks and forums".[91]

The 2019 UN Political Declaration on Universal Health Coverage identified specific aspects of public health that needed to be addressed, such as

88 WHO, "Implementation of the International Health Regulations (2005) Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation: Report by the Director General", available at https://apps.who.int/gb/ebwha/pdf_files/EB136/B136_22Add1-en.pdf (visited on 16 April 2022).

89 *Ibid*., Conclusion 1, para.21.

90 See Brigit Toebes *et al*., "Toward Human Rights-Consistent Responses to Health Emergencies" (n. 17), 106.

91 United Nations General Assembly, G.A. Res. 74/2, (2019) UN Doc. A/RES/74/2.

primary health care, access to essential health, emerging and re-emerging diseases, non-communicable diseases, mental health and equitable access to health products. This is a notable expression of international solidarity on public health in view of the fact that it is not enough to recognise the right to health as a human right in the abstract or in isolation. The right to health must be given a concrete meaning, identifying specific standards that need to be met. Especially the healthcare needs of the developing countries must be recognised and met in a systematic way. To start with, it must be stressed that every individual's easy access to medicines, vaccines and virus-testing has a direct bearing on their human right to health and that there exists a grave disparity between the people from developed and developing countries as regards the quality and availability of health care.[92] If only developed countries are able to maintain good standards of public health within their territory, pandemics will remain at large and can spread across the borders.

To effectively control any public health crisis, States, be they rich or poor, must coordinate their policies, take appropriate action and ensure that they do not remain indifferent to the potential of crisis. This will greatly contribute to improving the international public health order. A resolution adopted by the UN calls upon countries to make structural and institutional adjustments in order to enhance inter-agency coordination across policy sectors by integrating public health into each country's diplomatic and trade policies and, subsequently, to form more effective and collective action at the international level.[93]

The UN General Assembly, in September 2020, adopted a 14-page omnibus resolution titled "Comprehensive and Coordinated Response to the Coronavirus Disease (COVID-19) Pandemic",[94] confirming its commitment "to international cooperation, multilateralism and solidarity at all levels and as the only way for the world to effectively respond to global crises such as the COVID-19 pandemic and their consequences".[95] The resolution acknowledged the key leadership role of the WHO and the fundamental role of the UN system in catalysing and coordinating the comprehensive global response to the COVID-19 pandemic and called upon "Member States and other relevant stakeholders to advance, with determination, *bold and concerted actions* to address the immediate social and economic impacts

92 See Paul Farmer, *Pathologies of Power: Health, Human Rights and the New War on the Poor* (UC Press, 2003), 11; Amartya Sen, "Why and How is Health a Human Right" (2008) 372 *Lancet* 2001, 2001–2086.

93 U.N. Secretary-General, "Global Health and Foreign Policy: Strategic Opportunities and Challenges", U.N. Doc. A/64/365 (23 September 2009), para.67, available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/N09/522/15/PDF/N0952215(visited on 20 July 2022).

94 https://documents-dds-ny.un.org/doc/UNDOC/LTD/N20/231/11/PDF/N2023111.pdf?OpenElement. This resolution was adopted with 169 votes in favour to two against (Israel and the United States) and two abstentions (Hungary and Ukraine). See UN, "General Assembly Adopts Omnibus Resolution Calling for Holistic COVID-19 Response, among 3 Passed on Global Health Threats, Malaria" (11 September 2020), available at https://www.un.org/press/en/2020/ga12262.doc.htm (visited on 26 April 2022).

95 G.A. Res. A/74/L.92, "Comprehensive and Coordinated Response to the Coronavirus Disease (COVID-19) Pandemic", para.1.

of the COVID-19 pandemic" (emphasis added).[96] The Resolution "recognizes the value of an integrated One Health approach that fosters cooperation between the human health, animal health and plant health, as well as environmental and other relevant sectors, and underlines the urgent need for continued close work between the long-standing Tripartite, together with other relevant parts of the United Nations system and relevant stakeholders in this regard".[97] The UN reaffirmed its firm belief that, unless States cooperate closely and take bold and concerted actions, the pandemic may not be controlled in a short time and, as a result, the much larger goal of the world—the 2030 Agenda for Sustainable Development cannot be achieved. [98]

Just as important as international cooperation is the recognition that states and nations have developed their own unique approaches to curing diseases. These approaches have various representations, including plant cultivation and medical treatments.[99] Some patentees utilise traditional prescriptions and medicines, including extracts from local plants to develop their patented medicines. There has been much debate whether indigenous people, who had created traditional knowledge and genetic resources, should have an interest in such patented medicines. It must be noted that "traditional knowledge abuse has occurred for centuries"[100] and has long raised concerns within the international community.

The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity (Nagoya Protocol on ABS)[101] addresses some of the issues. The Convention on Biological Diversity provides that "[s]tates have . . . the sovereign right to exploit their own resources pursuant to their own environmental

96 *Ibid*., paras.1 and 30.

97 *Ibid*., para.44.

98 The G.A. Res. A/74/L.92 in its Preamble states, "Recognizing that the coronavirus disease (COVID-19) pandemic is one of the greatest global challenges in the history of the United Nations, . . . which is reversing hard-won development gains and hampering progress towards achieving the 2030 Agenda for Sustainable Development1 and all its Goals and targets", and its para.2 states: "Calls for intensified international cooperation and solidarity to contain, mitigate and overcome the pandemic . . . to get back on track to realize the 2030 Agenda for Sustainable Development". Paragraphs 42 and 51 also emphasised on international cooperation in combating the pandemic for the realisation of the 2030 Agenda for Sustainable Development.

99 Many plants, after several generations of cultivating and grafting, are no longer in their original status; therefore, this cultivating process contains traditional and cultural connotations. For example, the Brazilian rubber tree is the achievement of several generations of Brazilians. In order to produce rubber in other places, the British collected seeds of rubber trees from Amazon. John Tustin, "Traditional Knowledge and Intellectual Property in Brazilian Biodiversity Law" (2006)14 *Tex. Intell. Prop. L.J.* 131, 133–135.

100 Ameera Haider, "Reconciling Patent Law and Traditional Knowledge: Strategies for Countries with Traditional Knowledge to Successfully Protect their Knowledge from Abuse" (2016) 48 *Case Western Reserve Journal of International Law* 348, 350.

101 ABS stands for "Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization". The Nagoya Protocol on ABS was adopted at the tenth meeting of the Conference of the Parties of the Convention on Biological Diversity on 29 October 2010 in Nagoya, Japan and entered into force on 12 October 2014. See *About the Nagoya Protocol*, Convention on Biological Diversity (9 June 2015), available at https://www.cbd.int/abs/about/ (visited on 30 April 2022).

policies. . .".[102] "Resources" in the Convention includes traditional culture/knowledge and genetic resources. Pursuant to the two international instruments, each contracting party shall "respect, preserve and maintain knowledge, innovations and practices of indigenous and local communities embodying traditional lifestyles relevant for the conservation and sustainable use of biological diversity and promote their wider application. . ." subject to its national laws.[103] At the same time, holders of relevant knowledge, innovations and practices shall have the right to share benefits arising from such knowledge, innovations and practices.

The Nagoya Protocol on ABS, as a concrete measure of implementing the Convention on Biological Diversity, requires the Contracting Parties to protect traditional knowledge by legislation and to encourage cooperation and coordination among the Contracting Parties. The Nagoya Protocol on ABS further requires the contracting parties to "consider the need for and modalities of a global multilateral benefit-sharing mechanism" to "address the fair and equitable sharing of benefits derived from the utilization of genetic resources and traditional knowledge associated with genetic resources".[104] To date, the Convention on Biological Diversity and the Nagoya Protocol on ABS have the best defined international rules on protecting traditional knowledge and genetic resources. To incorporate these provisions into the international public health order is a task that must be carried out immediately.

Parties to the Convention on Biological Diversity, members of WIPO and of the WTO have considered "the concept of a disclosure requirement in the patent system . . . as a means of ensuring that patents on inventions derived from [traditional knowledge] and [genetic resources] are consonant with the principles of [prior informed consent] and [equitable benefit-sharing]".[105] The fact is that traditional knowledge and genetic resources have always been practised and sustained without any protection afforded by international treaties. For example, traditional Chinese medicinal practitioners combine traditional Chinese medicine with Western medicine to treat COVID-19. This practice of treatment was also used abroad, eliciting issues of protecting intellectual property rights arising from certain

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102 The Convention on Biological Diversity was adopted for signature on 5 June 1992 at the United Nations Conference on Environment and Development. The Convention entered into force on 29 December 1993. See "History of the Convention", Convention on Biological Diversity, available at https://www.cbd.int/history/ (visited on 30 April 2022).

103 The Convention on Biological Diversity, art.8(j).

104 The Nagoya Protocol on ABS, Preamble.

105 See WHO, WIPO and WTO, *Promoting Access to Medical Technologies and Innovation: Intersections between Public Health, Intellectual Property and Trade* (2nd ed., 2020), 92–93, available at https://www.wto.org/english/res_e/publications_e/who-wipo-wto_2020_e.htm. Some national laws also contain provisions protecting traditional culture/knowledge and genetic resources. For example, China has patent examiners specialised in traditional Chinese medical science. Thailand adopted the Act on Protection and Promotion of Traditional Thai Medicinal Intelligence, protecting "formulas" of traditional Thai drugs and "texts on traditional Thai medicine". Peru adopted a law titled Introducing a Protection Regime for the Collective Knowledge of Indigenous Peoples Derived from Biological Resources. *Ibid*., 93.

medicine and treatments. This integration of indigenous and Western medicine reflects a combination of culture, treatment and medicine.

Protection of the traditional knowledge and generic resources is not only a matter of national dignity and intellectual property rights, but it is also a crucial issue in enriching the international public health order. In this context, to incorporate traditional knowledge and genetic resources relating to medical care and public health into bilateral and regional arrangements will help the international public health order's efforts in realising "the right of everyone to the enjoyment of the highest attainable standard of health", as recognised by art.12(1) of the ICESCR.

Modern bilateral agreements are not restricted solely to matters of interest to the state parties. Some bilateral treaties contain provisions relating to public health.[106] In this regard, there appears to be a new trend to include the protection and standardisation of traditional culture/knowledge and genetic resources into the newly concluded or revised free trade agreements. On this basis, the international public health order may evolve into a two-dimensional model in which the multilateral mechanism, led by the WHO, collaborates with bilateral and regional arrangements.

From this perspective, the Belt and Road Initiative (BRI) may be of assistance.[107] As China has already been closely cooperating with the WHO, through the BRI, China should be capable of assisting the countries participating in BRI to build capacity in the area of public health. Since the 1960s, China has been sending medical teams to Africa, Asia and other developing countries and has initiated and participated in international endeavours to promote public health. With the experience gained internationally and domestically, China is in a position to assist other BRI-participating countries with public health projects and management mechanisms.

Most BRI participants are developing countries, which generally lack an adequate infrastructure and an adequate public health mechanism. They are most in need of technology, infrastructure and data collection and process for public health purposes. During the COVID-19 pandemic, there was hardly any information on the spread of the pandemic in African and Middle Eastern countries and the response of their governments to the crisis. At present, many of the BRI projects concern hospital-building, digital economy, communication and transportation, all of which are related to public health.[108] Where such projects can be incorporated into more formal agreements among the participating countries, the BRI will

106 For example, Annex III of the United States—Peru Trade Promotion Agreement signed on 12 April 2006 entails Understanding Regarding Biodiversity and Traditional Knowledge. See USTR, "Final Text", available at https://ustr.gov/trade-agreements/free-trade-agreements/peru-tpa/final-text (visited on 30 April 2022).

107 For discussions on the history and recent development of the Belt and Road Initiative, see Guiguo Wang, "Towards a Rule-Based Belt and Road Initiative—Necessity and Directions" (2019) 6:1 *Journal of International and Comparative Law* 29.

108 *Ibid*.

effectively contribute to the development of the international public health order led by the WHO.

In conclusion, the COVID-19 pandemic continues to be a serious challenge to the whole international community. The unprecedentedly devastating impacts of COVID-19 pandemic illustrate that in the globalised world, solutions for this and other health crises must be designed and implemented in the spirit of multilateralism and international cooperation. To this end, action must be taken at national, regional and international levels to improve the international public health order. Only by doing so would the right to health, a fundamental human right, be upheld and enhanced.

Whilst concerted multilateral actions within the existing international public health order may not be realistic, bilateral and regional arrangements could make a significant contribution to the international public health order, particularly by assisting developing countries. In this context, the China-launched BRI should be able to play a positive role, as the country has a long history in cooperating with the developing countries in Africa and Asia.