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I. INTRODUCTION

The fact that "[i]nfectious diseases are the leading cause of death worldwide"[1] may explain why the World Health Assembly[2] chose to adopt a new set of International Health Regulations ("IHRs 2005") in May 2005. According to the World Health Organization ("WHO"), the regulations will "prevent, protect against, control and provide a public health response to the international spread of disease."[3] While the purpose of the IHRs 2005 remains the same as that of its predecessor—to "ensure the maximum protection of people against the international spread of diseases, while minimizing interference with world travel and trade"[4]—the IHRs 2005 greatly expand the legal obligations of WHO member states in the area of public health operations.[5] The IHRs 2005 also call for significant changes in the operations of the WHO itself. In calling for these

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1 Christopher-Paul Milne, *Racing the Globalization of Infectious Diseases: Lessons from the Tortoise and the Hare*, 11 New Eng J Intl & Comp L 1, 36 (2004).

2 The World Health Assembly is the supreme decision/policy-making body of the World Health Organization and is composed of health ministers from the 192 member states of the WHO.

3 World Health Assembly, *Third Report of Committee A*, A58/55 at art 2 (May 23, 2005), available online at <http://www.who.int/gb/ebwha/pdf_files/WHA58/A58_55-en.pdf> (visited Apr 22, 2006) (hereinafter IHRs 2005). In this report, the World Health Assembly officially adopted the IHRs 2005 and included its provisions in the document.

4 WHO News Release, *World Health Assembly Adopts New International Health Regulations: New Rules Govern National and International Response to Disease Outbreaks* (May 23, 2005), available online at <http://www.who.int/mediacentre/news/releases/2005/pr_wha03/en/index.html> (visited Apr 22, 2006).

5 The former set of international health regulations, adopted in 1969, applied only to cholera, plague, and yellow fever. WHO, *Frequently Asked Questions about the International Health Regulations*, No 1, available online at <http://www.who.int/csr/ihr/howtheywork/faq/en/index.html> (visited Apr 22, 2006).

changes, the IHRs 2005 have taken into account recent changes in the political, economic, and technological climates that have forced the global community to think collectively with regards to public health governance.[6]

At the forefront of international concern is the emergence of newly discovered infectious diseases such as SARS in 2002 and the highly virulent strain of avian influenza (popularly known as "bird flu") in 2003. Although a series of travel restrictions and other methods successfully controlled the spread of SARS, there is no evidence that similar methods will prove effective in combating the threat of avian influenza.[7] To begin with, the avian influenza virus occurs naturally in birds and has already spread over vast areas as a result of bird migratory patterns. The virus, first detected in Asia, has made its way to Europe and Africa and will more than likely reach North America this spring.[8] Furthermore, the avian influenza virus is "capable of infecting humans and may evolve into a highly transmissible strain,"[9] making it the primary candidate for triggering a highly lethal human influenza pandemic.

Despite the international community's need to revise the outmoded regulations to adequately deal with these and other public health threats, the revisions finally adopted by the World Health Assembly have the potential to conflict with the cornerstone of international law—state sovereignty. According to the principle of state sovereignty, states decide which actions or measures take place within their territory—not other nation-states and certainly not third-party organizations such as the WHO. And even if WHO member states fully accept the most recent regulations and publicly demonstrate their compliance, public international law has consistently shown that such compliance only continues so long as it remains beneficial to the member state. Although the IHRs 2005 provide additional tools to help combat international health threats, the underlying factor affecting any program's success continues to be the immediate economic benefits derived as a result of state compliance. After all, WHO

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6 Lawrence O. Gostin, *The International Health Regulations and Beyond*, 4 Lancet Infectious Diseases 606, 606 (Oct 2004).

7 Center for Biosecurity of the University of Pittsburg Medical Center, *National Strategy for Pandemic Influenza and the HHS Pandemic Influenza Plan: Thoughts and Comments*, 3 Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 292, 294 (2005), available online at <http://www.liebertonline.com/doi/pdf/10.1089/bsp.2005.3.292> (visited Apr 22, 2006).

8 An estimated six million birds will arrive from Asia to Alaska in the spring of 2006, potentially bringing with them the deadly strain of bird flu. See Elizabeth Arnold, *Alaska on the Lookout for First Sign of Bird Flu*, National Public Radio: Global Health (Apr 5, 2006), available online at <http://www.npr.org/templates/story/story.php?storyId=5323435> (visited Apr 22, 2006).

9 Jonathan B. Tucker, *Updating the International Health Regulations*, 3 Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 338, 339 (2005), available online at <http://www.liebertonline.com/doi/pdf/10.1089/bsp.2005.3.338> (visited Apr 22, 2006).

member states do retain the option of simply not complying with any regulation adopted by the World Health Assembly.[10]

Part II of this Development discusses the legal initiative undertaken by the WHO when it first drafted the International Health Regulations in 1969 ("IHRs 1969"). This section also outlines the purpose of the IHRs 1969 and highlights some of their major shortcomings. Section II then discusses the 2005 revisions to the IHRs 1969 and analyzes them with particular attention paid to the increased legislative and constitutional power granted to the WHO. Section III considers the potential conflict between the IHRs 2005 revisions and the principle of state sovereignty as well as the revisions' conflict with federal structures of government inherent in a number of large Western states. Lastly, Section III addresses the extent to which the WHO is seeking to become a supranational organization capable of side-stepping states' rights irrespective of geopolitical boundaries.

Given the increased political power of the WHO and the level of state acquiescence to its power, Section IV concludes that public international health concerns appear to have superseded all notions of state sovereignty as a matter of customary international law. Furthermore, it can be argued that certain provisions within the IHRs 2005 are ineffective in preventing the globalization of so-called fast epidemics such as SARS or avian influenza and do little, if anything, to combat diseases, such as AIDS, which are already in their "true globalization phase."[11]

II. BACKGROUND ON THE INTERNATIONAL HEALTH REGULATIONS

The first International Sanitary Conference was held in Paris in 1851 to address the cholera epidemics that swept through Europe between 1830 and 1847. This conference adopted a series of regulations for intensive infectious disease diplomacy and multilateral cooperation in public health known as the International Sanitary Regulations.[12] In 1948 the WHO Constitution came into force and empowered the World Health Assembly to adopt regulations concerning infectious disease control. As a result, the WHO adopted the

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10 World Health Assembly–adopted regulations are binding on all WHO member states except those that notify the Director-General of rejection or reservations within a specified time. WHO Const (1948), art 22, available online at <http://w3.whosea.org/LinkFiles/About_SEARO_const.pdf> (visited Apr 22, 2006).

11 Roni Rabin, *HIV Infection Ravages World: About 5 Million People Were Infected Last Year, a U.N. Report Says*, Orlando Sentinel A3 (July 7, 2004) (internal quotation marks omitted).

12 For a history of international law on infectious disease control between 1851 and 1951, see David P. Fidler, *International Law and Infectious Diseases* 21–57 (Oxford 1999).

International Sanitary Regulations, renaming them as the International Health Regulations in 1969.

To prevent the international spread of disease with minimum interference to global commerce, the IHRs 1969 required, among other things, that WHO member states notify the WHO of outbreaks of specific diseases subject to the IHRs 1969[13] and maintain certain public health capabilities at points of international entry and exit. However, with the resurgence of epidemics such as cholera in South America, plague in India, and the emergence of new infectious agents such as Ebola in the early 1990s, the World Health Assembly sought to revise the IHRs 1969.[14] Specifically, revisions were needed to address the limited application of the IHRs 1969 to just three diseases (cholera, plague, and yellow fever); the failure of WHO member states to promptly report outbreaks of diseases subject to the IHRs 1969; and the often excessive and unwarranted travel and trade restrictions applied by WHO member states to other member states suffering from outbreaks. Nevertheless, it was not until the SARS outbreak of 2003 that the World Health Assembly finally passed two resolutions that gave the WHO more power and authority to combat the international spread of infectious diseases.

On May 28, 2003, the World Health Assembly passed resolution WHA56.29, which urged WHO member states to take eleven specific actions to enhance, support, and strengthen national, regional, and international efforts to address the SARS outbreak.[15] In addition, the World Health Assembly also requested that the WHO Director-General take specific measures to respond to threats posed by SARS.[16] That same day the World Health Assembly passed another resolution, WHA56.28, which urged member states to give "high priority" to revising the IHRs 1969 and "to provide the resources and cooperation necessary to facilitate the progress of such work."[17] Most importantly, WHA56.28 granted the WHO power to intervene by sending WHO teams to independently investigate and conduct "on-the-spot studies" to

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13 Under the IHRs 1969, WHO member states are only required to report outbreaks of cholera, plague, and yellow fever to the WHO.

14 See Lawrence O. Gostin, *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, 291 JAMA 2623, 2624 (2004) (referencing World Health Assembly Res No WHA48.7, *Revision and Updating of the International Health Regulations* (May 12, 1995)).

15 See World Health Assembly Res No WHA56.29, *Severe Acute Respiratory Syndrome (SARS)* ¶ 1 (2003), available online at <http://www.who.int/csr/sars/en/ea56r29.pdf> (visited Apr 22, 2006).

16 Id at ¶ 2.

17 World Health Assembly Res No WHA56.28, *Revision of the International Health Regulations* ¶ 3(1) (2003), available online at <http://www.who.int/gb/ebwha/pdf_files/WHA56/ea56r28.pdf> (visited Apr 22, 2006).

determine whether national authorities are taking "appropriate control measures."[18]

The SARS epidemic brought to the forefront the significant risks and public health challenges presented by the globalization of infectious diseases. One of the immediate responses by the global community was a call to increase the WHO's role in monitoring global health threats and ensuring conformity with international measures. This call was answered by the World Health Assembly's passage of resolution WHA56.28. In fact, The Washington Post reported that the actions by the World Health Assembly "mark the first significant expansion of WHO power in more than three decades."[19] WHA56.28 "frees [the] WHO from having to wait until a country officially reports an international health threat before beginning countermeasures . . . and gives the agency the authority to begin ground inspections without a formal invitation."[20]

III. IHRs 2005 Major Changes

The WHO is mandated to "act as the directing and co-ordinating authority on international health work."[21] Under the IHRs 1969, however, the WHO carried out its mandate under ad hoc arrangements and without a clear legal structure. As a result, early draft versions on the revisions to the IHRs 1969 sought to establish a formal system that would enable experts to convene rapidly in response to public international health threats and take necessary emergency action. On May 23, 2005, the World Health Assembly more than achieved this goal by formally adopting the current IHRs 2005.[22] The IHRs 2005 are a sixty-page document that outlines the roles and obligations of WHO member states when addressing public health emergencies of international concern. The IHRs 2005 also establish guidelines on the WHO's role and responsibilities in the event of such crises. Despite maintaining essentially the same purpose as its predecessor, the IHRs 2005 seek to achieve the same end but through radically different means.

A. Article 4: Responsible Authorities

The IHRs 2005 require WHO member states and the WHO, itself, to maintain clear points of contact. Member states are required to establish a "National IHR Focal Point," while the WHO is required to designate "IHR

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18 Id at ¶ 4(3).

19 Rob Stein, *WHO Gets Wider Power to Fight Global Health Threats*, Wash Post A15 (May 28, 2003).

20 Id.

21 WHO Const, art 2(a).

22 The IHRs 2005 will become legally binding on all WHO member states by June 2007.

Contact Points." The National IHR Focal Points are to provide and receive information from the IHR Contact Points on a twenty-four hour basis.[23] This measure is meant to ensure the operational link between WHO member states and the WHO on matters regarding the newly adopted regulations.

The establishment within each member state of a National IHR Focal Point that is responsible for reporting a possible public health threat directly to the WHO is not amenable to member states with an established federal structure of government. In the United States, for example, the Department of Health and Human Services ("HHS") is the principal agency charged with protecting the health and safety of the American public. Among the major operating components of the HHS are the Centers for Disease Control and Prevention ("CDC") that conduct research and investigations aimed at preventing and controlling the spread of infectious and chronic diseases. Once such a threat has been identified by the CDC, the HHS is then responsible for disseminating such information to the public only after it has consulted with other federal agencies regarding issues of national security. The integrity of this domestic system for detecting and assessing health threats of *possible* international concern would be seriously undermined by the establishment of a National IHR Focal Point.

To begin with, Article 4 of the IHRs 2005 requires that the National IHR Focal Point notify the WHO directly of any potential health risk.[24] In order to achieve this level of communication between the National IHR Focal Point and the IHR Contact Point, state agencies such as the CDC would be forced to report directly to their National IHR Focal Point as well as their respective governmental departments. And, once the WHO has received information from the National IHR Focal Point regarding a potential health threat, the WHO has the discretion to make such information public via a WHO–issued recommendation.[25] This, in effect, would circumvent the state's role of keeping its citizens apprised of any and all domestic health issues. For reasons of national security, it may not be in a member state's best interest to have information regarding a *potential* public health threat immediately disseminated to its public. For example, a member state may require more than twenty-four hours to mobilize the necessary resources to prevent a possible escalation of the domestic health threat. Although Article 4 does address a primary objective for revising the IHRs 1969 (namely to facilitate the prompt reporting of potential health threats), it does so by sacrificing a large degree of state sovereignty.

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23 IHRs 2005, art 4, ¶ 2 (cited in note 3).

24 Id.

25 Id at arts 15–17.

B. ARTICLE 5: SURVEILLANCE

The IHRs 2005 require each WHO member state to "develop, strengthen and maintain, as soon as possible but not later than five years . . . the capacity to detect, assess, notify and report events"[26] that *may* constitute a public health emergency of international concern.[27] Such intrusive duties on member states have never before appeared in the traditional law on infectious disease control. Furthermore, Article 5 fails to take into account that not all member states will have the resources or capacity to implement such vast public health programs. Implementation of Article 5 will be a demanding task both in terms of financial and personnel resources. Furthermore, the implementation of such programs requires that a certain domestic infrastructure already be in place, coupled with the necessary technological expertise to run and maintain the system. As one commentator recently stated, "[s]ome nations are poor and cannot afford sophisticated public health systems, whereas others are failed states in the midst of civil strife, war, or natural disaster."[28] Therefore, rather than simply requiring all member states to have certain surveillance capabilities in place within a relatively short time frame, the IHRs 2005 should contain provisions that facilitate implementation, especially in developing countries. As the examples of SARS and the avian influenza illustrate, outbreaks of some of the most recent international infectious diseases have their origins in less developed regions of the world. Furthermore, as these areas begin to develop, their citizens become more susceptible to traditionally Western illnesses such as cardiovascular disease. Thus, these developing regions face a "'double burden' as they experience a confluence of indigenous diseases and illnesses spawned by their struggles to move out of poverty."[29] And, to require these nations to increase their national capacity for the monitoring and surveillance of new, emerging health threats would amount to a "triple burden." Lastly, aside from requiring the almost impossible from less developed member states, Article 5 also appears to intrude on a state's right to decide how best to monitor what are initially domestic threats. The WHO is not and should not be viewed as a supranational organization with the power to mandate the domestic health standards of sovereign states.

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26 Id at art 5, ¶ 1.

27 An "event" as used in the IHRs 2005 is a "manifestation of disease or an occurrence that creates a potential for disease." Id at art 1, ¶ 1.

28 Gostin, 291 JAMA at 2626 (cited in note 14).

29 John D. Blum, *Law as Development: Reshaping the Global Legal Structures of Public Health*, 12 Mich St J Intl L 207, 210 (2004).

C. ARTICLE 6: NOTIFICATION

The IHRs 2005 require member states to notify the WHO, by way of the National IHR Focal Point, "of all events which *may* constitute a public health emergency of international concern within its territory . . . as well as any health measure implemented in response to the events."[30] Furthermore, each member state is required to notify the WHO within twenty-four hours of any such occurrence.[31] Because the IHRs 1969 only required member states to notify the WHO of outbreaks of specific infectious diseases listed in the regulations, the revised IHRs 2005 notification requirements represent, among other things, a significant expansion of the duties of WHO member states.

Given the fact that health authorities are often not able to understand completely the severity and impact of newly emerging diseases, information regarding potential public health threats will oftentimes be "clouded in a high degree of unpredictability."[32] This level of unpredictability, in turn, affects the ability of domestic health authorities to properly assess all the risks involved with a potential health threat.[33] Furthermore, once the WHO publicly releases information regarding the occurrence of defined syndromes, the affected member state runs the risk of serious economic and social harm *before* any actual disease has been identified.[34] Thus, because a state is required to report the occurrence of *any* event or syndrome that may constitute a potential public health threat of international concern, its ability to adequately assess domestic threats and take appropriate action will be compromised. Rather than mandating member states to immediately report the occurrence of any event or syndrome, the IHRs 2005 should instead require member states to only report those events or syndromes that have been clearly identified as international health threats or that, after thorough state health analysis, have been determined to constitute a probable health threat international in scope.

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30 IHRs 2005, art 6, ¶ 1 (cited in note 3) (emphasis added).

31 Id.

32 Blum, 12 Mich St J Intl L at 212 (cited in note 29).

33 Id.

34 For example, a WHO–issued warning that SARS–like symptoms have been reported in the US before the actual SARS disease itself has been identified will immediately impede the flow of goods and people into and out of the US. Within a relatively short period, however, it may be determined that the health threat is not, in fact, SARS and can easily be managed by domestic health authorities. Nevertheless, the US would still have suffered added economic and social harm as a result of the WHO–issued warning.

D. ARTICLE 9: OTHER REPORTS

The IHRs 2005 allow the WHO to take into account reports from sources other than a state's National IHR Focal Point regarding evidence of a public health risk.[35] The WHO is empowered to act based on such reports but must first "consult with" the member state where "the event is allegedly occurring."[36] Furthermore, where confidentiality is "duly justified," the WHO is not required to disclose the identity of the reporting source.[37]

Article 9 represents a radical break from the traditional approach under which the WHO received information on a potential health threat. In the past, the WHO was empowered only to receive information from the afflicted member state. Under Article 9 of the IHRs 2005, however, the WHO is also empowered to receive information from interested third-party states and nongovernmental sources. In fact, the "WHO has been increasingly relying on nongovernmental sources for alerts on new outbreaks," thus allowing it to "bypass the reluctance of many governments to reveal such events [and] . . . put pressure on [these governments] to verify the situation and provide epidemiological evidence."[38] The result of such a system is to allow nongovernmental entities, such as the WHO, to participate directly alongside domestic, sovereign governments in establishing a form of domestic health policy that may or may not have global implications. Lastly, Article 9 also has the effect of allowing interested third-party states to dictate, to a certain degree, the domestic health policies of other sovereign states. Under the IHRs 2005, the WHO may take action simply based on information provided by non-afflicted member states.[39] It is, therefore, possible that an interested third-party state may purposely provide false information for any number of political reasons. This likelihood is further exacerbated by the fact that the WHO is not required to disclose the source of its information if it is "duly justified."[40]

E. ARTICLE 10: VERIFICATION

"When [the] WHO receives information of an event that may constitute a public health emergency of international concern, it shall offer to collaborate with the State Party concerned in assessing the potential for international disease

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35 IHRs 2005, art 9, ¶ 1 (cited in note 3).

36 Id.

37 Id.

38 Gian Luca Burci, *Shifting Norms in International Health Law*, 98 Am Socy Intl L Proc 16, 17 (2004).

39 See IHRs 2005, art 9, ¶ 1 (cited in note 3).

40 Id.

spread, possible interference with international traffic and the adequacy of control measures."[41] If, however, the allegedly afflicted member state refuses collaboration, the WHO may, "when justified by the magnitude of the public health risk," share information regarding the public health risk with other member states.[42]

Article 10 represents perhaps the most serious intrusion on state sovereignty by the IHRs 2005. As discussed previously, a state may have legitimate reasons for not immediately disclosing information regarding a health threat of possible international concern. However, Article 10 essentially forces member states to disclose such information and open its borders to WHO inspection. As the WHO itself states, "although the IHR (2005) does not include an enforcement mechanism per se for the States which fail to comply with its provisions, the potential consequences of non-compliance, especially in economic terms, are a powerful compliance tool."[43] As the SARS epidemic illustrated, WHO–issued recommendations and travel advisories can cripple a nation's economy and force it into compliance with WHO demands. Ultimately, the WHO will be allowed to make judgments about events transpiring in the territories of its member states. Nowhere in the WHO Constitution was the allocation of such power to the WHO ever contemplated.

F. ARTICLE 12: PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN

A "public health emergency of international concern" is defined as "an extraordinary event which is determined . . . (i) to constitute a public health risk to other [member states] through the international spread of disease and (ii) to potentially require a coordinated international response."[44] Under the IHRs 2005, the WHO Director-General "shall determine, on the basis of the information received . . . whether an event constitutes a public health emergency of international concern in accordance with the criteria and the procedure set out in these Regulations."[45]

To help WHO member states identify what may or may not constitute a public health emergency of international concern, the IHRs 2005 provide members with a decision instrument referred to as Annex 2 of the IHRs 2005. A "yes" answer to any two of the following four questions means that the health

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41 Id at art 10, ¶ 3.

42 Id at art 10, ¶ 4.

43 WHO, *Frequently Asked Questions about the International Health Regulations*, No 16 (cited in note 5).

44 See IHRs 2005, art 1, ¶ 1 (cited in note 3).

45 Id at art 12, ¶ 1.

risk or event in question may potentially constitute a public health emergency of international concern and must be reported by the member state to the WHO for final determination: (1) "Is the public health impact of the event serious?"; (2) "Is the event unusual or unexpected?"; (3) "Is there a significant risk of international spread?"; and (4) "Is there a significant risk of international travel or trade restrictions?"[46]

Unlike its predecessor, the reporting requirements under the IHRs 2005 are triggered by events constituting a "public health emergency of international concern" rather than a defined list of communicable diseases.[47] This revision to the regulations has two negative effects. First, it increases the reaction-time to known international diseases such as smallpox, SARS, or avian influenza. Second, it runs the risk of being over-inclusive and can lead to a system of syndrome reporting that would essentially require a member state to notify the WHO of any event that may or may not pose an international risk. As mentioned previously in the discussion of Article 6, such broad measures could result in member states suffering serious social and economic harm while relinquishing more power in determining domestic health law to the WHO.

With regard to the proposed algorithm approach for detecting health threats of international concern, such a system could mean that known diseases such as SARS would actually *not* be reported to the international community. If, for example, SARS were to reappear in some remote province of China, the Chinese government may not be obligated to report the occurrence to the WHO simply by answering three out of the four algorithm questions in the negative. Because China has experienced this disease recently, the event may not be considered unusual or unexpected, and because the disease was detected in a remote area, there may not be a significant risk of international spread or a risk of restrictions on international travel or trade. This consideration provides but one example of how the revised IHR may prove ineffective in combating the spread of globally infectious diseases.

G. ARTICLE 13: PUBLIC HEALTH RESPONSE

The IHRs 2005 require each WHO member state to "develop, strengthen and maintain, as soon as possible but no later than five years . . . the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern."[48] For much the same reasons discussed under Article 5, the implementation of a public health response system of the

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46 Id at Annex 2.

47 Id at art 1, ¶ 1.

48 Id at art 13, ¶ 1.

type required under Article 13 is extremely demanding in terms of financial and personnel resources. Moreover, with regards to less developed member states, the implementation of such a response system is an all but impossible task. Likewise, in order for the regulations to be truly effective, the IHRs 2005 should include provisions specifically aimed at facilitating their implementation in developing states. After all, the recent outbreaks of globally infectious diseases have all occurred in these regions.

H. ARTICLES 15 AND 16: WHO RECOMMENDATIONS

Once the WHO has determined that a particular event constitutes a public health emergency of international concern, the IHRs 2005 require the WHO to issue either "temporary recommendations"[49] or "standing recommendations"[50] in response to the emergency. Temporary recommendations may include health measures to be implemented by the afflicted member state or by other states regarding "persons, baggage, cargo, containers, conveyances, goods and/or postal parcels" that may come into contact with the afflicted member state.[51] Temporary recommendations expire three months after their issuance but may be modified or extended for additional periods of up to three months.[52] The IHRs 2005 also allow the WHO to issue standing recommendations with respect to "specific, ongoing public health risks."[53]

Although the WHO issued recommendations in connection with the SARS outbreak in 2003,[54] its authority to do so was unclear. The IHRs 1969, which at the time constituted the only rules of international law on infectious disease control, did not explicitly grant the WHO authority to issue such recommendations or alerts. Furthermore, the WHO Constitution is silent on the issue and, therefore, cannot be presumed to grant the WHO such power. Thus, the current IHRs 2005, which formally grant the WHO power to issue recommendations and alerts, represent a very significant political step for the organization. It should also be noted that the WHO is using its newly acquired political power as an enforcement mechanism by which to assert control over its member states, depriving them of much of their state sovereignty over domestic health issues. Lastly, it appears that Articles 15 and 16 run counter to one of the very purposes for revising the regulations—to prevent the often excessive and

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49 Id at art 15, ¶ 1.

50 Id at art 16.

51 Id at art 15, ¶ 2.

52 Id at art 15, ¶ 3.

53 Id at art 16.

54 See note 15.

unwarranted travel and trade restrictions imposed on WHO member states suffering from outbreaks.

IV. CONCLUSION

The emergence of new communicable diseases together with the threat of a pandemic influenza make it clear that the traditional disease-based approach to public health surveillance is no longer sufficient. The revised IHRs should, therefore, be broad and flexible enough to adequately protect us against future threats to international public health. But as we move towards establishing a system of greater public health preparedness, we must also remain cognizant of the primacy of local governments in addressing what are initially domestic health concerns. The IHRs 2005 fail to recognize this basic tenet of international law.

The revisions to the IHRs have effectively transformed the WHO from a coordinator of public health services into an international health governance or regulatory body with powers so vast and so sweeping that traditional notions of state sovereignty may no longer exist in the international law context. Once the WHO receives information regarding a potential health threat from a member state or any other source, the WHO then conducts a series of verifications and decides whether or not to share the data with the afflicted member state or other interested parties. The WHO also decides what public health measures its members must implement and can always force members into compliance by threatening indirect economic harm through the issuance of WHO recommendations. Furthermore, the WHO decides when a public health emergency of international concern exists and what principal measures must be taken. Oddly enough, the IHRs 2005 have evolved into more of an international treaty in substance, despite the absence of a formal ratification process by legislatures of signatory states. However, given the IHRs 2005's treaty-like status, it may only be a matter of time before the relinquishment of state sovereignty for the universal good of international public health becomes a part of customary international law.

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