BETWEEN ISOLATIONISM AND MUTUAL VULNERABILITY: A SOUTH-NORTH PERSPECTIVE ON GLOBAL GOVERNANCE OF EPIDEMICS IN AN AGE OF GLOBALIZATION

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We meet as we fight to defeat SARS, the first new epidemic of the twenty-first century. . . . Globalization of disease and threats to health mean globalization of the fight against them. SARS has been a wake-up call. But the lessons we have learned have implications that go way beyond the fight against this public health threat. . . . The events of the last few weeks also prompt us to look closely at the instruments of national and international law. Are they keeping up with our rapidly changing world?[1]

I. THE CRUX OF THE ARGUMENT

The transnational spread of infectious and non-communicable diseases in an era of globalization constitutes one of the most formidable challenges facing the normative orthodoxy of the Westphalian governance architecture. Exponents of "globalization of public health"[2] have explored the globalized nature of

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1. Gro-Harlem Brundtland, Past Director-General, WHO, Address at the 56th World Health Assembly, Geneva, Switzerland (May 18, 2003).

2. For a discussion of "globalization of public health," see generally David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 IND. J. GLOBAL LEGAL STUD. 11 (1997); David Woodward et al., *Globalization and Health: A Framework for Analysis and Action, in* 79 BULL. WORLD HEALTH ORGAN. 875 (2001), *available at* http://www.scielosp.org/pdf/bwho/v79n9/ v79n9a14.pdf; Kelley Lee & Richard Dodgson, *Globalization*

emerging and reemerging public health threats in an interdependent world. The recent transnational spread of severe acute respiratory syndrome ("SARS") from Asia to North America, as Brundtland observed in the quote above, is not only a wake-up call; it has once again challenged the legal and regulatory approaches to global health governance. This paper juxtaposes two contending approaches to public health governance: *isolationism* and *mutual vulnerability*, and argues for a reconfiguration of transnational health governance structures based on an inclusive humane globalism. Despite the powerful arguments canvassed by the exponents of globalization of public health, the stark realities of the contemporary South-North health divide has regrettably popularized isolationism, thereby impeding the emergence and sustenance of humane governance of global public health threats.

Isolationism is premised on the impression that the developing world is a reservoir of disease. In the discourse of hard-nosed realism, isolationism is a conscious effort to create a health sanctuary in the developed world that maximizes the health security of populations in Europe and North America. As SARS and other historical epidemics have infallibly proven, the argument canvassed by scholars of globalization of public health on the obsolescence or anachronism of the distinction between national and international health threats has become less recondite and unassailable in an interdependent world. Using SARS as the subject of analysis, this article explores the challenges of global governance of transnational epidemics in an interdependent world. I argue that global health governance orthodoxy has failed to respond adequately to public health challenges in a world characterized by South-North disparities.[3] I offer a reconstructive perspective that goes beyond the normative parameters of state-centric Westphalianism. The reconstruction draws from Richard Falk's "law of humanity," and David Held's "cosmopolitan social democracy:" a cosmopolitan or quasi-cosmopolitan framework that captures the South-North health divide based on the mutual vulnerability of all of humanity to the menace of disease in an interdependent world.

II. ISOLATIONISM AND THE EVOLUTION OF PUBLIC HEALTH DIPLOMACY

> *Thus, the eleventh International Sanitary Conference in 53 years had as its essential purpose the protection of Europe against the importation of exotic diseases.*[4]

and Cholera: Implications for Global Governance, 6 GLOBAL GOVERNANCE 214 (2000); Derek Yach & Douglas Bettcher, *The Globalization of Public Health, I: Threats and Opportunities,* 88 AM. J. PUB. HEALTH 735 (1998); Derek Yach & Douglas Bettcher, *The Globalization of Public Health, II: The Convergence of Self-Interest and Altruism,* 88 AM. J. PUB. HEALTH 738 (1998).

3. I use the term "South-North" throughout this paper as suggested by IVAN L. HEAD in ON A HINGE OF HISTORY: THE MUTUAL VULNERABILITY OF SOUTH AND NORTH 14 (1991). Professor Head expressed a preference for "South-North" as a more accurate reflection of the current international system. *Id*. He argued that "North-South" is misleading because "it lends weight to the impression that the South is the diminutive." *Id*.

4. NORMAN HOWARD-JONES, THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851-1938, at 85 (1975).

Isolationism, a conscious effort to insulate populations within the geopolitical boundaries of a nation-state from exotic diseases, is as old as the history of public health diplomacy. Before the European-led international sanitary conferences in the nineteenth century that were driven by the European cholera epidemics in 1830 and 1847, Neville Goodman identified three dominant reactions by nation-states to the trans-boundary spread of disease.[5] The first was the predominant view that disease was a punishment from the gods that could only be cured by prayers and sacrifices.[6] The second reaction was the isolation of a healthy society from an unhealthy one through the practice of *cordon sanitaire* to prevent either importation or exportation of disease.[7] The third reaction was the practice of quarantine that enabled governments to isolate goods or persons coming from places suspected of suffering an outbreak of disease to protect the community from importation of exotic diseases.[8] Between the fourteenth and nineteenth centuries, almost the entire *civilized* world practiced some form of quarantine. This consisted mainly of imposing an arbitrary period of isolation on the ships, crews, passengers, and goods arriving from foreign sea ports and destinations believed to be reservoirs of major epidemic diseases, especially plague, cholera, and yellow fever.[9]

The nineteenth century, within which public health diplomacy evolved in Europe through the International Sanitary Conferences, raises intriguing questions on the transnational governance of infectious diseases. This is because the civilized-uncivilized construct invented in the Age of Columbus had become firmly entrenched in the vocabulary of nineteenth century international law and relations. Peter Malanczuk observed that the international community in the nineteenth century was virtually *Europeanized* on the basis of conquest and domination; the international legal system became an exclusive European club to which non-Europeans would only be admitted if they proved that they were civilized.[10] The *realpolitik* of nineteenth century public health diplomacy driven

5. NEVILLE M. GOODMAN, INTERNATIONAL HEALTH ORGANIZATIONS AND THEIR WORK 27-29 (2d ed. 1971).

6. *Id*. at 27.

7. *Id*. at 28.

8. For a history and discussion of the concept of quarantine, see *id*. at 29 (stating that quarantine derived from "forty-day (*quaranta*) isolation period imposed at Venice in 1403 and said to be based on the period during which Jesus and Moses had remained in isolation in the desert"); Paul Slack, *Introduction* to EPIDEMICS AND IDEAS: ESSAYS ON THE HISTORICAL PERCEPTION OF PESTILENCE 15 (Terence Ranger & Paul Slack eds., 1992); B. Mafart & J.L Perret, *History of the Concept of Quarantine*, 58 MED. TROPICALE 14, 14-20 (1998) (French) (defining quarantine as "a concept developed by society to protect against outbreak of contagious diseases") (on file with author).

9. DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 26 (1999); GOODMAN, *supra* note 5, at 31.

10. PETER MALANCZUK, AKEHURST'S MODERN INTRODUCTION TO INTERNATIONAL LAW 13 (7th ed. 1997). *See also* MOHAMMED BEDJAOUI, TOWARD A NEW INTERNATIONAL ECONOMIC ORDER 51-53 (1979) (discussing idea that international law in nineteenth century was synonymous with European imperialism); Antony Anghie, *Finding the Peripheries: Sovereignty and Colonialism in Nineteenth-Century International Law*, 40 HARV. INT'L L.J. 1, 2 (1999) (stating that virtually all territories in Asia, Africa, and Pacific were governed by European law by end of nineteenth century).

by the international sanitary conferences was the desire to protect civilized Europe from exotic diseases and pathogens that emanated from the uncivilized non-European societies. As Norman Howard-Jones observed, the international sanitary conferences were not motivated by a wish for the general betterment of the health of the world, but by the desire to protect certain favored (especially European) nations from contamination by their less-favoured (especially Eastern fellows).[11] Cholera presents an apt illustration of the European desire to keep exotic diseases far from reaching European territorial boundaries. Goodman observed that for centuries cholera, although terrible in rapidity and high morbidity, was considered a disease largely confined to Central Asia, particularly Bengal. But between 1828 and 1831, it was reported to have passed out of India and spread rapidly to the whole of Europe and to the United States.[12] From Punjab, Afghanistan, and Persia:

> [I]t reached Moscow in 1830 and infected the whole of Europe, including England, by the end of 1831. It reached Canada and the United States of America in the summer of 1832 . . . . Another pandemic followed in 1847 and five others in the next fifty years. This was a new and terrifying disease to the Western world . . . .[13]

The entire gamut of the international sanitary conventions and regulations negotiated at each of the European-led international sanitary conference is replete with conscious efforts to insulate Europeans from exotic diseases. Both the sanitary convention and regulations negotiated at the first International Sanitary Conference in 1851 by eleven European states and Turkey on plague, cholera, and yellow fever were focused on ships "having on board a disease reputed to be importable."[14] According to David Fidler, the objective of protecting Europe from "Asiatic cholera" dominated the European-led international sanitary conferences of 1866, 1874, 1885, 1892, 1893, and 1894 because each of these conferences were convened after another cholera scare in Europe.[15] The four international treaties concluded between 1892 and 1897 followed the trend of European insulation from diseases of the *uncivilized*. While the 1892 International Sanitary Convention focused on the importation of cholera from the Suez Canal by Mecca Muslim pilgrims, the 1893 International Sanitary Convention focused broadly on policing European geopolitical boundaries against the importation of cholera. While the 1894 International Sanitary Convention focused on Mecca pilgrimages and maritime traffic in the Persian Gulf, the 1897 International Sanitary Convention focused on keeping plague out of Europe.[16] At the 1897 international sanitary conference convened specifically on plague, Great Britain, then the colonial overseer of India, was

11. Norman Howard-Jones, *Origins of International Health Work*, 6 BRIT. MED. J. 1032, 1035 (1950).

12. GOODMAN, *supra* note 5, at 38.

13. *Id.* (footnote omitted).

14. *Id.* at 46.

15. FIDLER, *supra* note 9, at 28-30.

16. *Id.* at 30.

severely criticized by other European states because of a serious and persistent epidemic of plague from Bombay to the north-west littoral of India. Austria-Hungary proposed the 1897 international sanitary conference because it feared that its Muslim subjects from Mecca pilgrimage might bring plague with them after being in contact with pilgrims from India.[17]

Transiting to the twentieth century, public health diplomacy continued to evolve in the complex multilateral terrain of the civilized-uncivilized disease construct. Commenting on the 1903 consolidation of the 1892, 1893, 1894, and 1897 conventions, Howard-Jones observed that the 1903 international sanitary conference "had as its essential purpose the protection of Europe against the importation of the exotic diseases from the East."[18] Today, even in the age of globalization, the isolationist legacy of the nineteenth century public health diplomacy remains one of the dominant characteristics of global health governance. Notwithstanding the expansion of the international society through the establishment of the United Nations in 1945, and the decolonization and political self-determination of most African, Asian, and South Pacific entities in the 1960s and 1970s, contemporary public health Westphalianism is still embedded in a colonial-type relationship. The present South-North health divide conjures images of systematic exclusion of the *uncivilized* from the dividends of global public goods for health in the "emerging global village." Global governance, including global health, oscillates between the paradoxical challenges of what Upendra Baxi has explored as "Global Neighborhood and Universal Otherhood," a disguised or conscious entrenchment of age-old inequalities and structures which banish a sizable part of the developing world to the margins of global governance.[19]

The dominant perception in the developed world that the developing world is a reservoir of disease as a result of collapsed or even nonexistent public health infrastructure has led to isolationist national health policies in most of the global North. In nearly all the industrialized countries of the global North, immigrants from Africa are prohibited from donating blood to national blood banks because of the perception that every African blood is naturally tainted with malaria and other "*African*" diseases. Although the phenomenon of globalization has continued to erode geopolitical boundaries, globalization of public health has paradoxically reinforced the powers of nation-states in the global North to

17. HOWARD-JONES, *supra* note 4, at 78.

18. *Id.* at 78. *See also* FIDLER, *supra* note 9, at 31 (observing that "of the 184 articles in the 1903 International Sanitary Convention, 131, or approximately seventy-one percent of the treaty, deal with places (for example, Egypt, and Constantinople) and events (for example, Mecca pilgrimages) located outside Europe").

19. Upendra Baxi, "*Global Neighborhood" and the "Universal Otherhood": Notes on the Report of the Commission on Global Governance*, *in* 21 ALTERNATIVES 525, 544-45 (1996). I have applied Baxi's paradoxical matrix in the global health context. *See also* Obijiofor Aginam, *The Nineteenth Century Colonial Fingerprints on Public Health Diplomacy: A Postcolonial View*, 1 LAW SOC. JUST. & GLOBAL DEV. J. 1, 7-8 (2003) (discussing paradox between "global neighbourhood" and "universal otherhood"), *available at* http://elj.warwick.ac.uk/global/issue/2003-1/aginam.htm (last visited Sept. 7, 2004).

isolate potential immigrants who are perceived to be carriers of leading communicable diseases.[20] Immigration policies are now constructed around mandatory medical screening and testing of potential immigrants. Disease has emerged as a ground to shut the borders of Europe and North America against immigrants from Africa, Asia, South America, and the Caribbean. As Robert Kaplan observed in his widely cited essay *The Coming Anarchy*:

> As many internal African borders begin to crumble, a more impenetrable boundary is being erected that threatens to isolate the continent as a whole: the wall of disease . . . . Africa may today be more dangerous in this regard than it was in 1862 . . . . As African birth rates soar and slums proliferate, some experts worry that viral mutations and hybridizations might, just conceivably, result in a form of the [acquired immunodeficiency syndrome ("AIDS")] virus that is easier to catch than the present strain.
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> It is malaria that is most responsible for the disease wall that threatens to separate Africa and other parts of the Third World from more-developed regions of the planet in the twenty-first century. Carried by mosquitoes, malaria, unlike AIDS, is easy to catch.[21]

Although countries often overreact to outbreaks of epidemics in other countries with trade, travel, and economic embargoes ostensibly to protect their populations, these embargoes are always more severe and isolationist when the disease or health threat emanates from a developing country. While science and risk assessment played some role in the ban of British beef by most European Union countries following the United Kingdom mad cow disease/bovine spongiform encephalopathy ("BSE") crisis and the recent United States' ban of Canadian beef as a result of the single BSE case in Alberta, the embargoes that followed the Indian plague outbreak in 1994, and the East African cholera outbreak in 1997, and the Ebola outbreak in Zaire (now Democratic Republic of the Congo) were pure isolationist policies by the developed world. Commenting on the economic embargoes that followed the Indian plague outbreak, David Heymann stated that such excessive measures included closing of airports to aircraft arriving from India, unnecessary barriers to importation of foodstuffs from India, and in many cases the repatriation of Indian guest workers even though many of them had not lived in India for many years.[22] In 1997, the European Community ("EC") imposed a ban on the importation of fresh fish from East Africa following an outbreak of cholera in remote areas in certain

20. For an argument that globalization presents a paradox by opening the borders of developing countries to multinational corporations from the North while shutting the borders of developed countries to immigrants, see Obijiofor Aginam, *Global Village, Divided World: South-North Gap and Global Health Challenges at Century's Dawn*, 7 IND. J. GLOBAL LEGAL STUD. 603, 610 (2000).

21. Robert D. Kaplan, *The Coming Anarchy*, *in* GLOBALIZATION AND THE CHALLENGE OF A NEW CENTURY: A READER 34, 40 (Patrick O'Meara et al. eds., 2000).

22. David Heymann, The International Health Regulations: Ensuring Maximum Protection with Minimal Restriction, Annual Meeting of the ABA, Program Materials on Law & Emerging & Re-Emerging Infectious Diseases (1996) (unpublished manuscript, on file with author). *See also* Laurie Garret, *The Return of Infectious Diseases*, FOREIGN AFF., Jan.-Feb. 1996, at 66, 74 (stating that India lost almost two billion dollars as a result of excessive measures following outbreak of plague).

East African countries.[23] At the time of the ban, fish exports from the affected countries, Kenya, Mozambique, Tanzania, and Uganda, to the European countries stood at $230 million.[24] Is isolationism an effective public health strategy in an era of globalized epidemics? Does isolationism offer effective defenses against microbial forces that routinely disrespect geopolitical boundaries? History is in fact repeating itself. If *cordon sanitaire*, the dominant isolationist policy of European states in the nineteenth century was ineffective against the cross-border cholera epidemics of 1830 and 1847, then modern day isolationism would also be futile as globalization erodes national boundaries and renders populations within those boundaries vulnerable to the menace of disease. To gain deeper insights into the tension between isolationism and globalization of public health in the Westphalian system, we must explore the concept of mutual vulnerability in the dynamic of global health governance in an interdependent world.

III. MUTUAL VULNERABILITY TO DISEASE IN A GLOBALIZING WORLD

> *Today, in an interconnected world, bacteria and viruses travel almost as fast as e-mail and financial flows. Globalization has connected Bujumbura to Bombay and Bangkok to Boston. There are no health sanctuaries. No impregnable walls exist between a world that is healthy, well-fed, and well-off and another that is sick, malnourished, and impoverished. Globalization has shrunk distances, broken down old barriers, and linked people. Problems halfway around the world become everyone's problem*.[25]

Because globalization of public health postulates the anachronism of the erstwhile distinction between national and international health threats, it is now infallible that disease pathogens neither carry national passports nor respect the geopolitical boundaries of sovereign states. State sovereignty is an alien concept in the microbial world. With the contemporary globalization of the world's political economy, which is amply evidenced by the huge volumes of goods, services, and people that cross national boundaries, all of humanity is now mutually vulnerable to the emerging and reemerging threats of disease in an interdependent world. Mutual vulnerability, as employed in the global health context, is the accumulation of the vicious threats posed to humans by disease and pathogenic microbes in an interdependent world, the fragility of humans to

23. *See* Commission Decision of 23 December 1997 concerning certain protective measures with regard to certain fishery products originating in Uganda, Kenya, Tanzania and Mozambique, 1997 O.J. (L356) 64 (banning importation of "fresh fishery products from, or originating in Kenya, Uganda, Tanzania and Mozambique" because of cholera epidemic); Commission Decision of 16 January 1998 on protective measures with regard to fishery products from, or originating in Uganda, Kenya, Tanzania and Mozambique and repealing Decision 97/878/EC, 1998 O.J. (L15) 43 (mandating testing of all frozen or fresh fishery products from or originating in Uganda, Kenya, Tanzania and Mozambique "to verify that they present no threat to public health").

24. FIDLER, *supra* note 9, at 80 n.158.

25. Gro-Harlem Brundtland, *Global Health and International Security*, 9 GLOBAL GOVERNANCE 417, 417 (2003).

succumb to these threats, and the obsolescence of the distinction between national and international health threats.[26] International trade, travel, intentional and forced migrations fueled by wars, conflicts, and environmental disasters propel the efficacy of mutual vulnerability as a phenomenon of "South-North dangers"[27] and one of the fundamental determinants of the contemporary Westphalian system.

The multiple dimensions of mutual vulnerability, although complex, are not at all new in humanity's encounter with disease. Historical accounts of the Plague of Athens in 430 BC,[28] the fourteenth century European bubonic plague (Black Death),[29] and the microbial consequences of the Columbian exchange between the Old and New Worlds,[30] suggest that one dimension of mutual vulnerability–the permeation of national boundaries by disease–is an entrenched feature of humanity's interaction with the microbial world. In contemporary public health diplomacy, the crisis of emerging and reemerging infectious diseases ("EIDs") reinforces our mutual vulnerability to disease in a globalizing world. The United States' Centers for Disease Control and Prevention ("CDC") defines EIDs as "diseases of infectious origin whose incidence in humans has increased within the past two decades or threatens to increase in the near future."[31] In 1995, the United States' government interagency Working Group on Emerging and Reemerging Infectious Diseases ("CISET") listed twenty-nine

26. I do not claim originality of the use of the concept of mutual vulnerability. For earlier uses of the concept to explore the political economy of South-North relations, development, and under-development, see HEAD, *supra* note 3, at 185-87 (discussing global vulnerability to diseases such as AIDS and malaria); JORGE NEF, HUMAN SECURITY AND MUTUAL VULNERABILITY: THE GLOBAL POLITICAL ECONOMY OF DEVELOPMENT AND UNDERDEVELOPMENT 13-26 (2d ed. 1999) (analyzing global vulnerability).

27. Ivan L. Head, *South-North Dangers*, FOREIGN AFF., Summer 1989, at 71, 84-86.

28. *Thucydides: History Of The Peloponnesian War, in* 6 GREAT BOOKS OF THE WESTERN WORLD 345, 399 (Robert Maynard Hutchins et al. eds., Richard Crawley trans., 1952) (suggesting that the plague, which devastated Athens, originated from Ethiopia and spread through Egypt and Libya before it reached Athens following movement of troops during war).

29. J.N. HAYS, THE BURDENS OF DISEASE: EPIDEMICS AND HUMAN RESPONSE IN WESTERN HISTORY 39-40 (1998) (arguing that path of Bubonic Plague originated in Central Asia, spread across Asian steppes in the 1330s, was carried by ship from Crimea to Sicily in 1347, and followed international travel and trading routes before arriving in major European sea ports before the end of 1348).

30. *See generally* ALFRED W. CROSBY JR., ECOLOGICAL IMPERIALISM: THE BIOLOGICAL EXPANSION OF EUROPE, 900-1900 (1986) (arguing that Europeans' successful displacement and replacement of native peoples in world's temperate zones has a biological, ecological origin); ALFRED W. CROSBY JR., THE COLUMBIAN EXCHANGE: BIOLOGICAL AND CULTURAL CONSEQUENCES OF 1492 (1972) (discussing exchange of disease and food supply following Columbus' finding new world); DOROTHY PORTER, HEALTH, CIVILIZATION AND THE STATE: A HISTORY OF PUBLIC HEALTH FROM ANCIENT TO MODERN TIMES (1999) (describing mutual interchange of biological and epidemiological trends of Old and New Worlds).

31. CDC, ADDRESSING EMERGING INFECTIOUS DISEASE THREATS: A PREVENTION STRATEGY FOR THE UNITED STATES 7 (1994). *See also* WHO, WORLD HEALTH REPORT 1996: FIGHTING DISEASE, FOSTERING DEVELOPMENT 15 (1996) [hereinafter WHO, WORLD HEALTH REPORT] (describing emerging infectious diseases).

examples of new infectious diseases identified since 1973.[32] Some of the diseases in the list published by CISET include Ebola hemorrhagic fever (1977), Legionnaire's disease (1977), toxic shock syndrome (1981), Lyme disease (1982), acquired immunodeficiency syndrome ("AIDS") (1983), and Brazilian hemorrhagic fever (1984). The CISET Working Group categorized reemerging infectious diseases into three groups: (i) infectious diseases that have flared up in regions in which they historically appeared; (ii) infectious diseases that have expanded into new regions; and (iii) infectious diseases that have developed resistance to anti-microbial treatments and have spread through traditional and/or new regions because of such resistance.[33] Tuberculosis falls into each of the three categories of emerging and reemerging infectious diseases. It is an old disease that has reemerged in regions where it historically occurred, it has returned as a public health threat in the South and the North, and certain strains of tuberculosis have developed strong resistance to anti-microbial treatments.[34] Arno Karlen, in *Man and Microbes*, published a "partial list of new diseases" that first appeared between 1951 and 1993.[35] In Karlen's analysis, not even the most powerful country in the world, the United States, could insulate its populations from the outbreaks of Lassa fever and Legionnaires' disease suspected to have arrived in the United States from the developing world because "[h]igh-speed travel had created a global village for pathogens."[36] Even with an isolated disease like malaria, widely thought to be confined to Africa, high-speed travel, tourism, migration, and international airline networks have combined to entrench the disease firmly in the discourse of mutual vulnerability. Cases of "imported malaria" and "airport malaria" have reemerged in Europe, North America, and other regions of the world where the mortality and morbidity burdens of malaria constitute little or no threats to public health.[37] The disparities between the South and the North on the burdens of malaria are stark, with overwhelming malaria cases occurring in Africa. Nonetheless, airport and imported malaria can no longer be neglected, especially in Europe, because there have been reports of a surprising number of malaria deaths in countries of

32. NATIONAL SCIENCE & TECHNOLOGY COUNCIL COMMITTEE ON INTERNATIONAL SCIENCE, ENGINEERING, & TECHNOLOGY ("CISET"), INTERAGENCY WORKING GROUP ON EMERGING INFECTIOUS DISEASES, INFECTIOUS DISEASES: A GLOBAL THREAT 14 (Sept. 1995).

33. *See id.* (listing factors contributing to re-emergence of infectious diseases).

34. *See generally* JOHN CROFTON, GUIDELINES FOR THE MANAGEMENT OF DRUG-RESISTANT TUBERCULOSIS (1997) (discussing strategies for tuberculosis management); David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771 (1997) (analyzing emerging and re-emerging infectious diseases).

35. ARNO KARLEN, MAN AND MICROBES 6 (1995).

36. *Id.* at 7.

37. For a distinction between "imported malaria" and "airport malaria," see Norman G. Gratz et. al., *Why Aircraft Disinsection?, in* 78 BULL. WHO 995, 996-97 (2000) (stating that the "most direct evidence of transmission of disease by mosquitoes imported on aircraft is the occurrence of airport malaria, i.e. cases of malaria in and near international airports, among persons who have not recently traveled to areas where the disease is endemic or who have not recently received blood transfusions. Airport malaria should be distinguished from imported malaria among persons who contract the infection during a stay in an area of endemicity and subsequently fall ill.").

the North following unrecognized infection through a blood transfusion or a one-off mosquito bite near an international airport. Cases in Europe of airport malaria, which mostly occur in the absence of anamnestic signs of any exposure to malaria risk, are often difficult to diagnose.[38] From 1969 to 1999, confirmed cases of airport malaria have been reported in France, Belgium, Switzerland, the United Kingdom, Italy, the United States, Luxembourg, Germany, the Netherlands, Spain, Israel, and Australia.[39] Epidemiological data in Europe suggest that 1,010 cases were imported into the countries of the European Union in 1971; 2,882 in 1981; about 9,200 cases in 1991; and 12,328 cases in 1997.[40] In 1993, some thirty years after the eradication of malaria in the former Soviet Union, some 1,000 cases of malaria were registered in the Russian Federation and in the newly independent states: Belarus, Kazakhstan, Ukraine, Azerbaijan, Tajikistan, Turkmenistan, and Uzbekistan.[41] In the United Kingdom, 8,353 cases of imported malaria were reported between 1987 and 1992. A breakdown of this figure shows that United Kingdom nationals who visited their friends and relations in malaria endemic regions accounted for forty-nine percent of the cases, visitors to the United Kingdom accounted for nineteen percent, tourists accounted for sixteen percent, while immigrants and expatriates accounted for eleven and five percent respectively.[42]

The World Health Organization ("WHO") blames the global crisis of emerging and reemerging infectious diseases on "fatal complacency" as a result of antibiotic discovery, global eradication of smallpox, the progress made in rolling back the mortality burdens of measles, guinea worm, leprosy, poliomyelitis, and neo-natal tetanus.[43] This cautious optimism has turned into a fatal complacency that is costing millions of lives annually.[44] The emergence in the North of West Nile virus, airport and imported malaria, drug-resistant tuberculosis, and SARS through global travel, tourism, trade, and human migrations, provide the premise for an irrefutable conclusion: the distinction between national and international has become obsolete in an interdependent world. Populations within the geopolitical boundaries of Westphalian nation-states have now, more than ever before in recorded history, become mutually vulnerable to pathogenic microbes. Humanity is "on a hinge of history," and the Westphalian governance architecture must devise effective ways to protect humanity from advancing microbial forces.

38. WHO REGIONAL OFFICE FOR EUROPE, STRATEGY TO ROLL BACK MALARIA IN THE WHO EUROPEAN REGION 6 (1999), *available at* http://www.euro.who.int/document/e67133.pdf (last visited Sept. 7, 2004). S*ee also* Gratz et al., *supra* note 37, at 998 (stating that "[a]irport malaria is particularly dangerous in that physicians generally have little reason to suspect it. This is especially true if there has been no recent travel to areas where malaria is endemic.").

39. Gratz, *supra* note 37, at 998.

40. WHO REGIONAL OFFICE FOR EUROPE, *supra* note 38, at 6.

41. *Id.* at 3.

42. WHO, REPORT ON INFECTIOUS DISEASES: REMOVING OBSTACLES TO HEALTHY DEVELOPMENT 52 (1999).

43. WHO, WORLD HEALTH REPORT, *supra* note 31, at 1.

44. *Id*.

IV. SARS AND THE TENSION BETWEEN ISOLATIONISM AND MUTUAL VULNERABILITY

> *SARS, the first severe infectious disease to emerge in the twenty-first century, has taken advantage of opportunities for rapid international spread made possible by the unprecedented volume and speed of air travel. SARS has also shown how, in a closely interconnected and interdependent world, a new and poorly understood infectious disease can adversely affect economic growth, trade, tourism, business and industrial performance, and social stability as well as public health.*[45]

In February 2003, an infectious disease in the form of an atypical pneumonia of unknown cause, SARS, was first recognized in Hanoi, Vietnam. In a few weeks, WHO was informed of similar outbreaks in various hospitals in Hong Kong (China), Singapore, and Toronto (Canada). Subsequent investigations by WHO traced the source of the outbreaks to a hotel in Hong Kong with a visiting physician from the Guangdong Province in China. The physician had treated patients with atypical pneumonia before traveling to Hong Kong and was symptomatic on arrival. The Chinese Ministry of Health, on February 11, 2003, informed WHO of an outbreak of acute respiratory syndrome involving over 300 cases with five deaths in the Guangdong province. On February 14, WHO was informed that the disease had been detected as far back as November 16, 2002, and that the outbreak was coming under control.[46] According to WHO, SARS has several features that constitutes a serious threat to global public health.[47] First, "there is no vaccine or treatment, forcing health authorities to resort to control tools dating back to the earliest days of empirical microbiology: isolation, infection control and contact tracing."[48] Second, the virus has been identified as a previously unknown member of the coronavirus family, and some coronaviruses undergo frequent mutation thereby frustrating the development of effective vaccines.[49] Both the epidemiology and pathogenesis of SARS are poorly understood. Third, SARS had a high case fatality ratio in the range of fourteen to fifteen percent.[50] Between November 2002 and April 2003, over 3,200 SARS cases were reported in twenty-four countries.[51]

SARS implicated the tension between isolationist national responses to goods and people from SARS-afflicted countries, and mutual vulnerability to the

45. WHO Secretariat, *Revision of the International Health Regulations: Severe acute respiratory syndrome (SARS)*, 56th World Health Assembly, at 2, WHO Doc. A56/48 (May 17, 2003), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA56/ea5648.pdf.

46. *Id.* at 1.

47. *Id.* at 2.

48. *Id.*

49. *Id.* at 2-3.

50. *Id.*

51. WHO, Cumulative Number of Reported Probable Cases of Severe Acute Respiratory Syndrome (SARS), *at* http://www.who.int/csr/sars/country/2003_04_15/en/print.html (Apr. 15, 2003).

disease as a result of globalization and the speed of travel and trade. In part, this tension is epitomized by the heavy economic damage as a result of the embargoes and boycott of the SARS-afflicted countries, and the WHO's Global Outbreak Alert and Response Network that collaborated well with the United States' CDC and eleven laboratories around the world put together to identify the cause of SARS. In Canada, the economic cost of SARS was estimated at $30 million daily. It is projected that China and South Korea suffered some $2 billion in SARS-related tourism and economic losses. Visitor arrivals in China, South Korea, Singapore, and Canada dropped drastically as a result of the WHO travel advisories, isolationist responses, and overreaction from other countries.[52] In Hong Kong, it was estimated that lost revenue from hotels, restaurants, and shops could amount to 0.5% of its total gross domestic product in 2003. Thailand, whose economy relied on tourism, barred visitors suspected of carrying the virus from entering the country.[53] This modern-day *cordon sanitaire*, when compared with the mutual vulnerability to SARS as a result of its rapid spread across national boundaries - from Asia to North America – underscores why global collaboration is the best way to fight epidemics in an age of globalization. Echoing the central theme of globalization of public health, Ilona Kickbusch observed with respect to the transnational spread of SARS that:

> Countries – small and large – will need to pool both sovereignty and resources based on a new mindset; they will need to acknowledge that while health is a national responsibility, it is also a global public good. . . . As a global community, we need to stop focusing on the reactive mode that fights disease by disease and outbreak by outbreak. We need to ensure the international legal framework for such a fight and develop sustainable financing of global surveillance, rapid global response and local capacity.[54]

The continued oscillation of public health diplomacy between *isolationism* and *mutual vulnerability* indicts the governance architecture of the Westphalian system and opens new vistas in global efforts to fight transnational epidemics.

V. FIDELITY TO HUMANITY'S HEALTH: A POST-WESTPHALIAN EXPLORATION BETWEEN "LAW OF HUMANITY" AND "COSMPOLITAN SOCIAL DEMOCRACY"

Globalization of public health de-emphasizes the "territorialization" of public health risks simply because the concept of state sovereignty is alien to the

52. Michael D. Lemonick & Alice Park, *The Truth about SARS*, TIME, May 5, 2003, at 50-51.

53. CENTER FOR STRATEGIC & INTERNATIONAL STUDIES, SARS'S GLOBAL SPREAD DEMANDS INTERNATIONAL COLLABORATIVE CONTAINMENT EFFORTS, *at* http://www.globalization101.org/news.asp?NEWS_ID=49 (Apr. 14, 2003). For a detailed study on the economic cost of SARS, see Jong-Wha Lee & Warwick J. McKibbin, *Globalization and Disease*: *The Case of SARS*, AUSTRALIAN NAT'L UNIV. WORKING PAPERS IN TRADE & DEV., Working Paper No. 2003/16 (2003) (revised version of paper presented at the Asian Economic Panel, Tokyo, Japan, May 11-12, 2003), *available at* http://rspas.anu.edu.au/economics/ publish/ papers/wp2003/wp-econ-2003-16.pdf.

54. Ilona Kickbusch, *SARS: Wake-Up Call for a Strong Global Health Policy*, YALE GLOBAL ONLINE (Apr. 25, 2003), *at* http://yaleglobal.yale.edu/article.print?id=1476.

microbial world.[55] Globalized public health requires a global policy universe and humane global health governance framework involving a multiplicity of actors– international organizations, private and corporate actors, and civil society. Exploring the politics of the "domestic-foreign Frontier," James Rosenau identified a policy response that treats the emergent "Frontier" "as becoming more rugged and, thus, as the arena in which domestic and foreign issues converge, intermesh, or otherwise become indistinguishable within a seamless web."[56] Thus:

> While foreign policy still designates the efforts of societies to maintain a modicum of control over their external environments, new global interdependence issues such as pollution, currency crises, AIDS, and the drug trade have so profoundly changed the tasks and goals of foreign policy officials . . . .[57]

Global governance of transnational epidemics like SARS comes within the list of complex global issues that shape Rosenau's "domestic-foreign Frontier." Fashioning effective and humane global health governance accords will be difficult, but as Rosenau put it, "global governance is not so much a label for high degree of integration and order."[58] Governance of globalized public health threats in the 'Frontier' involves critical choices. What is most important is for evolving multilateral governance structures to focus on the "world" as its primary constituency, and humanity (human life) as the endangered species that it seeks to conserve. In an era of globalized epidemics, therefore, an indispensable part of post-Westphalian global governance architecture lies within the normative boundaries of Falk's "law of humanity"[59] and Held's "cosmopolitan social democracy."[60] According to Falk, "[t]he character of the law of humanity is not self-evident. It could mean law that is enacted by and for the peoples of the world, as distinct from the elites who act in law-making settings on behalf of states."[61]

The promise of civil society participation in humane governance is founded on the perceived or actual exclusion, by the state, of a sizable part of humanity

55. In adopting this view of globalization, I am a student of David Held and Anthony McGrew who defined globalization as "a process (or set of processes) which embodies a transformation in the spatial organization of social relations and transactions." DAVID HELD, ET AL., GLOBAL TRANSFORMATIONS: POLITICS, ECONOMICS AND CULTURE 16 (1999). *See also* JAN AART SCHOLTE, GLOBALIZATION: A CRITICAL INTRODUCTION 16 (2000) (characterizing globalization as "a spread of supraterritoriality").

56. JAMES N. ROSENAU, ALONG THE DOMESTIC-FOREIGN FRONTIER: EXPLORING GOVERNANCE IN A TURBULENT WORLD 5 (1997).

57. *Id.* at 20.

58. *Id.* at 10-11.

59. RICHARD FALK, LAW IN AN EMERGING GLOBAL VILLAGE: A POST-WESTPHALIAN PERSPECTIVE 33 (1998).

60. For a concise version of Held's perspective on cosmopolitan social democracy, see DAVID HELD & ANTHONY MCGREW, GLOBALIZATION/ANTI-GLOBALIZATION 118-36 (2002) (discussing reconstruction of world order). In exploring the discourses of Falk and Held, I do not suggest that "law of humanity" and "cosmopolitan social democracy" neatly overlap.

61. FALK, *supra* note 59, at 34.

from its protective structures from the Treaty of Westphalia 1648 to the present day.[62] This has led to vicious tensions between global policies, incubated in multilateral forums exclusively by nation-states acting as repositories of political power within geopolitical boundaries often perceived as not fully protective of human well-being, and an animation of transnational civic society agenda involving human rights, public health, the environment, and other substantive areas where states and market forces are perceived to be endangering public goods.[63] Falk uses "globalization-from-above" and "globalization-from-below" to explore the tension at the two extremes of law of humanity. In his metaphor of "predatory globalization," Falk argues that the governance frameworks of international institutions are now manipulated by market forces.[64] In a capital-driven, non-territorial world order, most states, especially developing countries, are unable to protect their citizens against decisions and policies of the World Bank, the International Monetary Fund, and the World Trade Organization within the colossal edifice of economic globalization.[65] Similar to this, Held's cosmopolitan social democracy postulates that:

> Political communities can no longer be considered . . . as simply 'discrete worlds' or as self-enclosed political spaces; they are enmeshed in complex structures of overlapping forces, relations and networks. . . . The locus of effective political power can no longer be assumed to be simply national governments – effective power is shared and bartered by diverse forces and agencies at national, regional and international levels.[66]

Reconstructing world order based on cosmopolitan social democracy, according to Held and Anthony McGrew, revolves around respect for international law, greater transparency, accountability, and democracy in global governance, a more equitable distribution of the world's resources and human security, the protection and reinvention of community at diverse levels, the regulation of the global economy through the public management of global financial and trade flows, the provision of global public goods, and the engagement of leading stakeholders in corporate governance.[67] Applied to the global health context, other cosmopolitan scholars like Thomas Pogge argue that the current distribution in national rates of infant mortality, life expectancy, and disease can be accounted for largely by reference to the existing world market system.[68] In contemporary global discourses, it has now been recognized, at least

62. *Id.* at 35.

63. *Id.* In using Falk's argument, I do not suggest that nation-states will become completely irrelevant in global governance or that they will automatically cede a significant part of their powers to civil society. Rather, I suggest that nation-states are no longer the only actors in global governance. A genuine dialogue between state and non-state actors is critically needed to review and fill the gap in the Westphalian system.

64. RICHARD FALK, PREDATORY GLOBALIZATION: A CRITIQUE 56 (1999).

65. *Id.*

66. HELD & MCGREW, *supra* note 60, at 123.

67. *Id.* at 131.

68. THOMAS W. POGGE, REALIZING RAWLS 237 (1989).

at the doctrinaire level, that health is a global public good.[69] As well, there now exists some persuasive evidence anchored on solid facts that significant financial and technical resources are urgently needed to address the mortality and morbidity burdens of killer infectious and non-communicable diseases, and the deadly partnership of poverty and ill health, in order to boost disease surveillance capacity in most of the Third World.[70] The pertinent question is whether emerging global health accords like the *Global Fund to Fight AIDS, Tuberculosis and Malaria*, and the *International Health Regulations* are cosmopolitan enough to catalyze a change in the sovereign mindset of poor and wealthy nation-states in the Westphalian system. Do they attract enough attention and resources to address the stark realities of contemporary South-North health divide? Do these accords place humanity as the epicenter of their core framework? Although this article does not provide all, or indeed any of the answers, the fact remains that the promise of global governance as a weapon against advancing microbial forces is uncertain. National, international, and global health regulatory institutions, as presently constructed, look like Michel Foucault's "panopticons," a strict spatial partitioning through which the North can catch every exotic disease from the South before it reaches their borders.[71] Regrettably, this isolationist global health governance policy has betrayed the public health trust that should drive interstate relations in an interdependent world. Deploring the betrayal of trust on which humane global public health architecture is presently constructed, Laurie Garrett observed that:

> The new globalization pushed communities against one another, opening old wounds and historic hatreds, often with genocidal results. It would be up to public health to find ways to bridge the hatreds, bringing the world toward a sense of singular community in which the health of each one member rises or falls with the health of all others.[72]

Leading epidemiologist, John Last reminds us that:

> Dangers to health anywhere on earth are dangers to health everywhere. International health, therefore, means more than just the health problems peculiar to developing countries . . . . There are

69. *See* David Woodward & Richard D. Smith, *Global Public Goods and Health: Concepts and Issues, in* GLOBAL PUBLIC GOODS FOR HEALTH: HEALTH, ECONOMIC, AND PUBLIC HEALTH PERSPECTIVES 3-8 (Richard Smith et. al. eds., 2003) (analyzing how global public good for health concept can best be utilized); Inge Kaul, Isabelle Grunberg, & Marc A. Stern, *Defining Global Public Goods, in* GLOBAL PUBLIC GOODS: INTERNATIONAL COOPERATION IN THE 21ST CENTURY 2-20 (Inge Kaul et al. eds., 1999) (introducing idea of global public goods).

70. *See* REPORT OF THE COMMISSION ON MACROECONOMICS & HEALTH (chaired by Jeffrey D. Sachs), MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT 4 (2001) (recommending "that the world's low- and middle-income countries, in partnership with high-income countries, should scale up the access of the world's poor to essential health services."), *available at* http://www.un.org/esa/coordination/ecosoc/docs/RT.K.MacroeconomicsHealth.pdf (last visited Oct. 21, 2004).

71. For a discussion of Foucault's panopticism, see MICHEL FOUCAULT, DISCIPLINE AND PUNISH: THE BIRTH OF THE PRISON 195 (Alan Sheridan trans., 2d ed. 1995).

72. LAURIE GARRETT, BETRAYAL OF TRUST: THE COLLAPSE OF GLOBAL PUBLIC HEALTH 585 (2000).

> several good reasons why we should be concerned about world health. The most obvious is self-interest: Some of the world's health problems endanger us all.[73]

While globalization has immersed all of humanity in a single microbial sea, global health governance constructed on South-North dichotomy and isolationist paradigms have left a sizable percentage of humanity, especially in the developing world, multilaterally defenseless in the face of advancing microbial forces. It is up to the future of global governance to humanize emerging and future global health accords to tackle global epidemics like SARS.

73. JOHN M. LAST, PUBLIC HEALTH AND HUMAN ECOLOGY 337 (2d ed. 1998).