THE EVOLUTION AND DEVELOPMENT OF
INTERNATIONAL HEALTH COLLABORATION

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ABSTRACT

The goal of this thesis is to document and explain the evolution and development of international health collaboration. Utilizing international relations theory, the initial development of the health regulatory regime is traced through the early sanitary conferences. The establishment of international health organizations is then documented, along with the transformation this entailed in international health collaboration. The resulting effect the institutionalization of the international health regime had upon international health collaboration is finally presented.

It is determined that states initial interest in international health collaboration grew out of a concern for reducing the impediments to international trade and commerce that quarantine measures imposed. States were, at first, reluctant to collaborate, but as scientific knowledge increased, international cooperation in this area expanded. Realizing the benefits of joint technical cooperation, states formed international organizations. The special characteristics of international health under the guiding influence of medical specialists were to cause an evolution within this regime.

Collaboration in this area has greatly increased. The primary concern of the international health regime is no longer the containment of pestilent diseases without significant
interference to international commerce. This regime is now concerned with improving the level of health care to all states, regardless of the effects this might have on the interests of the developed states. Technical cooperation and aid to developing countries is now the central focus of the World Health Organization. This evolution has not occurred without some degree of conflict, however, as it is the developing states and the medical elites of the organization have forced the evolution of the previous norms of this regime. The developing states have a clear interest in securing assistance in developing their health infrastructures, and the elites of the WHO are committed by nature of their scientific training to work towards this ideal. The developed states are not in favour of this change as it threatens their interests and power within this regime. Although it initially appeared that collaboration in this area would be relatively easy to secure as an improvement in health would be to every state's benefit, this has not always been the case. International relations theory is utilized in this thesis to explain the origins, the obstacles, and the evolution that has occurred within this regime.
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INTRODUCTION

THE POLITICAL ASPECTS OF THE EVOLUTION OF INTERNATIONAL HEALTH COLLABORATION

Before the modern age of scientific knowledge, pestilent diseases were thought to be the punishment of the Gods. It was not until it was realized that epidemic diseases were transmitted through human contact that health care and disease prevention became an international issue, as these were problems that crossed national boundaries and jurisdiction. Originally, the method most commonly employed to contend with the spread of epidemic disease was quarantine, with the earliest example occurring in 532 AD when the Emperor Justine of Constantinople instituted it to combat the great Plague epidemic.\(^1\) Widespread use of quarantine did not occur, however, until later in the fifteenth century, when the maritime city-state of Venice instituted a quarantine where persons or goods were to be isolated, in a restricted location, for a specific period of time, believed to be equal to the incubation period for the disease. This was to be the model, being quickly instituted by other European nations. Soon after, bills of health were inaugurated, although they did not come into general use until 1665.\(^2\) Issued by the country of destination's consul, they were designed to prove that as of the last port of call, the suspected ship was free from disease, thus freeing a ship from a lengthy quarantine period.

Quarantine regulations varied from state to state and
bills of health were frequently subject to bribery and corruption. These incidents caused great inconvenience to passengers and considerable financial loss to trading nations. Financial repercussions were soon to become acute with the first effects of the Industrial Revolution beginning to appear in the nineteenth century. Trade had rapidly increased, facilitated by the development of the steamship in 1810, and the common utilization of rail transport as of 1830. Mounting pressure from these financial losses would finally force states to convene meetings in an effort to solve the obstruction that quarantines and bills of health were posing to trade at the international level.

Initially, various proposals were made with regards to the coordination of quarantine measures along the Mediterranean. Although an international conference was first proposed by France in 1834, it was not until 1851 that the European nations finally agreed to assemble to discuss this international issue. Another factor that prompted this conference was the Cholera epidemic that ravaged Europe between 1828 and 1831, causing states to adopt stricter and thus, more economically costly quarantine measures. At the same time several other international conferences were occurring to discuss other highly technical issues that crossed national boundaries, such as the ones that led to the creation of the International Postal and Telegraphic Union.

It was, however, the financial pressures that quarantine
measures were placing upon growing trade that finally provided the impetus that resulted in the first international action to address this common problem. As well, the increase in the numbers of people attending the Mecca pilgrimage had greatly contributed to the spread of cholera to Europe and by immigration to the Americas, when it had previously been relatively contained in India and the East.4

Countries weighed their participation in such a conference against their national interest. Those with the greatest amount of trade, suffering the most from quarantine, were consequently the most in favour of the regulation and limitation of these damaging measures. European states also wanted to protect their populations from these ravaging diseases. There was, however, a distinct geographical determination to those countries in favour of greatly limiting the use of quarantine and those that considered it vital that these measures remained in place. The Southern countries on the Mediterranean, the Italian city-states, Austria and Southern France, were closer to the source of epidemics, and were the most supportive of quarantine. The Northern states of Europe, especially Great Britain, who, due to geography, were less affected by the cholera epidemic and, had in general, greater financial interests in trade, were anxious for the removal of all unnecessary impediments to trade.

Quarantine measures were very much a European device to protect the developed or "civilized" countries from
contamination by the "barbarous" and underdeveloped nations. Gradually, and as a result of increased scientific and medical knowledge regarding the etiologies of these epidemic diseases, it was realized that the cordon sanitaire approach to the prevention of the spread of disease was not only scientifically misguided, but also financially costly. As knowledge of how to combat these epidemic diseases increased, it encouraged international collaboration and the creation of international health organizations.

As a result of international collaboration in this area, a health regulatory regime was eventually established to coordinate the various quarantine measures and bills of health. A regime may be defined simply as a set of principles, norms, rules and decision making procedures around which actor expectations converge in a given issue area. It should be pointed out that regimes refer to voluntary collaborative ventures undertaken by independent nation states. As the international system remains anarchical, with no supreme power, regimes have no power to enforce their codes or regulations. A state is then free to violate international regulatory codes; the only motivation for a state's compliance with a regulatory regime's provisions is to gain some item that it cannot secure independently.

In the case health the regulatory regime preceeded the establishment of an international health organization. When the Seventh International Sanitary Conference resulted in a
successful convention in 1893, this regime came into being. Its principles were: the regulation of international trade and travel with regards to the prevention of epidemic diseases, while ensuring a minimum of interference to these commercial activities. The health regime was to become more firmly grounded with the addition of several more Sanitary Conventions over the next ten years, culminating in 1903 in a single unified version.

Cooperation in this regime was soon to evolve beyond mere regulation, however. An international body, l'Office International d'Hygiène Publique, was formed to coordinate and administer the existing international health codes. This agency was very much a European organization, although the functions that it performed gradually grew until they were global in scope.

With the advent of the League of Nations in 1919 and the growth of international cooperation after the Second World War, the responsibilities of international health organizations grew tremendously. The international system itself had also grown to include those states beyond the borders of Europe and North America; it now encompassed many of the less developed states, whose numbers were to increase greatly in the period of decolonization. This expansion in the number of states and the general destruction that occurred as a result of the two great wars was to lead to an increasing role for international health organizations such as the International Red Cross, the League

At the national level states began to take greater responsibility for the health and well being of their individual citizens, and this principle was gradually transferred to the international level. It eventually became a norm in international society that health care was a right for each citizen, and furthermore, that it was the duty of more advanced nations to help those nations that were less developed or not as well endowed in health resources. The most concrete expression of this sentiment occurs in the Charter of the World Health Organization, where its stated objective is declared to be "the highest attainment by all peoples of the highest possible level of health". This is in addition to the previous norms of the regime, which were established by the developed states and imposed on their colonies. As a result of decolonization, these Third World nations have been successfully challenging the norms of the previous health regime, which existed for the developed countries' benefit. The World Health Organization has incorporated this new norm of primary health care involving a transfer of health resources in the new global health strategy, Health For All by the Year 2000. This development has not occurred, however, without some resistance on the part of both the developed nations and the international organization itself.

Ultimately this thesis will seek to examine and assess the
evolution within the health regime; how cooperation itself evolved in this area. In so doing, it will be necessary to first examine, the creation of the health regulatory regime itself, and its transition from the Sanitary Conferences to today's World Health Organization. Then, the evolution that has occurred within this regime will be outlined as well as the important factors that have shaped this development. Finally the obstacles that have existed and continue to exist to full cooperation in international health will be explored making use of several theories of international relations.

The first chapter will lay the theoretical groundwork for the evolution of the health regime. It will outline four theories of international relations, and show their relevance in explaining not only the development of the international health regime, but also the obstacles this process has encountered. The second chapter will detail the initial developments of the international health regulatory regime in the establishment of the sanitary regulations and codes. The third chapter traces the further developments in international health, from the establishment of the League of Nations to the creation of the World Health Organization. The fourth chapter is concerned with presenting the evolution that has occurred within the health regime and within the World Health Organization. The conclusion will interpret these developments and utilizing the applicable theories of internation relations explain the reasons behind this evolution. Ultimately, the
obstacles to full international collaboration in this area will be assessed, along with the implications they have for future international action in this area.
ENDNOTES - INTRODUCTION


4. Ibid., p. 38.


CHAPTER ONE

THEORETICAL FRAMEWORK - THE DEVELOPMENT OF INTERNATIONAL HEALTH COLLABORATION

From the perspective of most international relations theorists the international transmission of disease is an area where one would expect international collaboration to arise with relatively few obstacles, as disease is a problem that all nations face to a degree and the control of its spread cannot be achieved through the actions of one state alone. As well, it is believed that health is a relatively uncontentious issue amongst states; an area of "low" politics, not generally thought of as involving the security or economic well-being of a state. When the development of the international health regime is examined, however, one finds that collaboration did not occur as readily as some theorists of international relations would have predicted. International health issues have increasingly impinged upon issues of "high" politics, affecting trade and even the security of a nation state.

In examining the emergence of international health cooperation, four main approaches in international relations theory will be compared to explain the intricacies in this particular area of international action. They are the following: Realism, Neo-Realsim or Modified Structural Realism, Liberalism and Functionalism. Each one of these theories considers a specific factor to be the key explanatory
variable in explaining why collaboration has or has not occurred. Each explains a particular aspect of international health cooperation: the variables relevant to the actors, the level of scientific knowledge, and the state of international health at that time. Realism and Neo-Realism, it will be shown focus on the disadvantages of collaboration, and explain why states are unlikely to collaborate, or violate the terms of collaborative efforts. Functionalism and Liberalism are, on the other hand, more optimistic in their expectations for international collaboration; they predict instances where international collaboration is likely to occur.

Realists are concerned with the competition for power, specifically the power of one nation state in relation to all others, as expressed in both military and economic terms.

Modified Structural Realists propose that states' paramount concern is for their security or national autonomy, rather than their power relative to all other states. Maintaining the national autonomy and economic well-being of the nation state is the key factor in determining the possibilities of international collaboration.

Liberals focus on states' concern with national wealth. They want to eliminate impediments to international commerce and to ensure the continued growth of national prosperity. They would predict international collaboration to occur when impediments to international commerce are removed and when collaboration results in an increase in the wealth of nations.
Functionalism looks to international technical organizations to gradually overlay political divisions with common tasks. In this manner, war will become both impractical and unnecessary. According to functionalists, meaningful collaboration will occur with increased scientific knowledge and the participation of technical elites in trans-national ventures.

The above theories will now be considered in greater detail and their explanatory variables for international collaboration will be further explained.

REALISM

The theoretical construct of realism has, by and large, dominated the study of international relations. From the writings of Thucydides to Hans Morgenthau, certain essential concepts that form this theory's theoretical base can be seen consistently reappearing in the works of various realists. In general, realists believe human nature to be basically evil; human beings are concerned with acquiring as much power and influence as they possibly can for themselves. Human nature is also thought to be constant: there is little chance or hope for improvement. And unlike liberal theories of international relations, there is no belief in an underlying harmony of interests. As there is no superior force imposing order upon states, the actions of human beings and nations will naturally come into conflict and lead to war as each state struggles to acquire power to protect itself or dominate others. The world
of states is considered to be zero-sum: one state's loss is another's gain in terms of power and influence. This is the traditional realist viewpoint, best expressed by Hans Morgenthau in *Politics Among Nations*.¹

The essential tenets of realism, can be summarized as the following: states act in a rational manner and are the dominant actors in the international system; force is an effective method of achieving foreign policy goals, and security issues in general prevail over economic and social affairs in the determination of a state's foreign policy. Within the international system political integration among nations has only occurred to a slight degree and is transitory. As such, transnational actors have little or no power of their own.²

Recently realism has been modified to a certain extent so that it more closely corresponds to international developments of the post world war two era. Classical realism considered power, expressed ultimately in military terms, to be the predominant goal of all states.³ Modern realists, or neo-realists, believe that nation states are more concerned today with their security, taking into account more than just military power.

NEO-REALISM or STRUCTURAL REALISM

Neo-realists or structural realists have added to the traditional realist assumptions of human nature and the behaviour of nation states the concept of the international
system. This is described as anarchical, where the main ordering principle is self-help. A state's primary responsibility must be to guarantee its own survival in an anarchical system with other competing states. But as power is not the only factor in defining security, there are other goals that a state must seek to attain. Economic considerations can often be crucial to the national interest of a state. Some structural realists believe that states in the international system are growing more interdependent;⁴ that a state's national interest or security depends to an extent on its interactions with other states in matters where individual action cannot lead to an optimal solution.

Traditional or classical realism predicts little collaboration between states; states are considered unlikely to collaborate and will only enter into joint ventures when there is no political cost in terms of a loss of power or influence to them. Structural realism, in comparison to classical realism, is primarily concerned about the security of states within the international system. As such, collaboration is likely to ensue when a state's security would be enhanced to any degree without serious costs to another area. The world of nation-states is not seen as being zero-sum; states can trade off elements of their national security for increased commercial or other benefits. States are even likely to do this if it enhances their overall position within the international system. As such, states are likely to
collaborate when individual action does not lead to the best outcome in terms of national interest. States will collaborate to avoid a particular outcome or to ensure an optimal solution to a common problem.5 States will also participate in international regimes to overcome the barriers to more efficient cooperation, as they not only establish negotiating frameworks, but also facilitate decision-making by coordinating actor expectations and providing high quality informations.6

LIBERALISM

Where classical realism's expectations of international collaboration is small, and structural realism more optimistic, liberalism is certain that increased collaboration will occur, largely as a result of modernization.7 This school of international relations theory believes that increases in collaboration are inevitable as relations among nation states become more complex and interdependence amongst them grows. With the technical developments of the last century coming fully into force, trade has grown immensely and states have come into greater contact and conflict with one another than ever before. As a direct result this theory would argue that the structure of international society has changed completely.8

The classic goals of the realists, power and security, have been expanded or superceded by goals of wealth and welfare. Maintaining the security of its geographical boundaries has become less important for states than providing wealth and social welfare goals for citizens. States, in order to provide
for these new demands, have increasingly been forced to collaborate with one another, and in the process, to surrender some degree of their political autonomy. The key deciding factor in collaboration is whether this action will result in greater economic prosperity for a nation state, which is valued above all else. States have faced a dilemma: whether it was preferable to maximize the benefits of increased collaboration or to preserve political autonomy, as the benefits of close economic relations can be enjoyed only at the expense of giving up a certain amount of national independence or autonomy in setting and pursuing economic objectives.  

Essential to the liberal conception in international relations is the philosophy of Adam Smith. His belief in a harmony of interests -- that the actions of individuals fulfilling their own self-interest would result in an increase in the common good for all through the action of the invisible hand -- forms the foundation of the political beliefs of the liberals. As a consequence of his theory, liberals believe that the less government restrictions and regulation in the life of private individuals, the better. Following logically from the above argument, the less restrictions that were placed upon international trade, the greater the return on investment which would result in a larger increase in wealth for all states.

According to liberal theorists Richard Cooper and Edward Morse, states are no longer concerned solely with maximizin
their security. Instead of striving for power in terms of military might, a state's main interest is in economic issues and in the scope and terms of trade. The true problem now facing states is how to keep the manifold benefits of extensive economic intercourse free of crippling restrictions, while at the same time preserving a maximum degree of freedom for each nation to pursue its legitimate economic objectives. This conundrum is the result of modernization forces -- the corresponding centralization of government institutions and the predominance of domestic goals over external ones. As a state's wealth increases and every member of society experiences this improvement, internal demands are made for an expansion of this wealth: "once economic growth reaches high levels and sits as a continuous dynamic process increasing the real wealth of most members of society.... minds [turn] away from those foreign policy goals pursued by ruling elites of monarchical Europe and toward the further development of domestic wealth through domestic means and under peaceful conditions." States are, therefore, willing to give up political autonomy and sovereignty to achieve their economic goals. This contradicts the realist perspective that maintains that states will strive, above all else to maintain their political autonomy and security.

For Liberals the role of the nation state has also changed. The traditional power of the state has been undermined to a certain extent by the resulting interdependence
of nations conducting trade with one another. A state no longer has total control over its productive capacity and wealth if it relies on other states for raw materials or markets. Although Cooper and Morse's writings are specific to the post World War Two era, the developments of modernization forces had their beginnings in the technological advancements and trade liberalization movements of the nineteenth century.

FUNCTIONALISM

Functionalism, as espoused by David Mitrany, shares many of the underlying assumptions of the liberals and their criticisms of the realist view of the world. Present is a belief in the goodness of human nature and a harmony of interests ultimately guiding human action. Mitrany also believes that the nation state, constantly striving for power and security, is the cause of war. His remedy for this situation is for the traditional form of government to be superceded by supranational functional organizations. Designed to provide highly technical functions that could no longer be performed efficiently or effectively by national governments, these organizations would gradually grow in scope until a web of interdependence would link the interests of all countries, causing an end not only to war, but eventually to the nation-state itself: "functionalism overlays the political divisions with a spreading web of international activities and agencies in which and through which the interests and life of all nations would be gradually integrated."
According to functionalism, a key factor in determining the possibilities of international collaboration is the degree of technical specialization that a transnational problem requires before it can be successfully resolved.\textsuperscript{13} For Mitrany the roles of the scientific elites who manage these international institutions are important. He assumes that technical specialists share common knowledge and approaches and will put aside their political loyalties to perform their tasks in international institutions for the betterment of all, not simply for the sake of their own country.\textsuperscript{14} There will be no political overtones to international collaboration because of the nature of scientific elites. This is a result of the highly specialized training technical elites share; they speak a common scientific language, have been taught similar concepts, and strive for impartiality in achieving scientific goals. Further, these technical elites will pass down the lessons of collaboration to the general public. In so doing the lessons of technical cooperation in one international area will spillover to other areas.\textsuperscript{15} According to Mitrany, humans are capable of learning from their past mistakes. Collaboration will in time beget further collaboration.

Each of these theories of international relations creates a different perspective to the explanation of the development of cooperation in international health. Each highlights certain factors as being the key to the instigation of collaborative efforts. Classical realism considers the
survival and sanctity of the nation state to be the overwhelming concern of national leaders. This explains why collaboration in international health was so difficult to achieve in the first place. It further explains why states, even though they may recognize the necessity of common action would refuse to cooperate when their sovereignty or interests were seen as being threatened by international regulation. Liberalism and Functionalism, suggesting that there are other motivations behind foreign policy such as technical and economic factors, add another facet to the realist explanation for international collaboration. It was the commercial interests of states and their concern for increased wealth through trade that prompted cooperation. And scientific knowledge had to be advanced to a certain stage before collaborative ventures would ensue.

The international health regime has in fact substantually changed from its original form and it has had an effect on the actions and motivations of its members. Obstacles to collaboration have been gradually, yet consistently, removed. There is now a much greater degree of collaboration in this area than before. The reasons for this occurrence will be examined in light of the insights of international relations theory. The next chapter will review the origins of this process, the international sanitary conferences and the initial development of the health regime.


3. Morgenthau, p. 27.

4. This does not include Kenneth Waltz, who with his influential book, The Theory of International Relations is one of the pioneers of neo-realism. Other neo-realists, such as Keohane and Nye, fall into this category.


7. As stated by Edward Morse in Modernization and the Transformation of International Relations, (New York: The Free Press, 1976), p. 8-9. Modernization is identified as the resulting specialization, self-sufficiency and level of centralization that becomes characteristic of states after industrialization. This caused a revolutionary change in human life: overall population expanded as the available technology and resources grew to support more people.

8. Ibid. p. 89.


10. Ibid. p. 5.

11. Morse, p. 80.


13. Ibid., p. 27.

15. Mitrany, p. 44.
CHAPTER TWO

THE EARLY SANITARY CONFERENCES --
THE INITIAL DEVELOPMENT OF THE HEALTH REGIME

The history of the earlier international sanitary conferences is one of nations driven to international negotiation and regulation by a common danger, but completely unable to reach agreement because of the limitations of scientific knowledge. -- Norman Howard-Jones

INTRODUCTION AND SCIENTIFIC BACKGROUND

The history of the International Sanitary Conferences reflects the history of public health in an international perspective -- the first movement towards what today is the World Health Organization. This second chapter will document the historical progress of European states as they moved towards international regulation in a joint effort, not only to combat the spread of disease, but also to lessen the impediments quarantine measures increasingly posed to growing trade. Despite states' willingness to discuss these issues at the international level, progress was to come slowly to this area. It was to take seven actual conferences before a limited convention could be ratified by the necessary countries. The obstacles to agreement were, in part, due to a lack of scientific knowledge as expressed by the differing and opposing views on the transmissibility of pestilent diseases.

Cholera, the disease that caused the greatest concern
amongst Europeans, was spread through human contact. Governments reacted out of fear and sought to impose a cordon sanitaire between their nations and the affected areas. No westward spread of this disease had occurred until the nineteenth century. A special problem controlling the spread of cholera was presented by the large number of people participating in the Mecca pilgrimage, most often enduring crowded and unsanitary conditions during their voyage and stay.

The quarantine practices of the day were arbitrary and often destructive, resulting in considerable damage to both ships and their cargo. Goods were confiscated, or destroyed and travellers were subject to extensive periods of quarantine in questionable establishments that were virtual prisons. Clean bills of health, which were necessary to escape quarantine procedures, were often fraudulent, being highly susceptible to bribery. Quarantine practices were based to a great extent on superstition and hearsay, rather than on scientific knowledge and fact. Countries were in fact best protected by the development of good public health and sanitation services, which would greatly reduce the number of cholera attacks. Unfortunately, it was to take many years before the contagions of the major diseases were identified and these facts confirmed.

Opinions concerning the spread of these epidemic diseases were divided into two main groups, the contagionists, who believed that diseases such as cholera were spread through
direct human contact, and the anti-contagionists, or sanitationists who believed that the causes of cholera lay in unsanitary conditions of the victims' living quarters, food production and sanitation disposal. The British medical scientists were proponents of the latter position, while most of the other countries' physicians found credence in the former, contagionist explanation. Undoubtedly the British position had much to do with their commercial interests. England had the most advanced sanitary system and public health care system, as well as being geographically removed from the source of the spread of epidemics, the Middle East. As a consequence, Britain was far less affected by these diseases than were other European nations. As anti-contagionists, the British felt that quarantine measures were as likely to fail as they were to succeed. They further believed that medical inspection of ships and cargo at points of departure and arrival were as effective as quarantine in preventing the spread of disease as well as being far less damaging to commercial trade. Other countries would slowly acknowledge the logic of the British argument as their own trading interests grew.

As well as the growing medical controversy regarding quarantine, there was also political opposition to its imposition on the grounds that it was an instrument of state interference in private commerce. Some suspected that it was used for alterior motives such as espionage.
In Europe cholera had only recently appeared in epidemic form, previously being confined to Central Asia and India. It was considered a new and terrifying disease to Europeans who had not experienced a similar situation since the plague epidemic two centuries previously. Five cholera pandemics, beginning in 1818, were to strike Europe over the next fifty years. As a result of mounting public fear, states quickly increased existing quarantine practises which began to place severe pressure on the growing trade of European countries. Gradually, these obstacles were to force states to consult and devise measures against the common peril these epidemic diseases posed.

THE FIRST INTERNATIONAL SANITARY CONFERENCE: PARIS, 1851

The first proposal for an International Sanitary Conference was made by the French Sanitary Service as early as 1834, with the British later proposing one in 1843. Administrative difficulties, and a failure to agree on its necessity, were to pre-empt this conference for sixteen more years. Landlocked countries such as Austria, who were consequently less affected by the last cholera epidemic felt that the idea of an international conference was premature. When cholera reappeared in the third epidemic wave that century, it was finally concluded that this was a problem that must be approached and solved at the international level. The First International Sanitary Conference was convened in Paris on July 27, 1851. As the French Foreign Minister stated in his
opening address to the conference: "this was [to be] an age where all the industries of the universe seemed to have forgotten their former rivalries to join hands".

Twelve countries attended this conference; all were European and were represented by both a medical doctor and a diplomat, the latter to represent the commercial interests of their countries. The objective of this first conference was to "regulate in a uniform way the quarantine and lazaretto in the Mediterranean." Yet the debate at the conference was as much about epidemiological theories of the diseases between the rival contagionist and sanitation schools, as it was about standardizing quarantine regulations. This was a pattern to be repeated at future conferences.

The United Kingdom was the strongest opponent of quarantine, arguing the it was totally impotent in preventing the spread of epidemic diseases, whereas the Mediterranean countries as well as Russia were in favour of strict quarantine measures. France was divided between its regions; the Mediterranean ports approved of strict quarantine, while the Northern ports felt it threatened their commercial interests.

After six months of debate, five of the twelve countries had reached agreement on 137 articles that were to form the first International Sanitary Code. This code was not to be a success, however; it was ratified by only three countries and two later withdrew because of an inability to carry out the requirements.
Despite the apparent failure of this conference in terms of securing a lasting agreement, it provided an important precedent in many respects. A number of important principles had been agreed upon, which would later be embodied in international quarantine practices. It was agreed that quarantine was not applicable to ships with a clean bill of health; that maximum and minimum periods of quarantine were to apply, differing for each disease (plague, cholera and smallpox); that lazarettos should be hospitals, not prisons, and that quarantine dues should be uniform and not regarded as a source of revenue.\(^7\)

THE SECOND INTERNATIONAL SANITARY CONFERENCE: PARIS, 1859

As the first Sanitary Conference was clearly a failure by 1856, with the withdrawal of Portugal and Sardinia, the remaining signatory, France, proposed another international conference for 1859. Its objective was to draft a convention that embodied the principles of the first code that would be acceptable to all countries. As there had been great disagreements between the scientific experts the time before, only diplomatic delegates were sent. This time the political unrest of Europe and wide disagreement over the basic aims and elements of the convention were to keep new regulations from being concluded. Instead, the final draft contained only recommendations, was signed by the delegates of only eight countries, and was promptly forgotten, never to be ratified. Countries' views on the utility of quarantine had not
significantly altered from their stances at the First conference, eight years previously.

THE THIRD INTERNATIONAL CONFERENCE: CONSTANTINOPLE, 1866

In much the same way that the third onslaught of cholera had galvanized the European countries into initiating the First Sanitary Conference in 1951, the fourth wave of the cholera pandemic precipitated the third conference. The delegates of sixteen countries met at Turkey's invitation to discuss the origins of cholera, its transmissibility and propagation, special preventative measures with regards to the Mecca pilgrimage such as hygiene, quarantine and disinfection, as well as the route the 1865 pandemic had taken.\(^8\)

The objective of this conference was to find an effective means of arresting the spread of cholera, rather than the coordination of quarantine measures, which had been the main concern of the two previous conferences. The conclusions this conference came to were suprisingly accurate, despite the fact that cholera vibro would not be scientifically determined for another seventeen years. At this conference delegates agreed it was unlikely that cholera would become endemic in Europe as it was in India, along the Ganges River. It was also determined that the Mecca Pilgrimages were an important source for the spread of this disease, either through maritime routes, or alternately through rail.\(^9\)

On the basis of the above conclusions, the French proposed the immediate appointment of a committee to consider the
imposition of a ban on all maritime communications between Arabian ports and Egypt if cholera was again to break out amongst the pilgrims. The chair-elect, Stuart of Great Britain, moved, however, his committee be dismissed as it was not yet determined how cholera was transmitted. He further stated that he considered it to be his task, as the British delegate, to oppose any measures that would cause interference with trade, unless their necessity could be proven.\textsuperscript{10}

The Asian countries of Turkey and Persia also objected to this measure on the basis that it violated the sovereignty of the Muslim countries by imposing the customs, doctrines and logic of European nations on their subjects.\textsuperscript{11} Other delegates objected on the grounds that it would place the pilgrims in a considerable predicament if they were forced to return over land, through the desert, or worse, remain in Mecca indefinitely. Countries such as France, Portugal, Prussia and Spain, who felt they had a greater need for quarantine and possessed a greater belief in its efficacy, urged that the committee proceed with its original task of imposing a ban on communication between Egypt and other Arabian ports.

It was finally agreed that an official quarantine would be imposed if cholera did again break out at the site of the pilgrimages. As this convention was never signed, none of the participants were officially bound by this conclusion. Of later significance, Britian had agreed with the rest of the delegates that: "Asiatic cholera, which on various occasions
had travelled throughout the world, has its origins in India, where it arises and where it exists in a permanent endemic state." This point was to be later denied by Britain at subsequent conferences due to the implications it would have for British ships transversing the Suez Canal. Already the seeds of the later British position can be seen, for at this conference they were not prepared to admit that cholera was exported from India by ships flying the British flag. Britain did, however, admit to having a special responsibility with regards to controlling the spread of cholera from India, for which it proposed a series of sanitary improvements designed to contain this disease.

While no conventions resulted from this conference, it marked an advance in international public health. Sound principles were established for the control and spread of cholera at the Mecca pilgrimages, with emphasis placed upon the importance of measures being taken before departure. Yet the divergent positions of many countries regarding the principle of quarantine remained firmly in evidence. Issues of national interest prevented states from reaching an agreement. Turkey was concerned about its international reputation, its prestige and political autonomy. Great Britain had its financial interests clearly in mind at this conference, and other European countries were genuinely concerned with arresting the spread of cholera, regardless of the negative effects their provisions would have on other countries.
The Fourth International Sanitary conference was proposed by Russia in an effort to gain relief from the damaging quarantine regulations imposed along the Danube River. The official objective of the twenty-one states that attended this conference was to re-examine and codify the conclusions that were made at the Third Conference, eight years previously. The delegates to this conference were almost all medical scientists and the debate concerning the transmission of cholera continued unabated from previous years. This debate can clearly be seen in the commissions that were convened to prepare draft legislation for the regulation of quarantine in Europe. While it was easily agreed that land quarantine, considered to be "unworkable and consequently useless", should be abolished, the situation was to prove more confrontational with regards to maritime quarantine.14

Originally the committee proposed that quarantine should be replaced by rigorous medical inspection. This committee was largely composed of Northern European states, and the Southern states, who were more supportive of quarantine measures, moved that the committee be asked to make a further report, taking into account the "special conditions of quarantine in certain states of Southern Europe". They also requested that additional members representing these states should be added to the committee.15 While this motion was defeated it was decided that the committee's report should be revised to
include both principles of quarantine and medical inspection, but that they should only be recommendations, with each state being free to choose between the two, as long as they were applied in an uniform fashion. The lack of scientific knowledge and the clear differences in the perceived self-interest of Northern and Southern states was to prevent a successful conclusion of a sanitary conference for twelve more years.

Although this conference reached few conclusions, one positive development lay in its proposal for a permanent international commission on epidemics. It was declared that such an institution would be valuable "from the triple point of view of science, humanity and international material interests." Its duties were to include the study of epidemics; to present reasoned advice on the establishment and administration of quarantines; to consult with states regarding the above two topics, and to propose the convening of future international sanitary conferences when necessary. Despite the fact that this proposal was unanimously well received by the delegates it was not to be acted upon for almost thirty years. It was not until 1907 that the Office International d'Hygiène Publique (OIHP) finally came into being. At this time, certain governments were reluctant to act upon this proposal; they doubted the use and necessity of such an organization. The British, in particular, felt that it would be of little use: "we must confess to want of faith," reported
the British delegate, "in the value of co-operative international scientific work".\textsuperscript{17} Despite the fact that this proposal was not well received then, the OIHP differed little from the guidelines established at Vienna in 1874.

The opposition of the British to international regulation of health concerns must be understood in relation to their views on the utility of quarantine. As the foremost trading nation in the world at this time, quarantine had the greatest detrimental effect upon Britain. As the mood of international conferences often was contrary to British interests, favouring the retention of quarantine in some form or another, the British usually found themselves to be in the minority. They consequently grew more suspicious of the international sanitary conferences, as the measures they proposed would hamper Britain's significant commercial interests.

In the end, this conference added little to the development of international sanitary regulations, for it failed to reach consensus on any of the proposed resolutions. In fact, the final document, in approving of both the continued use of quarantine and also the new method of medical inspections, left countries free to do whatever they wished, as if the conference had never occurred. Surprisingly, there was little discussion of the ramifications of the Suez Canal, opened five years earlier in 1869, that would have a dramatic influence on the spread of cholera and future sanitary conferences.
The Fifth International Sanitary Conference was an anomaly in terms of the development and progression of these conferences. It had no logical connection to either the proceeding or succeeding conferences, and was the only one to be held off the European continent. It was held at the request of the United States of America to secure international assent for a piece of American domestic legislation that otherwise would be unenforceable. The United States was greatly concerned with controlling the spread of cholera and especially the spread of yellow fever, a disease that was localized to the Western Hemisphere. The US Congress had passed an Act in 1879 designed "to prevent the introduction of contagious or infectious diseases coming from infected ports abroad." The provisions of the act required that a vessel with a US destination possess a certificate from a US consular official "setting forth the sanitary history of said vessel". The United States believed that a lack of attention at the point of departure resulted in the costly application of quarantine restrictions at destinations, and sought to remove this unnecessary impediment to trade.

As the act stipulated that American consular officials were required to ensure personally the facts on the health certificates, foreign ships would have to be examined by US nationals. Thus, a ship could not embark on its voyage if bound for a US destination until it had been boarded in its
home port, inspected and given a clean bill of health by an agent of a foreign power. Objections were quickly raised to this proposal as it was regarded as an infringement of national sovereignty as well as a veiled criticism on the integrity of foreign sanitary offices. Spain and Italy, believing their own national systems of inspection to be adequate, felt particularly insulted and strongly resented the US's implicit charge. Great Britain, the Netherlands and Portugal suggested instead that each country's medical officials should be the ones to give bills of health, also resenting the thought of a foreign inspection of their ships. This proposal was easily defeated, largely as a result of the implications it would have had for each country's prestige and national sovereignty. A compromise was reached, however, whereby a consular official of the country of destination could endorse the bill of health and be present at the inspection of a ship, but the sanitary official of the country of departure would actually issue the certificate and conduct the investigation.

A significant proposal that emerged from this conference was for the establishment of an international organization to exchange epidemiological information. This suggestion as with the previous conference's proposal for a scientific organization to study epidemics, was slow in coming to fruition and emerged only in 1907, twenty-five years later.

An important scientific discovery that was to have far reaching consequences on the debate between the contagionists
and the anti-contagionists or sanitationists was also revealed at this conference. The yellow fever vibro was announced. The proposition that an insect, in this case a mosquito, could be the carrier of a disease, gave credence to both theories and had the effect of suggesting that both should also be followed to some degree. The discovery of the insect vector also formed the basis for the later scientific unravelling of the typhus and plague vibros, as they too were transferred from person to person through an intermediary agent.

This conference was unique in other ways besides being the only one to be held in the Western Hemisphere. It marked the first appearance of the United States in this forum, and was the first truly international sanitary conference, having twenty-six participants, many from beyond the borders of Europe. Included were seven Latin American countries and even Japan. The breadth of participation demonstrates how great the spread of epidemic diseases was at this time, reaching even into the previously uncontaminated "new world". It also shows how international regulation and action to control this situation was needed and was becoming more acceptable, in principle, if not yet in action, to all states.

THE SIXTH INTERNATIONAL SANITARY CONFERENCE: ROME, 1885

The Sixth International Sanitary Conference was prompted by the reappearance of cholera in Egypt in 1883. Initiated by Italy the objective of this conference was to secure an agreement on standardized requirements for quarantine, which
were still quite archaic despite previous conventions on the same issue. This was to be a practical conference, without reference to scientific debate or the causes and mode of transmission of cholera. The major issue of the conference was the regulation of quarantine along the Suez Canal, and despite good intentions, the old arguments of the sanitationists and the contagionists broke out once again.

At this time there was still great scientific debate over the causes of the spread of cholera. Although the correct means of transmission was identified as being through contaminated drinking water as early as 1840 by John Snow and in 1854 by Filippo Pacinni working independently, this fact was not to be recognized for another half century. Instead the views of Max von Pettenkofer, who believed that the cholera vibro was transmitted through an intermediary agent such as water, soil or air, held sway. The person normally credited with discovering the cholera vibro, Robert Koch, announced the discovery of this bacillus in 1884, and proposed that its method of transmission was through contaminated drinking water. This was not well received by the British, who refuted the idea of a specific contagion, as they had the most to lose by admitting that the disease was spread even indirectly through human intercourse. The intensity of this scientific debate was to prevent the conclusion of a successful sanitary code for another ten years.

In the discussions at this conference, Great Britain,
supported by the United States and Denmark, wanted to replace the old method of quarantine with medical inspection. Over their objections, the conference recommended the re-introduction of a twenty-four hour period of observation for all healthy ships passing through the Suez Canal, and a three to six day quarantine for healthy persons from infected ships. Italy and Austria-Hungary, feeling at the greatest risk of infection, were the strongest supporters of this re-imposition.

Britain and its colony, India, were represented by strong anti-contagionists who, throughout the conference, sought to have all restrictions on the passage of their ships removed. This led the other delegates to accuse them of placing their trading interests above the common concern of international health: "The Gladstonian government," said the German delegate, "[is] brutally setting aside the most elementary regard for international safety." Britain staunchly defended its actions by citing the fact that cholera had never been directly imported into Europe by a vessel reaching the Mediterranean from the Suez Canal. Britain further asserted that the idea that cholera was imported from India was nothing but a preconceived notion, unsupported by evidence, despite the fact that its delegates had agreed to this "fact" at the Third Conference some twenty years earlier. In the interval, British trade interests had grown substantially, due in part to the opening of the Suez Canal. Now Britain maintained that cholera was transmitted by the pilgrimage to the Middle East
and then to the rest of Europe. As further proof of the worthlessness of quarantine, Britain cited the fact that despite its close connections and trade with India they had not had an epidemic outbreak of cholera for close to twenty years.

While the British referred to the lessons they had learned through their experiences controlling pestilent diseases in India as being the reason why they so strongly opposed quarantine, the damaging effects these measures had upon their trade must also be viewed as a major factor. Four out of every five ships transversing the Suez Canal were British, most of them originating in India. As the British ambassador noted in a letter to the President of this conference, the three to six day period of quarantine that was suggested would reduce the time saved by utilizing the Suez Canal to two days, and add further to the costs associated with the canal, which were already little less than the additional costs of rounding the Cape itself. As such, the British refused to sign the final convention and the sixth conference was adjourned without results.

SEVENTH INTERNATIONAL SANITARY CONFERENCE: VENICE, 1892

The Seventh International Sanitary Conference was to provide the first limited success for these endeavours. A limited regulatory code was imposed on ships traveling home from the Mecca pilgrimage. Austria-Hungary had proposed this conference and had made special efforts to secure British participation. Since the last conference, seven years earlier,
Britain had not changed its position regarding quarantine and was not anxious to resume international discussions on a subject where it was consistently outvoted. Austria-Hungary promised to "endeavour to exclude from discussions at the conference everything that might seem unacceptable to English interests". Austria-Hungary had recently concluded a protocol with Britain whereby British ships could pass freely through the Suez Canal if bound directly for a port within the United Kingdom. At the opening of this conference they suggested that other countries agree to a similar protocol. The British had proposed this same idea at the last conference in Rome and now added the promise that sanitary guards would board the vessel for its voyage through the Suez to ensure that the ship's passengers and goods did not come into contact with the shore or other ships. This proposal was quickly vetoed by the other countries' delegates who pointed out that there was no method of ensuring a ship could transverse the Suez Canal without meeting objectionable weather forcing it to land. The German delegation sarcastically commented on the "suprising coincidence between England's commercial interests and its scientific convictions." 

A limited agreement was reached, however, concerning the Mecca Pilgrimage. All ships returning northwards with foul or unacceptable bills of health had to undergo a minimum quarantine period of fifteen days. This instituted a system of protection for Europe against the importation of cholera from
the pilgrimage, a measure that was to be reinstated from time to time even into the twentieth century. This convention was relatively easy to secure as it was limited to pilgrim ships and thus did not encroach upon British commercial maritime interests in the slightest.

It had taken forty-one years to achieve a limited international agreement to restrain the spread of epidemic diseases. Progress was now to quicken in this area with the scientific discovery of many of the vibros of the pestilent diseases. The announcement of the role of the insect mosquitoes in the transmission of yellow fever at the fifth conference had been followed by the discovery of the cholera vibro in 1884. Although this discovery initially supported the views of the contagionists, it gave future conferences a scientific base from which these matters could be discussed. Consent was far from unanimous as to the cause and means of transmission of the cholera vibro. Was cholera a contagious disease, spread through human contact and foul drinking water, or were individuals predisposed to the disease by virtue of some mysterious element, as the British believed? This question was soon to be answered by medical science.

EIGHTH INTERNATIONAL SANITARY CONFERENCE: DRESDEN, 1893

The Eighth International Sanitary Conference was again initiated by Austria-Hungary in the hopes of reaching agreement on a set of codified quarantine regulations for Venice in much the same way that the seventh conference had established
regulations regarding the Suez Canal. Austria-Hungary was greatly concerned with the serious impact quarantine measures, imposed the year previously as a response to the fourth cholera epidemic, had upon both international travelers and commerce. These restrictions were not "justified by the requirements of a sanitary service based on the results won by modern science". Opinions regarding the utility of quarantine were beginning to change in the face of modern developments in both science and trade, as Austria-Hungary's change in opinions demonstrates. Originally Austria-Hungary did not view quarantine measures as an issue in need of attention; their position then switched within a few years from one of complete disinterest to being strongly supportive of quarantine measures and, further, to viewing these measures as being obstructive to their trading interests.

Not all nations were ready to abandon their trust in the values of quarantine, however. When Russia was to propose at the Eighth Conference the removal of all sanitary regulations on the Danube River, citing the damaging effects this had on international traffic, this idea was strongly opposed by Romania. As a result, all non-infected ships on the Danube had to endure a three day quarantine. In order to secure the support of other nations for this decision, Romania had to point out that only a minimal amount of Russia's shipping transversed the Danube. This exchange is evidence of the growing concern that many nations were beginning to feel
towards the necessity of securing the removal of financially damaging impidements to trade.\textsuperscript{28}

Agreements were quickly reached on the findings of the scientific committees of the Eighth Conference and it closed a little more than a month after it had convened. In the resulting convention ten European nations promised to notify each other quickly if any outbreaks of cholera broke out within their territories, and also agreed to specific regulations of what was permissible in their quarantine procedures. The only goods that were to be subjected to restrictions were bed linens and rags, which could either be prohibited or disinfected, but were not quarantinable. Letters and newspapers were to be free of all restrictions and to travel freely between countries. Land quarantine was forbidden and travellers could only be detained if they displayed symptoms of cholera.\textsuperscript{29} As it had now become widely accepted that cholera was not in fact transmitted by direct human contact, but that unsanitary conditions played a great role in its transmission, these agreements were relatively easy to secure.

\textbf{NINTH INTERNATIONAL SANITARY CONFERENCE: PARIS, 1894}

The French initiated the proceedings for the Ninth International Sanitary Conference to complete the process that had begun with earlier conferences, the sanitary control of the Mecca pilgrimages. At its opening, the President of the conference stressed the need to eliminate once and for all the major factors in the westward spread of cholera, which had been
determined earlier at the Seventh Conference in Venice (1892). At this time states had agreed on steps to prevent cholera from spreading to Egypt and the Mediterranean. This minor success was followed by the Eighth Conference in Dresden (1893) where states agreed to a system of notification for the outbreaks of cholera and on the maximum precautions to be taken in the event of a such an occurrence.30

The approach taken at this Ninth Conference was to differ significantly from previous ones, as countries were now less concerned with the regulation of quarantine than with the reduction of the possibility of the spread of disease at its source, the pilgrimages themselves. By this time the sanitationists had largely defeated the rival contagionist school, hence the attention devoted to preventing the transmission of cholera at its source. A convention was drawn up that included: proposals for mandatory hygiene on pilgrim ships, the establishment of additional facilities on the route of the pilgrimage, and a "means test" for the pilgrims at their point of departure. This last item was the source of strenuous objections from Britain and from Turkey whose assent would be necessary before the code could be put into practise. Turkey refused to sign this convention on cultural and religious grounds; it reported that the pilgrimage was one of the five basic commandments of the Muslim religion and it could not be forbidden by any international convention or code. Britain's refusal was, in part, due to the impossible burdens
this would have placed upon their Indian colony. This position also must be seen as reflective of their assertion that cholera was not endemic to India. As the two countries whose assent was vital for the Ninth Convention to be put into practice refused to sign, this conference added little to the development of international sanitary regulations. It is significant, though, that it was the third such conference in the short space of two years, demonstrating the importance and urgency that states were beginning to place on international action to control the spread of epidemic diseases such as cholera.

TENTH INTERNATIONAL SANITARY CONFERENCE: VENICE, 1897

This Conference differed from past conferences in one major respect. While the others had been convened to deal specifically with cholera, (with the exception of the fifth that was primarily concerned with yellow fever), the primary purpose of the Tenth was to discuss methods to curtail the epidemic of plague that was then spreading throughout Europe. Austria-Hungary had proposed this meeting out of fear that its pilgrims would return with this disease. Many European countries had already forbidden their citizens to attend the pilgrimage and others such as Austria-Hungary adopted special measures to deal with this looming health crisis.

The first order of business for this conference was to secure the ratification of the 1894 convention on cholera. This effort met with little success except for the addition of
Britain as a signatory. A new convention was drawn up, however, and signed by eighteen countries. It dealt with both external and internal European measures to control the plague, the disinfection of ships and goods, and the surveillance that was to be performed by the Egyptian and Constantinoplian Sanitary Councils. A provision that healthy passengers and ships were to be given free passage regardless of the state of the bills of health was adopted, demonstrating the advances that had been made in defeating the principle of quarantine. Obligatory telegraphic notification of the first cases of plague was also unanimously accepted by all countries, even those that did not sign the convention, namely the United States and Denmark. Nation-states were beginning to realize the importance of epidemiological information being relayed between countries as effective tools in controlling the outbreak and spread of pestilent diseases.

Despite the promise of all signatories to implement immediately this convention, it was not to provide much relief for shipping interests, as it was really a patchwork of solutions. To remedy this situation, the suggestion was made that a technical commission be established to harmonize and codify the four previous conventions, although this practical solution would not be acted upon for six years.

ELEVENTH INTERNATIONAL SANITARY CONFERENCE: PARIS, 1903

The convening of this conference was a result of many factors. In the first place, if only for administrative
purposes, there was an obvious need to consolidate the accomplishments of the last four conferences into one coherent document. Second, a congress of shipping interests meeting at Vienna in 1902 had strongly recommended to their respective governments that another sanitary conference be convened for the same purpose. Trade was by now an important source of national revenue for all European states. Competition amongst them was fierce as they sought to secure as much profit from their overseas colonies as possible. As liberalism ruled the political discourse of the day, known impediments to trade were being abandoned as quickly as possible.

This conference was held in Paris during the fall of 1903 at the invitation of Italy. This conference had been convened in the belief that new scientific knowledge of the etiology of pestilent diseases called for a revision of the existing international sanitary codes. It had been determined since the last conference in 1897, which had dealt almost exclusively with the plague, that rats played a fundamental role in the epidemiology of this disease. It had also by now become known through scientific discoveries and medical advances that the main items to be eliminated or neutralized in controlling the spread of pestilent diseases such as cholera, the plague, and yellow fever, were unsanitary living conditions, rats and insects such as fleas and mosquitos. Yellow fever, still regarded primarily as a North American issue, was not to be considered. This conference, as with the previous ones, was
designed to protect Europe from the exotic diseases of other lands with which it came into contact through trade. The countries of the Americas were thus tackling health issues by themselves. Two American Sanitary Conferences had already led to the creation of the Pan American Sanitary Bureau in 1902.

The Eleventh Conference had in fact succeeded in its objective of uniting the four previous conventions into one international sanitary code. It was signed by twenty countries, and by 1907 sixteen of them had ratified the convention. This single code replaced the near anarchy that had previously existed with various conventions regarding the imposition of quarantine. The period of allowable quarantine was further reduced from fifteen days to a maximum of five. In practice it was becoming increasingly popular to replace quarantine with a system of medical inspection. Moreover, the new convention contained two obligatory principles. The first was the necessity of a state informing all other signatories of the appearance of an epidemic disease within territory under its jurisdiction. The second was that states, upon being notified of such a situation, would not impose measures against the afflicted country in excess of what was prescribed by the convention. These principles were based on the lessons learned over the past half century of international disease control. While it was important to control the spread of disease, it was now agreed that measures could not unnecessarily interfere with trade. These two principles formed the basis
of the international health regulatory regime and remain today as essential components.

CONCLUSIONS - THE EARLY CONFERENCES

Although it seems as though the early conferences accomplished little, they did in fact contribute slow yet steady progress towards the development of today's health regime. By their very existence the early conferences led countries to accept international discussion and action on controversial questions that involved domestic medical practises and trade questions, which previously would have been regarded as issues of national jurisdiction only. They also brought arbitrary and corrupt quarantine practises under the scrutiny of public debate. In demonstrating the damaging effects and the inadequacy of the contagionist theories, these conferences quickened the search for more rational and scientific premises to explain the spread and the necessary treatment for these pestilent diseases.\(^{35}\) The French delegate to the Eleventh conference (who had attended all since 1871, with the exception of the Fifth) pointed out, "that although it appears that the first six conferences accomplished little, with no conventions resulting, they had in fact, contributed to the disappearance of excessive, absurd and even barbarous measures".\(^{36}\)

After fifty-three years an acceptable and inclusive sanitary code was duly signed and ratified by a sufficient number of states. An international health regulatory regime had
been created. It contained two essential principles that remain in the health regime today, although in a somewhat diluted form. The first was to contain the spread of epidemic diseases, and the second was to ensure the first without imposing unnecessary barriers to the free flow of goods and commerce. There are also two reasons why this event finally came to pass. The first was undoubtably the mounting pressure that growing trade had placed upon nations to eliminate or, at the minimum, to reduce and standardize the existing quarantine regulations that had proved to be such great impediments to the free flow of trade. Second, advances had been made in medical knowledge and science regarding the sources of these pestilent diseases which allowed states to reach agreement on the most effective methods of controlling the spread of disease. It is clear that without these two developments, agreement would not have been possible in this area of international collaboration.
ENDNOTES - CHAPTER TWO


2. Ibid, p. 38.


5. Goodman, p. 43.


8. Ibid., p. 279.


10. Ibid., p. 235.


15. Ibid. Italy was the exception.


17. Cited in Goodman, p. 60.


22. Ibid., p. 379.

23. Cited in Gooman, p. 64. Quotation if from a speech by the French Delegate, quoting an article that appeared in the Hungarian Press.


27. Cited in Howard-Jones, p. 414. Included in the introductory address made by the Austo-Hungarian delegate at the Eighth Conference.


29. Ibid.

30. Ibid. p. 455.


33. Ibid. p. 465.

34. Gear and Deutchman, p. 281.

35. Ibid.

CHAPTER THREE

THE INSTITUTIONALIZATION OF THE HEALTH REGIME --
THE ESTABLISHMENT OF INTERNATIONAL HEALTH ORGANIZATIONS

While the art of healing and the prevention of disease is essentially world-wide, the technical method of its application had been too often limited by politico-geographical boundaries.

-- Melville D. Mackenzie

The successful adoption of an international sanitary code in 1903 after almost fifty years of effort was to foreshadow the achievements of international public health this century. This chapter will be concerned with outlining the developments originating in the latter part of the nineteenth century that manifested themselves in both the creation of international health organizations and in the adoption of several comprehensive sanitary codes. These developments were largely the result of the changing scientific philosophy for treating epidemic diseases. Quarantine was increasingly being replaced by a policy of disease containment. Instead of erecting barriers to prevent the spread of disease it was decided to contain disease through epidemiological surveillance. This had become increasingly necessary as new developments in transportation reduced international travel time to below the period of incubation for most diseases. As a result, quarantine was no longer an effective means of disease control.
It was realized that epidemic diseases must be arrested at their source, before they could spread to other populations. This philosophy of disease containment was not to be fully realized until the creation of the World Health Organization in 1948. The seeds of this philosophy can be recognized, however, in the actions and deeds of the Health Organization of The League of Nations and the health organization that preceeded it.

ORGANIZATION INTERNATIONAL D'HYGIENE PUBLIQUE 1907-1948

Acting upon a recommendation from the last International Sanitary Conference in 1903, the first permanent international health organization, the Office International d'Hygiene Publique (OIHP) was founded in 1907 at a conference in Rome. This organization was to be located in Paris, with the French also taking responsibility for drafting the constitution, reflecting their long-standing interest in international health regulation. Thirteen countries attended the inaugural conference and with the exception of Brazil and the United States, the delegates were all European. Notable for their absence were the countries of Germany, Austria-Hungary and Scandinavia.

The purpose of the Paris Office, as the OIHP soon became known, was: "to collect and bring to the knowledge of the participating states the facts and documents of a general character which relate to public health, and especially as regards infections diseases, notably cholera, plague and
yellow fever, as well as measures taken to combat these diseases.\textsuperscript{2} This office was also to provide a link between medical and scientific advances throughout the world and to keep the sanitary conventions up to date. In actual practise, however, the organization was later to take on a much greater role in international health regulation. Most importantly the Paris Office became a clearing house for epidemiological information. Future sanitary conferences were to bestow upon the office the duties or receiving, organizing and transmitting to members' public health offices information regarding the status of communicable diseases such as the plague, cholera, yellow fever, typhus and smallpox, as well as lists of ports with sanitary equipment for deratification. Gathering this information enabled the office to publish the Weekly Epidemiological Report, which was useful in ensuring the compliance of the Sanitary Codes, as nations who were traditionally concerned about falling prey to a spreading epidemic were able to ascertain the true status and risk a disease posed to them. Gathering such information was the first step in epidemiological disease containment.

The need for an international health institution had finally, after many years of discussion, become obvious, as had the need for a central unit to interpret and monitor the sanitary conventions. The coordination of research under one organization avoided costly duplication of scientific enquiries, saved time, effort and money, and ensured that
epidemiological information was quickly transmitted to all members. All states would now have the benefit of scientific knowledge and expert assistance.3

The Paris Office held its first meetings on the fourth in November, 1908, with nine countries attending. And although this meeting produced little practical results, it is important to observe that its orientation differed little from the attitude of the early sanitary conferences. Once again the essential aim of the exercise was to protect Europe from the importation of cholera and the plague.4 Consumed largely with administrative details, this conference did not actually begin to discuss the technical questions of pestilent diseases until the spring of 1910. The health agenda was also significantly broadened; where the focus had previously been on contagious diseases such as cholera, the plague, smallpox, and occasionally yellow fever, biological standardization had now become a topic for international action. For example, discussions took place on the necessary measures to ensure that the diptheria antitoxin was of equal potency in every country. Attempts were also made to coordinate the reporting weeks for health statistical purposes. These efforts at the standardization of epidemiological reporting were to be continued under the auspices of future international organizations as well.

The Paris Office began preparations for the revision of the Sanitary Convention of 1903 at its fifth session. Members
agreed at this time that the sanitary precautions regarding cholera would be the main item on the agenda, with some discussion on plague and yellow fever actually taking place. The membership of this organization had expanded beyond the confines of Europe; it had risen from nine to twenty-two states in just two short years. Now delegates from as far away as Australia, Algeria and even Canada attended, and countries that had earlier expressed reservations about joining the Paris Office agreed to send delegates to this preparatory meeting. A notable exception was Great Britain and India, relying not for the first time in the history of the sanitary conferences on their own judgement regarding health safeguards and the imposition of quarantine.

TWELFTH INTERNATIONAL SANITARY CONFERENCE: PARIS, 1912

The Twelfth International Sanitary Conference was attended by forty-one countries, including China, Siam and sixteen delegations from Latin America. Although this conference had no formal connection with the OIHP other than preparatory consul, it made use of OIHP studies and background material, and the staff of the Paris Office were invited to attend and participate in the deliberations.5

As it had by now been scientifically determined that healthy persons could carry the cholera vibro, the question repeatedly raised at this conference was how long could an otherwise healthy person be reasonably quarantined? Despite the fact that international commercial interests desired less
rigorous quarantine periods, the general public exerted great pressure on states to retain quarantine as protection against these pestilent diseases. In the end it was decided that "in a country where sanitary conditions are good, the danger of the importation of cholera by germ carriers is minimal". It was to be left to individual countries to decide whether further bacteriological testing would be necessary.\[6\]

The last meeting of the OIHP had confirmed the role that rats played in the transmission of bubonic plague. It was therefore strongly recommended at this time that all merchant ships undergo systematic and periodic deratting of their ships, to control the spread of this disease.

Yellow fever was again raised in discussion as a disease meriting international attention, but as in previous conferences it was perceived to be a "North American phenomena". Therefore, and in the words of the British delegate, "it was inappropriate to discuss it at a European conference."\[7\] This comment sparked a debate as to whether there should continue to be a distinction between the two International Sanitary Conventions, one consisting of European states, the other of non-European states. Besides initiating their own sanitary conferences, the Americas had also formed their own separate health organization, the Pan American Sanitary Bureau. Created in 1901 to gather and report epidemiological information within the Americas it had already produced two Sanitary Codes. Its primary function was to
similar to the OIHP's. It formulated sanitary agreements and regulations with the objective of reducing quarantine requirements to a minimum.\textsuperscript{8} Controlling the spread of yellow fever was a major concern of this organization, but protecting the United States and other American countries from the importation of pestilent diseases from European immigrants became a later function of this organization.

The Twelfth conference was concluded, after much debate, with a convention designed to replace the existing Sanitary Code. The general trend towards reducing the application and damaging effects of quarantine was maintained. Provisions were also made in the convention for controlling the spread of yellow fever, although the two sanitary conferences were to remain separate. The inclusion of this disease in the European regulations demonstrates the beginning of the gradual expansion of the sanitary regulations to include diseases outside the immediate concerns of Europe. Unfortunately, the implementation of this code was delayed for eight years as a result of World War One; it did not actually come into force until 1920.

THE EFFECTS OF WORLD WAR ONE ON INTERNATIONAL HEALTH COLLABORATION

World War One, lasting from 1914-1918, wreaked havoc not only upon the physical and economic well-being of countries but also upon the very fabric of European society itself. The destruction of several European countries' social infrastructure in the aftermath of World War One was to have a
great influence on the development of international public health. Issues of public health had largely been neglected during the war years, with states instead concentrating all their efforts on fighting the war. As a result of the deteriorating health and sanitary conditions, Europe, was struck with massive epidemics of influenza and typhus, which were particularly severe in the eastern sections of Poland and in Western Russia. The seriousness of this situation caused the Organization International d'Hygiene Publique to reflect upon its essential purpose. When the OIHP resumed meetings in 1919 its President suggested that as a result of the war there was now a need for a change in orientation of international health affairs. The idea of erecting a barrier against contagious diseases as with quarantine was declared to be scientifically outdated. All efforts were now to be directed at eliminating these epidemic diseases at their source through well developed public health services in all countries. Unfortunately this progressive attitude was not to remain characteristic of the OIHP. Staffed largely by seasoned veterans of earlier sanitary conferences, it was resistant to change and new epidemiological theories. Furthermore, the Paris Office, as primarily a monitoring agency, was not empowered or equipped to provide the necessary aid required to remedy the drastic situation in Eastern Europe at this time. This was a task for the International Red Cross, an organization that had been very successful in mobilizing both
funds and volunteers to aid the victims of the war.

After the war, the League of Red Crosses believed it should continue its original goal to aid humanity by combatting disease throughout the world.11 This coalition of organizations was actually the first to take steps towards the creation of a postwar international health organization. In April 1919 representatives of five national Red Cross organizations met to discuss the founding of an international Red Cross society that would cooperate with the League of Nations in "a systematic effort to anticipate, diminish and relieve the misery produced by disease and calamity."12 In so doing, it would of course cooperate with the existing international public health institution, the OIHP. This cooperation was not to be as easy to secure as it was initially thought.

DIFFICULTIES IN INTERNATIONAL HEALTH COLLABORATION—INSTITUTIONAL LOYALTY

The League of Nations, designed specifically to safeguard and promote the peace, also created several technical bodies. Included in its Covenant were three articles that deal with the matter of international health. Article Twenty-Three stated that the League of Nations was: "to endeavour to take steps in matters of international concern for the prevention and control of disease." Article Twenty-Five further stated that: "members of the League agree to encourage and promote the establishment and cooperation of duly authorized voluntary National Red
Cross associations, having as purposes the improvement of health, the prevention of disease and the mitigation of suffering throughout the world." While the League was fully supportive of the Red Cross initially, especially as the Treaty of Versailles did not come into force until January 1920 and current health problems needed immediate attention, it also had its own aspirations as an international health organization. Included in the Covenant was Article Twenty-Four which states that "there shall be placed under the direction of the League all international bureau established by general treaties if the parties to such treaties consent." In effect, this provision called for the OIHP to be subsumed by the activities of the new international health organization of the League. This was a proposal that was to prove impossible to secure, as later events will demonstrate.

At first, the OIHP had given its assent to a merger when the League of Red Crosses Society had suggested it in 1919. Yet six months later this organization had clearly changed its mind: it rejected the move indicating that only the original signatories of the OIHP's Rome Convention could alter its assigned functions and purposes. While the Paris Office agreed to have technical relations with both the League and the International Red Cross, it believed it must also act to preserve its own independence and autonomy. The French delegation had objected to the merger proposal at the last moment. They were greatly involved in this organization as both
the original instigator and as the home of the organization. Its demise might possibly result in a loss of prestige and influence for the French that they could not recapture in the League's organization. They were supported in this view by the United States which had failed to ratify the Covenant of the League and, as a result, refused to allow the Arrangement de Rome to be rescinded and the OIHP to be absorbed into the League.

Meanwhile the League of Nations had been unable to proceed with any of its functions. All of its efforts and energies were consumed in attempts to gain the cooperation of the Paris Office. The League of Red Cross Societies had grown, both in size and budget; several top-level medical scientists participated in its activities. At this time, it was the only effective international public health organization, publishing not only a monthly bulletin, but also, the bimonthly International Journal of Public Health, both of which dealt exclusively with epidemiological reports.

The deadlock between the League and the OIHP continued unabated until June 1921 when the League proposed an ingenious solution, that was to have far reaching consequences on the development of future international health organizations. A "Provisional Health Committee" was to be created, consisting of fourteen individuals who were to be selected by the Council of the League on the strength of their technical qualifications, and not on the basis of their nationality. This device
allowed members of the Paris Office to participate in the Health Organization of the League's activities. Twelve of the fourteen committee members were in fact members of the Permanent Committee of the OIHP, but participated only in their personal capacities. The League of Red Crosses and the International Labour Organization each also sent a delegate. This committee was to consult with the OIHP whenever circumstances required. Except for routine communications and the exchange of epidemiological information, real collaborative efforts between these two organizations was to remain nonexistent.

An important precedent was established by the efforts of the Health Organization of the League to surmount the obstacles regarding cooperation with the OIHP. The invitation to delegates to attend the League's health conference in their own personal capacity as health experts, as opposed to being representatives of their national governments, established the principle that members of international health organizations should be selected as individuals according to their scientific and technical merit, a principle that remains intact in the WHO today. While the WHO is at times politically charged due to ideological debate, the League largely avoided this fate as a result of this compromise. The League devoted itself almost exclusively to technical issues. This situation allowed the Soviet Union to participate in the International Health Committee of the League, which was vitally necessary,
considering the state of its national health, but was unlikely, considering the political tension between the Soviet Union and the rest of the members of the League.

The dispute between the Health Organization of the League and the OIHP was not the first time that international politics had intruded upon what was supposedly an organization dedicated to providing a mechanism for peaceful multilateral consultations between all nations of the world, assisting in the exchange of information in technical fields, including, of course, the prevention and control of disease. At the initial meetings where the Health Organization of the League was created, the French physicians declared that, while they were grateful for the honour of cooperating in such a humanitarian endeavour, this participation could not be interpreted in any way as suggesting that they were now prepared to take up relations of any kind with the nations they had fought against in the Great War. The political world continually intruded upon attempts at technical cooperation. This situation, despite the advances in scientific knowledge and cooperative spirit, remains virtually unchanged today.

Later attempts were made to rationalize the structure of international public health, especially when the League of Red Crosses began to collapse in 1923 after the wartime enthusiasm responsible for their initial success began to fade into the background. Efforts at rationalization were constantly opposed by the OIHP. Its strongest supporter was the American
government, which did not want the Paris Office to be engulfed by the League, as the United States would then lose its foothold in international health affairs. Other countries also opposed this merger, however: Britain refused to condone such an action until American representation was secure in the League, and the French also objected, for reasons of prestige. All efforts at reconciliation ended in failure; the OIHP and the Health Organization of the League continued to collaborate only as much as necessary while remaining totally independent. This situation was to last until the conclusion of the Second World War and the formation of a unified international health organization in its wake.

The state of international public health between the two world wars was one of flux and change. Older health organizations, still advocates of the ancient practises in public health, were slowly fading into the background while the Health Organization of the League, embodying the newer beliefs in international hygiene and disease control, began slowly to gain in both credibility and support. The Health Organization of the League greatly expanded its original functions. It created a Far Eastern Bureau located in Singapore to report on the epidemiological situation in the Far East, especially with regards to the plague. It also took over the publication of the "Weekly Epidemiological Report" in which facts gathered by the OIHP were distributed to members of the League. Valuable in the control of disease, this report continued to be
published throughout the Second World War when most other functions of these two organizations were discontinued. Advances were also made in establishing minimum acceptable standards in fields such as nutrition, housing and rural hygiene towards which all nations were to strive.

THE HEALTH ORGANIZATION OF THE LEAGUE ON NATIONS

The League inaugurated a new form of international health cooperation with its Malaria Commission. It enjoyed great success in controlling malaria's insect vector through repeated spraying of insecticides. This body was to foreshadow the new form of international technical commissions that would be created under the United Nations. The object of the Malaria Commission was not only to study and advise countries on the best means of controlling malaria within their boundaries, but to institute a new approach in international health, which went beyond the cordon sanitaire approach of quarantine to combatting diseases wherever they existed by controlling their spread. Work had also started on the standardization and unification of various pharmacopias, which would eventually have a great influence on the pharmaceutical industries of the developed countries. All of these functions were to provide the foundations for the technical assistance programs of the future World Health Organization.

These achievements greatly differed from the approach of the OIHP, which remained firmly rooted in the epidemiological goals of the past -- to keep pestilent diseases outside Europe
and North America, and to limit restrictions on international trade and commerce. There was little concern with taking any action to alleviate either the suffering or the causes of these diseases themselves. The antiquity of the Paris Office's mission was perceived at the time. It did not enjoy the respect of the scientific community which the League's Health Organization came increasingly to possess. The OIHP was by then considered to be largely "a club of elderly health bureaucrats ... that had been reluctant to renounce the gastronomic and other delights of Paris". For the two interwar decades it was viewed as the only obstacle to the realization of the ideal of a single worldwide international health organization. This goal was finally achieved with the formation of the World Health Organization in 1948, which owed much of its heritage to precedents established by the Health Organization of the League.

While the Health Organization of the League was increasingly providing both advice and aid for countries to deal with their internal health care problems, the Paris Office was still concerned with the supervision and regulation of international quarantine measures. For instance, in 1924 it oversaw an agreement signed in Brussels by fourteen countries regarding arrangements for the treatment of merchant seamen suffering from venereal diseases. The OIHP also made the necessary advance preparations for International Sanitary Conferences, still largely concerned with the regulation of
quarantine in order to lessen the impediments to commercial traffic, while protecting the Western developed world from the importation of exotic diseases. These guiding principles were already well established; they now had to be applied and reinterpreted for a changing world in terms of transportation and mass travel. International commerce demanded the extension of the principles of the health regime to cover new areas of concern that had only recently arisen with modernization.

THIRTEENTH INTERNATIONAL SANITARY CONFERENCE: PARIS, 1926

The Thirteenth International Sanitary Conference was convened in 1926 (the seventy-sixth year of such meetings), to debate again the virtues of land and sea quarantine. Sixty-five states assembled in Paris to consider whether modifications to the 1912 convention were necessary. Technical commissions studied three health problems: cholera, influenza and the control of rats in preventing the plague. In each case it was decided that quarantine was not the most effective means of containing the spread of these diseases. States again expressed reluctance in detaining otherwise healthy cholera carriers. With similar reasoning, it was decided that influenza was far too prevalent to be the subject of quarantine restrictions. Instead of the quarantine of suspected ships and their cargo, it was determined that the destruction and control of rats was the best prevention for the spread of bubonic plague. Two additional diseases were added to the international public health agenda at this time: typhus, which
had struck Europe in epidemic proportions following the First World War, and smallpox.\textsuperscript{21}

As demonstrated by these decisions, states had begun to move firmly away from the old fashioned concept of quarantine and bills of health. In its place, international certificates were being issued to certify the deratification and health of ships. Decisions regarding the health of ships were to be assessed on the basis of their actual condition once reaching their destination, rather than at their point of departure, as was the previous practise. Furthermore, quarantine, if it was to be imposed at all, was not to exceed the maximum limit as decided by this sanitary convention.\textsuperscript{22} These measures acted to reduce greatly the remaining health-related barriers to the free flow of trade and commerce. The convention was duly signed by all members and remained in force until 1952 when the World Health Assembly drafted a new version.

At this conference political overtones once again overshadowed the spectre of international collaboration in this supposedly noncontentious area of international relations. The United States made it expressly clear when signing the final convention that this act in no way implied its recognition of another signatory. This move was aimed at the USSR, also a signatory, with whom the United States was not to enjoy diplomatic relations for another seven years.\textsuperscript{23}

Egypt also expressed its extreme displeasure at the continuance of the Sanitary Consul that had been established
the century previously to oversee maritime quarantine for the Suez Canal. This organization, administered by foreign powers, was an affront to Egyptian sovereignty. Egypt's public health care system, its delegate reported, could easily perform this task. This situation was rectified twelve years later at the Fourteenth International Sanitary Conference in 1938, where it was the sole item on the agenda. At this same convention a clause was inserted in the 1926 convention which made the Permanent Committee of the Paris Office the "court of arbitration" for the interpretation of sanitary conventions. This development shows states' growing recognition on the need for arbitration in interpreting international health regulations. States were still imposing excessive measures in violation of international arrangements if they felt it was in their national interest to have additional protection. And countries adversely affected by these actions wanted recourse to an impartial body for adjudication.

This was to be one of the last International Sanitary Conferences, as it was a mode of international health cooperation that was rapidly becoming outdated. Comprehensive sanitary arrangements had already been concluded for most epidemic diseases, and only periodic updating was needed to respond to new developments that affected their operation.

As a result of increasing air travel it soon became obvious that the previous sanitary regulations would need to be modified to administer adequately this new area of
international concern. This time a conference was not called, the documents were merely circulated and in 1935 the International Sanitary Convention for Aerial Navigation came into force. Agreement had been relatively easy to secure for the principles of sanitary control and regulation were no longer contentious. The underlying assumptions of the international sanitary regulations had been established at earlier conferences creating an international health regulatory regime. Its norms and principles were designed to ensure the maximum security against the international spread of disease with a minimum interference with world traffic. The aerial convention was, in fact, the maritime regulations of 1926 adapted to the conditions of air travel. Previous conventions had dealt only with the regulation of maritime quarantines, as it had earlier been established at the Fourth International Sanitary Conference that land quarantine was both impractical and useless in preventing the spread of disease.

Eventually, as international travel became more extensive, the norms of this sanitary regime would be updated and significantly changed. This process would not truly begin until after the Second World War, however, when technological developments would precipitate a revision of health regulations. This would not be the first, nor the last, occasion these changes would have this effect upon the health regime.

THE EFFECTS OF THE SECOND WORLD WAR ON INTERNATIONAL HEALTH COLLABORATION
With the eruption of war in Europe yet again, the scope of international public health returned to its former role of epidemiological reporting and the provision of emergency aid. The Health Organization of the League continued to exist throughout the war. Its reputation was greatly reduced, however, as the stature of the League of Nations declined. Along with the remaining members of the OIHP, it continued to publish the Weekly Epidemiological Report and provide as much epidemic intelligence as possible, but this became increasingly difficult as the war progressed. New developments, pioneered by the work of the Health Organization of the League in areas such as nutrition and housing standards, and the feasibility of health insurance schemes, were forced to be abandoned in order to deal with the larger health problems that the war created. Although these were to be limited ventures, they were to foreshadow the next stage of international public health development. In its short duration, the Health Organization of the League had managed to shift the purpose of international health cooperation from limiting quarantine measures and arresting the spread of disease from underdeveloped nations, to attacking these pestilent diseases themselves, by improving the strength of the developing world's health care services. This change was brought about largely as a result of the technical nature of the Health Organization of the League's work. Technical elites assessed situations on the basis of medical need, rather than political orientation. For this reason
certain activities of thes organization were highly successful.

POST WAR HEALTH COLLABORATION - THE UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION

Immediate action was needed to respond to the health care emergencies World War Two created. The Allied countries moved quickly to establish the United Nations Relief and Rehabilitation Administration (UNRRA) in 1943. They recalled the health disasters that followed in the wake of World War One. Smaller health agencies were formed initially, such as the Inter-Allied Post-War Relief Committee in 1941, but it soon became clear that a much larger organization would be needed to deal with the approximately fifty to seventy-five million people who would be medically destitute after the liberation of Europe.

Health care was only a small part of UNRRA's duties, yet it was one of its least controversial and most successful activities. It was, at its time, the largest intergovernmental cooperative effort in the field of health. The aim of this organization was to provide for the liberated population of Europe: relief from immediate suffering; food; clothing; shelter, and assistance in the return of prisoners and exiles to their homes. Also required, as a result of such a large displacement of persons, were measures of aid in the prevention of pestilent diseases.

This organization also instigated epidemic control measures through the distribution of medical personal, supplies
and sprayings of DDT. This was to eliminate the typhus, malaria and yellow fever vectors. Outbreaks of cholera, plague and the more social epidemic diseases such as tuberculosis, influenza and venereal disease also necessitated UNRRA's attention. In addition to these functions, in 1945 UNRRA replaced the Paris Office in the administration and reporting of epidemiological information.

UNRRA was by its very nature a temporary solution, designed to bridge the gap between the two world health organizations. In 1946 its funds and duties were transferred to the Interim Commission of the United Nations. This allowed the continuance of aid to countries still in need, while avoiding the political disputes that had arisen over the administration of UNRRA supplies. The Allied countries of the West had declared that they were not prepared to continue supplying this organization after 1946, as they believed they were receiving nothing but opposition and hostility in return from the recipient nations. This, no doubt, referred to their disappointment over the political orientation of the countries of Eastern Europe. This move was regarded by the USSR as proof that East and West could not cooperate. This development was not to set a positive note upon which to initiate the United Nations as the first global peace and social welfare organization.

ORIGINS OF THE WORLD HEALTH ORGANIZATION

Although international public health had been a prominent
aspect of the League of Nations, the need for this service was abundantly clear in the aftermath of the Second World War. This topic was initially overlooked in the discussions leading up to the formation of the United Nations; it was not until the United Nations Conference on International Organizations at San Francisco that the idea of including international health as a field of UN activities was raised. Discussion on this matter was instigated by the Chinese and Brazilian delegations. Their initiative in this matter is significant as it came from two developing countries, suggesting the future orientation of this organization. As time progressed this organization would come to increasingly represent the interests of the developing nations, whereas previous international health institutions, on the whole, were created by the developed nations to serve their interests.

Article Fifty-Five of the Charter of the United Nations recognized health as an international field for United Nations activities, while Article Fifty-Seven provided for the establishment of a specialized health agency with wide powers. A technical Preparatory Committee met in 1946 to discuss the form this organization should take. At this meeting the constitution of the organization was drafted and agreement was reached regarding the fate of previous existing international health bodies. The Health Organization of the League's functions were to be completely taken over by the new United Nations health organization, and this time the scientifically
and medically outdated Organization d'Hygiène Publique was absorbed without a struggle.

Yet the formation of a single, centralized international health body was not to occur with complete ease. This time the Pan American Sanitary Bureau objected to its proposed takeover by the WHO. The countries of Latin America strongly opposed this measure. They wished to preserve their ability to form a regional body, as they had been able to secure in the provision for regional collective defense under Article Fifty-Two of the Charter of the United Nations. A compromise was reached, however, whereby the Pan American Sanitary Bureau became a regional body within the World Health Organization. The PASB continued to perform its traditional functions, but with the WHO remaining superior in establishing the general goals and objectives for the organization. The end result of this action was to create a highly decentralized international organization.

Representation in this organization was designed to be global in scope. All nations were invited to join, even those who were not members of the UN. As well, within the organization all members were to be equal. There were no permanent functions assigned to any specific member, although in practise those nations with the highest level of technical expertise came to yield the most influence. In a manoeuvre carried over from the provisions of the Health Organization of the League, delegates were to be chosen according to their
technical competence in the field of health, and were not merely to represent their country, but the principles of international health care in general. Further, it was suggested that delegations come from the national health administrations of members, as opposed to the departments responsible for foreign affairs. The WHO desired technical, as opposed to political, representation, and to this end established the practise of communicating directly with national health ministries. Although interference from foreign ministries, by their very nature political in orientation, could not be totally eliminated.

The fundamental differences between the World Health Organization and its precursors can best be found within the constitution of the World Health Organization. Article One states that: "the objective of this organization shall be the attainment by all peoples of the highest possible level of health". Further, in Appendix Eight to the constitution, health is defined as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The WHO was founded upon the idea that more was required from an international health organization than an international system of defence against common diseases. One of its declared functions was to
strengthen the health services of member governments through programs of direct technical assistance. This doctrine is stated in the first Annual Report of the Director General of the WHO: "the World Health Organization's fundamental objective is to strengthen the health services of member governments." It reappears later in his third report: "WHO's third full year of activity was characterized by the gradual, but unmistakable development of a world health consciousness and by a broadening of the general concept of the right to health."

In its first few years, the organization was to continue with the old pattern of serving the interests of the developed states, at the expense of those who most needed their assistance. The organization was to be further delayed from implementing its stated long-term goal of improving the health of all citizens by the emotional appeal of a short-term solution to the problem of contagious diseases by initiating a selected program of disease eradication. Despite these occurrences, the WHO was an improvement over past international health organizations. The scope of collaboration broadened, and a true progression in the work of the organization can be seen developing over the years. This progression will form the subject of discussion for the next chapter.
ENDNOTES - CHAPTER THREE


5. Ibid., p. 495.

6. Ibid., p. 497.

7. Ibid., p. 496.


11. Ibid., p. 1.

12. Ibid., p. 13.

13. Ibid., p. 15.

14. Ibid., p. 16.

15. Ibid., p. 29.

16. Ibid., p. 7.

17. Ibid., p. 11.


27. Ibid. p. 138.

28. Ibid. p. 147.

CHAPTER FOUR
THE WORLD HEALTH ORGANIZATION
AND THE EVOLUTION OF THE INTERNATIONAL HEALTH REGIME

The problems of economic, social and technical development for all nations have evolved in such a way since 1945 as to make organized international cooperation across all barriers of politics, ideology and culture a sheer necessity if each of them is to reap the benefits of the new developments in science and technology without creating tensions and risks.

- Dag Hammarskjold

INTRODUCTION AND EPIDEMIOLOGICAL REVIEW

In 1945, the year of the formation of the World Health Organization, traditional epidemic diseases that had sparked the implementation of quarantine were receding, with other contagious diseases arising to take their place. The list of epidemic diseases of the last century - cholera, the plague, and yellow fever - was revised now to include smallpox, typhus, malaria, influenza, and poliomyelitis. The control of the more social diseases such as tuberculosis and venereal diseases was now pursued by the Western nations. As previous methods of disease containment had not proven effective in preventing epidemic invasions, it was decided to embark upon a new course of action, a select policy of eradication, to eliminate the epidemic foci of certain diseases at their source. Before World War Two there had not been adequate scientific knowledge to embark upon such a campaign. Instead, attempts were made
only to contain disease. Quarantine had been used as a means of protecting the developed European countries from the spread of Asian disease. Yet these measures had not only proved ineffective in achieving their goal, they also came under increasing criticism for their detrimental effects on international trade.

With the establishment of international health organizations at the turn of the century, attempts were made to move beyond a purely defensive response. It had by this time been scientifically confirmed that the best method to control the spread of epidemic disease was to develop a country's public health facilities, thereby increasing its internal resistance to disease. For this solution to be enacted both technical and financial aid was needed for the developing countries, which more often than not was where the spread of these diseases had originated. They lacked the basic resources to implement such a program on their own. The Health Organization of the League of Nations had attempted to reorient public international health in this direction by initiating studies that determined guidelines for minimum standards of hygiene, nutrition, and sanitation services. This organization, unfortunately, lacked the resources and political power to put any of their studies' conclusions into general practice.

Despite the progressive nature of the World Health Organization's stated goals to promote the welfare of all
citizens through the strengthening of the health services of member states, international health collaboration was to progress only slowly from its former concern with defense against the spread of disease toward the establishment of these newer ideals. Although the WHO embraced the idea that more was required of an international health organization than an international system of defense against common disease, the initial actions of its Interim Commission were very much a continuation of the traditional work of previous international health organizations. These duties centered primarily on epidemiological reporting and providing emergency aid for outbreaks of contagious disease when they threatened the interests of the more developed nations. For instance, during its brief history, cholera had again broken out in Egypt and immediate action was needed to contain its spread before it reached the Mecca pilgrimages. The Mecca pilgrimages were again a source of international concern and action because of their potential to spread disease normally epidemic only in Asia to the uninfected West.

During its two year tenure the Interim Commission of the World Health Organization was not concerned with eradicating contagious diseases at their source, only with containing their spread to uninfected areas. This action was again required when Italy and Greece, in their weakened condition, succumbed to an extensive attack of malaria. They received quick attention from the Commission, even though the malaria
infestation in these two Western developed countries was not nearly as severe as it was in many of the lesser developed members of the WHO. This point especially demonstrates the strong continuity between the WHO and previous health organizations. For the first few years the programs of this organization continued to center on providing emergency relief and protective regulation to the developed countries.

PROGRAMS OF DISEASE ERADICATION

It was not until its second decade that the WHO was to embark upon a program of disease eradication. It first singled out malaria at the Eighth World Health Assembly and later embarked upon an international effort to eliminate the scourge of smallpox at the Eleventh Assembly. The first of these efforts was an abysmal failure; the second was to prove eventually a complete success. The reasons for one program's effectiveness and the other's failure are very much related to the scientific natures of the two diseases. Malaria is spread from person to person, through an intermediate agent, the mosquito. As there is no vaccine for malaria, repeated spraying of insecticide is necessary to destroy the insect vector. Few of the lesser developed nations possessed the medical, technical, or financial resources to guard constantly against a reoccurrence of this disease. As well, social customs, such as nomadic migrations and the seclusion of women greatly increased the difficulties involved in disease control. A further difficulty was posed by the tendency of mosquitoes
to become resistant to insecticides, which in any case were only effective for a short duration. What was most damaging to this campaign, however, was the complacency that developed after the initial outbreak was under control and contained. Constant vigilence is required to prevent a reoccurrence of the disease in epidemic form. Yet a substantial portion of the countries where the disease was endemic were reluctant to accept the implications of this epidemiological fact and preferred, instead, to devote resources elsewhere.

Smallpox, in comparison to malaria, was a much easier eradication program to implement. A protective vaccine had been in existence since 1798. What was needed was a system and program of global innoculation. The vaccine needed to be strengthened and improved first, however, so it could withstand long storage times in hot climates. A special bifurcated needle was also developed under the auspices of the WHO's technical research programme on smallpox eradication and this greatly improved the efficiency of vaccination. It had been demonstrated that eradication from an endemic area can be realized when eighty percent of the population is successfully vaccinated within a time period of five years. This is considerably easier to achieve than what appears to be necessary to eliminate malaria.

The World Health Organization was central to the development of these programmes, providing both technical assistance and medical personal to countries that lacked
adequate resources of their own. A central body was needed to coordinate the planning for these campaigns, for political boundaries are illogical parameters within which to conduct an eradication program. It proved to be quite easy to secure the necessary approval of states for these programs, as the costs of eradication were often less than the economic cost that the diseases themselves enacted in terms of losses to the labour force. For instance, according to a WHO sponsored study, "malaria is the most expensive disease in the world; it stunts the physical and mental growth of persons, hampers the community in exploration of national resources, reduces agricultural production and impairs industry and commerce."³

In the developed countries these pestilent diseases no longer posed a substantial health risk. Most were eradicated and, if an outbreak did suddenly occur within these countries, it could be quickly contained by their well-developed health care systems and resources. And yet the developed countries were supportive of these eradication programs. One explanation as to why is the emotional appeal of eradication programs. It was very much in the spirit of the United Nations to embark upon such a worthwhile humanitarian venture. Supporting such a proposal would only enhance a developed country's international standing with the newly independent members of the WHO. This no doubt was one of the motivating factors behind the Soviet Union's proposal for a global eradication program for smallpox.

Moreover, the degree of international travel had also
undergone a great expansion. Developed nations required travel to be safe from the spectre of infectious diseases, as well as to be fast and efficient and free from the delays of quarantine. International traffic is one of the foundations of modern economic development. Efficient trade requires the control of epidemic diseases and the elimination of lengthy quarantine periods. Tourism was also an area of growing economic importance to many countries. This industry could be greatly damaged by an outbreak of a contagious disease. Further, with the growing interdependence of the world's economies and the emergence of multinational firms, operating on a global scale, disease control was clearly desirable. It was desired by the developing country, hoping to attract such a firm, and by the multinational itself, needing a healthy workforce and not willing to expose its own employees to possible unhealthy situations.

THE INTERNATIONAL HEALTH REGULATORY REGIME - THE ISSUE OF SANITARY REGULATIONS

The old methods of disease containment, quarantine and bills of health, were increasingly proving to be ineffective as well as scientifically outdated. One of the first functions of the World Health Organization had been to revise and amalgamate all of the previous sanitary conventions, even though they had not proven to be very effective in their stated goals of ensuring the maximum security against the international spread of disease, with a minimum amount of interference with world traffic. The recently updated version of the sanitary
regulations, originally implemented in 1952, did not prevent an outbreak of cholera in Asia and the Middle East in 1961. There were also constant instances of noncompliance with the sanitary regulations that not only damaged any effectiveness they might have had, but increasingly brought the credibility of these regulations into disrepute.

The 1952 edition of the sanitary regulations contained several new provisions that were a significant improvement over earlier versions. Recognizing that one of the most troublesome aspects of earlier conventions was securing their ratification, the new edition of the sanitary code had abandoned the traditional treaty form. Instead, upon becoming a member of the WHO under Article 22 of its Constitution, the sanitary regulations were to come into immediate effect, unless a state notified the Health Assembly within nine months of its reservations regarding certain Articles. This process, termed "contracting out", was suggested by the American delegation and was agreed to by the Interim Commission after a brief debate regarding its implications for state sovereignty. In the end it was decided that as these regulations governed only highly technical issues they would not endanger the power of the nation state in a significant fashion.

The WHO was also given, under Article 21 of the Sanitary Regulations, wide authority to draw up regulations on any new health issue that might arise. To date it has not exercised this option.5 "Footnotes" are used instead as additional
recommendations added on to provisions in the sanitary regulations that permit the organization either to interpret or amplify specific components of the regulations. The option to use this procedure to implement policy changes, as opposed to the more formal procedures in Article 21, is evidence of the WHO's efforts to preserve a noncontentious role in matters of international health.

If a state has objections to particular regulations, it can choose to adopt the regulations with reservations against specific articles. The assumption behind this provision is that by allowing states to opt out of particular regulations for specific reasons it will encourage more widespread compliance of them overall. There is, however, a three year time limit on reservations and they must be approved by the World Health Assembly. This prevents the emasculation of the regulations and ensures that reservations do not in fact constitute an actual rejection of the sanitary regulations.

Article 99 of the Sanitary Regulations also allows for states to adopt, under "special arrangement", health measures in addition to those prescribed in the sanitary code. The underlying purpose of this provision is to facilitate the eventual application of the sanitary code in its original and complete form. Special arrangements are to be utilized when a particular health situation warrants them. For instance, countries that consider themselves to be at great risk because of their lack of public health facilities can impose sanitary
provisions in excess of the regulations to protect themselves from a contagious disease that has not yet infected their population. In such a case, a special arrangement can be in the best interests of international public health. Again, as with reservations, special arrangements are limited to interpretation by the Health Assembly; if not considered to be justifiable, they are deemed excessive and prohibitive.

Reservations have proven very useful over the years when utilized by states who agree with the regulations in principle, but, for unforeseen circumstances, are unable to comply with them. Ethiopia established this precedent in 1951 when it reported that it would have serious difficulties complying with regulations to notify outbreaks of contagious diseases because of poor communications between the capital and the country, although it accepted the principles of the sanitary code.⁸

The advantages of contracting out are obvious. It allows the quick submission and approval of the highly technical international sanitary agreements, as well as flexibility in updating these regulations to meet current situations.⁹ Over the years there has even been a drop in the number of reservations, as states are increasingly able to adhere to the norms of the sanitary code in greater detail. ¹⁰

The norms of the health regime are not, however, synonymous with the stated goals of the World Health Organization. The norms of this regime are still based largely on principles established during the sanitary conferences.
This regime had undergone a period of transition, with the formation of international health organizations. The degree of this evolution can be seen in the general principles that were drawn up to guide the drafting of the new sanitary regulations:

1. Accurate and rapid notification are the basis of effective measures against the international spread of disease and there should be a withdrawal of restrictions on international traffic as soon as the danger of infection is passed.

2. Each country should develop its internal resistance to disease rather than rely on measures taken at frontiers.

3. Measures taken at frontiers should be the minimum compatible with the existing sanitary situation. Excessive measures not only exert undue interference with traffic and have severe economic consequences, but by their very excess might lead to deliberate evasion of the sanitary code and thereby defeat the original object.

While these principles show the continued presence of the norms of the earlier health regime, the prevention of the spread of disease with a minimum amount of interference with international traffic, they also codify two new concepts in international health protection originating from the work of earlier international health organizations. The first is the value of epidemiological notification in containing the spread of disease; the second is the value of increasing a country's internal resistance to combat disease itself.
To further the first of the above principles, all members were required to transmit accurate and rapid notification on any outbreaks of specific diseases. At the formation of the WHO these included yellow fever, cholera, plague, and smallpox. This list was a reduction in the number of diseases covered by the previous agreement of 1926.

The second principle advocating countries develop their own internal resistance to disease forms the justification for the many technical and direct assistance programs. This new development is still not totally accepted by all members of the organization, but it was approved by the technical elites, who put this policy into practice. It was also significant as the adoption of this policy is a further demonstration of the abandonment of quarantine as a public health measure.

The third principle reasserts the norms of the earlier health regime by stressing that the health measures contained in the regulations are the maximum allowable. Under the WHO, it was still an important component of the regime to preserve the free flow of international trade.

The regulations themselves were largely concerned with halting the spread of disease through the provision at airports and ports of proper medical facilities to treat communicable diseases. The sanitary regulations constituted the maximum procedures allowable in terms of demanding health certificates and imposing quarantines, anything above these provisions is deemed to be an "excessive measure" and is subject to review by
the organization. The WHO assumes that the sanitary provisions contained in its regulations will be effective in countering the spread of disease, and that along with a regular flow of information regarding the status of these communicable diseases, they will discourage the deployment of excessive measures.

The regulations can be viewed as part of an evolutionary process. Bills of health were finally abolished and the process of contracting out made the adoption of regulations and their subsequent ratification much easier. This enabled more states than ever before to become signatories to this set of sanitary regulations. For the first time the sanitary regulations were in complete harmony with modern public health and epidemiological theories. Quarantine had been replaced by a system of epidemiological intelligence and notification.

**NON-COMPLIANCE AND THE SANITARY REGULATIONS**

Despite these evolutionary advances in the 1951 sanitary code, states continued to violate these regulations for a myriad of reasons. Some states were not able to implement the regulations, lacking the adequate technical resources, while others preferred their own solutions to the ones suggested in the sanitary code. There are two particular areas of noncompliance: notification of an outbreak of reportable diseases and the imposition of excessive measures. The extent of noncompliance has been extensive in certain areas, enough to question the feasibility of the health regime itself. The
successful functioning of the health regime is based, in part, on states notifying the organization of outbreaks of contagious diseases. Aid and technical resources can then be concentrated in this area to enact a rapid solution to the problem. If states fail to notify, the spread of disease can grow and this, in turn, prompts states to impose extra measures to protect themselves from an apparently uncontrollable epidemic. Ironically, failure to notify the outbreak of a particular disease is often motivated by fear of the imposition of excessive measures. It appears to be in a state's best interest both to comply and not to comply with the sanitary regulations. To comply with them allows for quick action and promotes confidence in the regime, but also entails the risk of other states imposing excessive measures against their trade or nationals.

The application of sanitary regulations for a nation state is balanced against its economic and administrative concerns. Reporting the outbreak of a notifiable disease is regarded by many developing countries as the mark of a Third World country and entails a loss of prestige. Admitting the existence of one of these pestilent diseases can also greatly harm the tourist industry of a country, which often constitutes a large percentage of a developing country's revenue.\(^{12}\)

The WHO is virtually powerless to stop these violations; as an international organization it has no power to force the compliance of states regarding its regulations. The most it
can do is publish the violations to bring the pressure of the international system upon a state in an effort to force its compliance. There are very strict regulations as to what epidemiological information can be transmitted. Under Article Eleven of the Sanitary Regulations, the WHO may only publish information from authorized sources; the national health ministries of members. Even when the organization has confirmed information of the existence of a notifiable disease from other reliable sources, such as a medical delegation from another country, it is reluctant to act for fear of antagonizing a member. The WHO prefers to keep correspondence at the level of national health ministries; accusing a country of violating the sanitary regulations would undoubtedly bring the more political foreign ministries into the dispute. The organization feels it is counterproductive to publicize noncompliance. When it receives information from other sources, it attempts to persuade the country in violation to notify on its own accord.

In a particular case where the respect of the Director-General was high, the WHO has reported the existence of a notifiable disease, despite that country's failure to admit the existence of this situation. During the 1970 outbreak of cholera in the sub-Saharan region of Africa, Guinea refused to notify the outbreak of this disease. Not only was this outbreak particularly severe, it was also the first outbreak of this highly susceptible region in a number of years. After
repeated requests by the Director General to report the existence of this disease, he finally announced it under the authority of Article Two of the Sanitary Regulations.

This one example has, so far, been the only instance where the organization had reported the existence of a disease against the wishes of a member state. In this case, several unique conditions were present. First, there was serious concern over the possibility of a new outbreak of cholera in a uninfected population with poor medical services. Second, repeated efforts to have the offending country notify the organization of its true status were met with silence. And third, the Director General at this time, Dr. M. G. Candau, enjoyed great respect and authority within the organization. This development is a further sign of the evolution of the international health regime. Where once officials would only have acted with the direct authority of member states, they acted in this instance upon their own authority, usurping the traditional power of the nation state to a degree.

The World Health Organization recognizes that in many cases noncompliance is not due to intransigence on the part of a member, but the lack of adequate resources in terms of equipment and personnel to comply with the sanitary regulations. Many of the health problems that the regulations refer to, such as the containment of contagious diseases, cannot be solved by mere regulation alone. The World Health Organization appreciates that the health problems the
developing states face are outside the scope of regulation. What is needed instead is improvements in basic health care and sanitation services.

Another reason behind the failure of states to inform the WHO of an outbreak of a notifiable disease is their fear of excessive measures that other states might unjustifiably place upon their trade or travelling nationals. In many cases states have reason to worry over the possible imposition of these measures as they had occurred in the past with some degree of frequency. For instance, in 1966 Iraq duly notified the WHO of an outbreak of cholera. Surrounding countries immediately imposed extra restraints on traffic from Iraq. Despite repeated appeals from the WHO, these nations refused to respond to these charges or to remove the excessive measures. Four years later a similar situation arose with regards to Israel, which had also notified the WHO of a cholera outbreak.

As a result of the unfair imposition of excessive measures, countries have taken to minimizing the appearance of an outbreak in order to avoid possible retaliatory measures. Information regarding the status of notifiable diseases submitted to the WHO has often been incomplete, inadequate, or has only reported a minimum number of cases. As well, states would prematurely announce that they were free of disease in an effort to avoid the damaging effects of excessive measures. The WHO often had information from other reliable sources that contradicted the information that a member reported. Yet
again, under Article Eleven of the Regulations, it was powerless to issue any of this alternative information. The organization also understood the predicament many of these infected states were in and did not want further to alienate them by challenging the validity of their information.

In most cases excessive measures were irrational responses on the part of states, who greatly feared an outbreak of one of these pestilent diseases. As with quarantine in the past, excessive measures reassured states by providing a psychological barrier against an infectious disease that could inflict great harm upon them. Yet excessive measures were not the best means of protection against these pestilent diseases; instead states needed to promote the internal development of good public health and sanitation facilites. The countries that most often utilized excessive measures were the ones with less advanced public health care systems and therefore felt themselves to be at greater risk.

The WHO was virtually powerless to stop these infractions, despite the fact that their continued use, greatly weakened the credibility of this organization and the health regime. The WHO published the imposition of excessive measures in the Weekly Epidemiological Report in an attempt to discourage their utilization and offered to use its "good offices" to try and settle disputes that arose over these measures. This is officially provided for under Article 106 of the Sanitary Regulations, although the matter is usually dealt with under
less formal conditions. The overwhelming majority of disputes are handled at the technical level, between respective health administrators and officials of the WHO.  

Article 106 does provide, however, for a more formalized method of settling disputes: "any such dispute which has not been thus settled (through the use of WHO's good offices), may by national application, be referred by any state concerned to the International Court of Justice for decision." This provision has only been utilized once, in 1970 with an incident involving Turkey, Romania, and Bulgaria. As a result of the cholera epidemic of the 1960s many countries sought to impose severe frontier restrictions on persons and goods from neighbouring countries suspected of harbouring cholera, despite the fact that this was prohibited in the regulations. While most of the countries that faced this situation appealed to WHO's good offices, Turkey invoked Article 106 of the Regulations. It complained that Bulgaria and Romania had closed their frontiers to Turkish convoys of food produce and were requiring vaccination certificates from their nationals, despite that fact that Turkey had been declared infected. The measures were not permitted under the Sanitary Regulations. This matter was quickly settled after it was brought to the official level, where the more political departments of governments, the foreign affairs bureaus, became involved. The offending countries withdrew the objectionable measures to avoid adverse publicity.  

Although in this first instance
Article 106 achieved a successful resolution of the dispute it has not been employed since, no doubt reflecting the desire of health ministries to keep health disputes at a technical level, avoiding the more political solutions.

The reappearance of cholera in epidemic form in the 1960s in Africa and Asia had a far reaching effect upon the health regime; it caused a serious revaluation of the aims and methods of this organization. Widespread noncompliance with the sanitary regulations, the failure of states to notify outbreaks of cholera, as well as the prevalent use of excessive measures had combined to create a serious problem of credibility for this regime. Failures to notify outbreaks of cholera were so predominant that they led to discussions of it being removed from the list of notifiable diseases. It was decided, however, that this measure would only exacerbate the situation, and as the requirement to notify encouraged some degree of compliance it should remain.  

The eradication campaign for malaria had also experienced substantial setbacks. Several states that had entered the "maintenance" or "consolidation" phases of the programme, where they were declared free or nearly free of the disease, suddenly experienced major outbreaks. In light of these developments the Twentieth World Health Assembly recommended a reexamination of the entire strategy. It was gradually realized that eradication programmes were doomed to failure -- the countries of the developing world did not possess the resources to successfully carry out such a task, and the
developed countries are unwilling to contribute these resources to them.

EVOLUTION WITHIN THE WORLD HEALTH ORGANIZATION

Advances in the two eradication programs had occurred when states concentrated their resources in health care. Once results were achieved their attention to this area weakened however, and setbacks occurred.\(^2\) These incidents and the general failure of the sanitary regulations to generate the compliance of states and control the spread of disease was to lead to major innovations in the policies and orientation of the World Health Organization.

It had become clear in the late 1960s that in the near future eradication was impossible for the majority of contagious diseases. As such, it was decided to embark upon a policy of "epidemiological surveillance". Recognizing that the importation of epidemic diseases could not be halted it was decided to concentrate resources on notifying, assessing, coordinating, and controlling all communicable diseases, both at the national and at the international level. It was hoped through this process that early containment of disease would become progressively more plausible; successful disease control was to be achieved through attrition, rather than by a direct assault.\(^2\) This policy was inaugurated at the twenty-first World Health Assembly and resulted in a revision of the Sanitary Regulations.

Changes in the 1971 edition of the regulations included
the absorption of the International Quarantine Bureau by the Global Epidemiological Surveillance Bureau. The name "International Sanitary Regulations" was also changed to "International Health Regulations." The term "quarantinable disease" was dropped and the number of diseases subject to regulation was reduced to four, as typhus was no longer considered a serious health hazard. More significantly, these changes are a development away from the narrow, legalistic "sanitary policing" method of disease control to a more cooperative approach. The 1970s was to witness a major evolution in the orientation of the World Health Organization and the International Health Regime. It had been realized that regulations had not been effective in eradicating or even controlling the spread of disease in the past. Thus, a growing trend in the WHO was to employ recommendations instead of regulations. In fact, there has not been a new regulation for fifteen years.²⁵ It had been learned that the best method of combating world health problems was to create efficient health services in all countries. The World Health Assembly had recognized that regulations were of no use unless states possessed the capability in terms of financial and health resources. In order for this to occur, there had to be a change in the policies of the organization. The origins of this position can be seen in the realization of the limitations of the former strategies of regulation and eradication. What was vitally needed was a program whereby the
WHO would provide direct technical assistance to its member states. This position was to only slowly gain support within the organization; but by 1975 and the conference on Primary Health Care at Alma Ata, it was firmly in place.

The explanation for the evolution in the orientation of the WHO is two-fold. In the first instance the WHO was subject to the same pressures as the United Nations was as a result of decolonization. A large influx of developing nations entered the organization, most lacking adequate public health facilities. The regulative aspects of the organization did not interest these states to a large extent as they did not have substantial trade interests that would be hampered by the imposition of excessive measures. While epidemiological surveillance no doubt provided them with some benefits, these countries had never known a period without a serious epidemic. Arresting the spread of a single disease would not cause a substantial increase in the health of their populations. What was needed was the provision of basic medical and health care improving the quality of life for all citizens, as well as slowing the spread of disease.

This change in orientation was not well received by the members of the developed states. Their goals for the organization differed dramatically from those of the developing states. Their interest in the health regime was to control the spread of pestilent diseases from the less developed countries, while limiting the restrictions placed upon international trade.
and travel, the same principles they supported at the sanitary conferences. While the eradication of disease and the reduction of its scope was clearly in the interests of international travel and had a certain emotional appeal for the developed states, they were not willing to finance the development of the Third World's health infrastructure.

While the members of the Executive Board of the WHO, were not all pleased with the direction the organization was taking with the increasingly vocal pronouncements of the developing states, they came as the policy-making body of the organization to accept the validity contained in some of these demands. It was realized by several members of the Executive Board that a change in policy was necessary as they were genuinely committed to the ideals expressed in the original goals of this organization.

Despite the objections on the part of certain states and a few members of the Executive Board, the WHO launched this new program in the mid-1970s. The beginnings of this new stage in international health care can be seen by the selection of a new Director-General, Dr. H. Mahler replacing Dr. M. G. Candau, who had held this office for over twenty years. The new Director General had a distinct vision for the organization, which he was determined to see fulfilled. During its first twenty-years the WHO was primarily a multilateral institution, concerned largely with campaigns against specific diseases, following largely the lead of the developed countries who set its agenda.
Accordingly, the development of systematic health care was the responsibility and concern of member states. The United States who, because of its technical expertise and significant budget contribution, was perhaps the most influential state, sought to ensure that the organization's activities were limited to the problems of public health and preventative medicine. The U.S. did not want the organization to become involved in any way in the area of socialized medicine. As a large number of states from the Third World joined the organization, however, it became increasingly accepted by the executive board that the WHO should provide assistance in strengthening the health services of member states.

This movement within the organization was linked to the calls for a New International Economic Order in the General Assembly of the United Nations. In his 1976 Annual Report to the World Health Assembly, Mahler embraced this movement and referred to its appeal to the WHO, "to intensify the international effort aimed at improving basic health conditions in developing countries . . . primarily to the prevention of diseases and malnutrition by providing primary health services to the communities, including maternal and child health as well as family welfare." Mahler went on to suggest that the General Assembly had vindicated the stance the WHO had already embraced, having learned from its mixed experience with disease eradication the need to build up local health services by improving the social and economic systems of the developing
The New International Health Order was to be implemented by providing what was termed "primary health care" to all citizens of the world. The plan of action for implementing this program was termed "Health for All by the Year 2000". The goals of this program were quite ambitious; they called for a global mobilization of health resources, whereby the main target of governments in cooperation with the WHO was the attainment of the highest level of health for every individual, which would allow them to lead a socially and economically productive life. The WHO wants to ensure by the turn of the century that: all people have access to essential health care and referral facilities; all governments will have assumed overall health responsibility for their people; everyone had access to safe drinking water and sanitation facilities; all are adequately nourished; that all children will be immunized against the major infectious diseases; control will exist of the major communicable diseases; and, finally, essential drugs will be available to all. The aim of the program is to provide health care at the local level, and it was designed to be adapted by each country to meet their specific needs. The WHO had realized that in the past it was guilty of not providing the most appropriate health care advice to the developing countries; universal models, based largely on the experiences of the developed countries were doomed to failure.
This movement can be interpreted as a return to the ideals contained in the constitution of the WHO that: health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, and the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.\(^3\) The reason behind the renewed interest in these aims was the growing conviction that health care was a fundamental social right, and the belief that national governments shall be responsible for creating the conditions for its implementation. These principles have gradually become a norm for most of the industrialized states and were eventually transferred to the international level.\(^4\)

Despite the high ideals of this program it has not been a total success in terms of its implementation. When Mahler stated that it was regrettable that members, "spend three quarters of the health budget on highly sophisticated, disease-oriented institutional care of individual patients in capital cities - leaving large parts of the cities without primary health care", he also declared, "that by 1980 the organization should be restructured so that sixty percent of its regular budget was allocated to technical cooperation, and the provision of services to member states."\(^5\) This meant that the administrative budgets of the regional offices would be reduced with a corresponding reduction in staff. This had not been well received by some members of the world health
bureaucracy who have failed to implement this program to the best of their abilities. They have grown too fond of the benefits that working for an international organization can provide.\textsuperscript{37}

Objections have also been raised by several of the developed states as the "Health for All Program" has brought this organization into conflict with the interests of business and the larger multinational corporations of the world.\textsuperscript{38} The WHO has become increasingly active in this area in the late 1970s. Its entire involvement in the development of a marketing code for breast milk substitutes raised great concern amongst the multinational corporations. The pharmaceutical industry fears that it will be the next target of WHO sponsored interference. For this organization has frequently made statements regarding the substantial drain of resources pharmaceutical products are for developing countries, and how the drugs supplied are, to a great degree, inadequate for the needs of these countries. The WHO has already proposed they be standardized and regulated to ensure a fair distribution throughout the world. The WHO has also incurred the wrath of the tobacco firms. It has increasingly condemned smoking as a health risk and initiated a worldwide campaign against it, to improve the overall general level of health. These recent forays of the Organization have brought it into conflict with the more developed states who represent the interests of the multinationals. The United States, in particular, has had the
strongest reaction to this change in the agenda of the WHO. It was the only country to vote against the Marketing Code for breast milk substitutes and has especially under the Reagan administration accused the WHO of catering to "Third World Marxist ideologues". It has expressed its displeasure with the organization by increasingly reducing its budget contribution; to date it has paid $10,000,000 of its assessed $62,000,000 dues this year (1987). This action has placed the organization in a severe financial crisis and is viewed as an attempt to force the WHO to return to positions that are more compatible with U.S. business interests.  

CONCLUSIONS - WHY THE EVOLUTION ?

While this conflict with the developed states had been reflected to some degree in the World Health Organization's General Assembly, it has not in fact permeated the top level of this organization, the Executive Board. These individuals remain committed to the goals of "Health for All by the Year 2000" Program. This is largely the result of the technical nature of the WHO. At the level of the Executive Board all representatives are physicians; they share a common professional bond, as medicine has certain universal principles. It is only natural for these individuals to desire an improvement in the health of all people, for this is what they were trained to provide. These physicians are committed to improving international public health and to the current organizational ideology of the WHO: the attainment of the
highest level of health for all; the value of a preventative rather than a curative approach -- developing internal health structures, rather than responding to emergencies -- they agree that the organization should be universal in membership and technical in scope, with political intrusions kept to a minimum. As well, the issues discussed by the Executive Board are largely technical, directly relating to health. Symbolic decisions involving East-West conflicts are rare; those statements occur in the more political arena of the World Health Assembly. Most on the Executive Board represent their country's national health ministry, they are not concerned with the more political issues of state departments.

Despite the high degree of technical representation, the WHO has not been completely free from the larger political debates that have plagued the United Nations. The World Health Assembly has been subject to the same political forces of ideology and political manoeuvring. The first example of such forces at work occurred shortly after the first session of the World Health Assembly. The Soviet bloc countries withdrew from the organization citing their dissatisfaction with its operation. In reality, they withdrew to protest the WHO's failure to provide supplies as well as services. Other incidents with strong ideological overtones have occurred in this organization, although for the most part the conflict today tends to be more North-South than East-West. In the past, political resolutions included condemning South Africa
and Israel, not for health reasons, but because of ideology.

States are not willing to collaborate for altruistic reasons; they take action that benefits their self-interest. To decrease the threat of disease to international business enterprises and travellers, developed states supported eradication programs. They were also willing to devote limited resources to developing countries health infrastructures, to encourage their cooperation in other areas. When it comes to greater issues of political importance, however, states act to preserve their traditional concerns: power and national autonomy. They act according to their national interest.

It is the technical elites that are responsible for the evolution of the goals of the WHO. They have initiated, on their own accord, the "Health For All Program", which has brought the organization into direct conflict with several multinational firms and a few developed states. This evolution is beyond the boundary of the traditional aspirations of this international organization, but as with other bureaucracies, the WHO had developed a dynamic of its own and has evolved in ways that could not be forseen by the original signatories to its charter. Compliance has ceased to be a concern of this organization. It was realized by members of the Executive Board that states failed to comply with regulations, not because of a lack of will, but because they lacked the necessary resources to comply. As such, the international health regime is no longer concerned with regulation; it is
concerned with helping to provide adequate health measures for every citizen.


4. Ibid., p. 78.


6. Ibid., p. 142.

7. Ibid., p. 148.

8. Ibid., p. 141.

9. Ibid., p. 25.

10. Ibid., p. 31.


12. Leive, p. 96.

13. Ibid., p. 78.


15. Ibid., p. 84.

16. Ibid., p. 88.

17. Ibid., p. 94.

18. Ibid., p. 58.

19. Ibid., p. 64.
21. Ibid., p. 96. India and Sri Lanka (then Ceylon) once extensively infected had passed into the maintenance phase, only to experience some 2,000,000 cases during the years 1967-69.


23. Ibid., p. 78.

24. Ibid.

25. Interview with Dr. Maureen Law, Deputy Minister of Health and Welfare, and Head, Canada's Delegation to the World Health Assembly, Past Chair of the Executive Board of the WHO. Ottawa, Ont., July 2, 1987.


30. Ibid., p. 218.


32. Ibid., p. 12.


34. Contained in the Preamble to the Constitution.

35. Pannenbourg, p. 23.


37. I am indebted to Dr. Nancy Morrison of the Department of Sociology, UBC, for pointing out this fact to me.


The aim of this thesis has been to document the progression of international health collaboration, to account for both the success, and the obstacles it has encountered. As it has been demonstrated cooperation throughout the development of the international health regime has undergone an evolution, in terms of its degree and intensity.

The Evolution of the Health Regime

As collaboration in international health grew the international health regime itself evolved. It surpassed its initial purpose as a regulatory regime to become a technical assistance-oriented organization. Originally the regime was only concerned with the regulation of quarantine measures. Through the years the focus of this regime has gradually expanded to include much more than the regulation of restrictions on international travel. In its second century this regime has become concerned with arresting the spread of disease; it undertook a program of eradication against certain pestilent diseases. These programs did not meet with total success, but demonstrated to the organization the need to develop the health infrastructure in the lesser developed countries, where the majority of epidemic diseases were endemic. Assisting states in providing primary health care to their nationals is now the focus of instructional health
collaboration, representing a long progression from its former concern with regulation.

This evolution has occurred within the dynamics of the growth in international health regimes. At first, the sanitary conferences were ad hoc affairs, convened only when a threatening epidemic suddenly presented itself. The conferences had only one item on the agenda, a temporary solution to either impending quarantine restrictions, or the establishment of measures to combat the spread of a raging epidemic. Over time it was realized that the lack of a permanent body to apply and interpret sanitary regulations did not encourage compliance. Thus, the creation of successive international health organizations, each with greater responsibility and jurisdiction than the one before it. Membership in these institutions also expanded; the international health regime went from a largely European composition to global membership under the United Nations.

The agendas of these regimes have greatly expanded from erecting measures to protect against a single, specific disease, to considering several pestilent diseases, as well as directing research into a myriad of international health concerns and coordinating international technical commissions.

Where the international health regime once consisted of prohibitive regulations, it is now composed of suggested guidelines and requests. The emphasis of the regime has evolved from the prevention and defense of the developed states
to assistance and advice for Third World nations. Regulation has increasingly ceased to be an activity of the health regime. Under the World Health Organization recommendations and requests are the rule. Compliance continues to be problematic in the international health regime; it does not appear to have significantly improved or deteriorated under any formation of the regime.

Within the regime itself there has been a fundamental change in leadership. Where the developed European nations initiated the Sanitary Conferences to protect themselves from the importations of exotic disease from lesser developed countries, it is now the issues and concerns of the Third World that dominate the world health agenda. These countries are largely unconcerned with ensuring the reduction in impediments to trade and multinational corporations' activities. Instead, they are anxious to ensure the development of their health infrastructures and to gain an equal distribution of health resources, in terms of medical personnel, and pharmaceuticals. Under the World Health Organization, the health regime has, in fact, evolved from protecting the interests of international business from damaging quarantine restrictions, to at times posing a direct threat to the interests of large multinational corporations.

In spite of the great scope of this evolution it has not been free of conflict or political opposition. As this thesis has suggested there have been several obstacles to
achieving complete cooperation in international health.

OBSTACLES TO INTERNATIONAL HEALTH COLLABORATION

States were, at first, reluctant to participate in collaborative ventures to control the spread of disease. They were quite content to follow their own policies of quarantine until the substantial growth in international trade and travel forced them to accept the necessity of joint action to remove the barriers to trade individual action had created. Despite states' realization of the necessity of collaborative action, they were unable to reach agreement on the appropriate measures to be taken. A scientific debate over the means of transmission, and the origins of these diseases was in progress, with states supporting different positions, according to their views regarding quarantine. A lack of scientific knowledge regarding the etiologies of these diseases was to prevent states from agreeing to a regulatory code for forty years. After these discoveries were made in the late 1800s international collaborative efforts became much easier to instigate.

Gradually the need for international health organizations became apparent, to administer the sanitary conferences and to revise the codes that had resulted from these collaborative efforts. Through their experiences in the sanitary conferences states had learned that the coordination of research on an international level made economic sense, as all states could then benefit from scientific advances in epidemiology without
duplicating the process. This encouraged states to support further collaboration in health issues.

Other obstacles to collaboration were to be posed by international health organizations, which had a tendency to develop their own institutional loyalties. Due in part to the benefits that came from participation in this organization, including the delights of living in a foreign, cosmopolitan city such as Paris, the employees of the OIHP developed a loyalty to the aims and process of their organization. Similar to other employees in a large bureaucracy, they were resistant to changes in the organization that could either threaten their position or the institution itself. The OIHP was largely staffed by veterans of the early Sanitary Conferences. They brought to this new organization their beliefs in the aims of international health collaboration formed, in part, by these conferences. These members were, therefore, not keen on the new developments in international public health care in terms of technical assistance that the Health Organization of the League intended to provide. Instead, they wanted to continue the goals of the early sanitary regime to lessen the impediments to international trade and travel while preventing the spread of epidemic disease from less developed countries.

This same process was repeated when the Pan American Sanitary Bureau was to be absorbed into the newly formed World Health Organization. Again the members of the smaller institution objected to a loss in their traditional influence
and power. The WHO is presently experiencing a similar situation of bureaucratic revolt in its implementation of the Health For All Program. The aims of this program, to return to the provision of primary health care by individual states, threatens the large appendage of bureaucratic elites that have accumulated in the regional offices of the WHO.

The last three examples all show obstacles to the furthering of international health collaboration caused not by states, but by the international health organizations themselves.

After the First World War it was generally believed that international health work should be carried out under the auspices of the first multilateral institution designed to foster international goodwill, the League of Nations. Also, there was an obvious need for an international health body to respond to the serious typhus and influenza epidemics that struck Europe after the war. Only a coordination of effort at the international level could adequately respond to this crisis. The League had a mandate to further international technical cooperation, and its health organization became increasingly involved in conducting technical studies on diseases that had a strong international presence.

While the League was to be a technical institution political issues did occasionally arise. The French expressed some reluctance to cooperate initially with countries it had recently fought against. The United States was also wary of
the Soviet Union's participation in the health organization's activities; it was not to enjoy diplomatic relations with this country until after the Second World War. To a certain extent, however, political disputes were subsumed by the technical goals of the organization. Russia, Germany, and Japan all participated in the Health Organization of the League's activities, even though they did not at the time belong to the League. Ultimately, however, the success of this international health organization was tied to the success of the League itself, and as one's credibility faltered, so did the other's.

Throughout the duration of the League, epidemic diseases were largely under control in the developed nations. Consecutive sanitary codes had been established and consolidated in 1903 with amending conferences occurring in 1912 and 1926. These had, for the most part, abolished quarantine and had ensured the minimal obstruction to international trade and travel. By this time scientific knowledge was well developed in the treatment and containment of these diseases, as the Western states had well established social welfare systems that provided public health care facilities for their citizens. While the original objectives of the health regime had been fulfilled, collaborative efforts in international health were to proceed.

Adequate sanitary and health provisions were still needed in the underdeveloped nations, and with the formation of the
World Health Organization, providing for these needs became a stated goal of the international health regime. This is demonstrated by the comprehensive definition of health that the Constitution of this organization contains. At first, the WHO sought to eradicate disease, as it still posed a danger to the international traveller and the multinational corporation setting up a factory in a disease plagued country. It was soon discovered, however, that eradication programs were likely to encounter failure because of the lack of medical and sanitation services in the very countries where the diseases were rampant. As well, there were often cultural differences that accounted for the failure of eradication programs. Complacency developed once an outbreak was under control and had receded from the capital cities. Many of these underdeveloped countries had neither the resources, nor the will to carry out a full eradication program.

Other difficulties in controlling the spread of disease were states' failure to comply with the regulations of the Sanitary or Health Codes. Noncompliance was extensive for many reasons: a lack of resources to either collect data or transmit it, fears of financial losses to tourism, as well as repercussions to trade caused by the imposition of excessive measures by other countries as a result of their reporting the existence of a pestilent disease. Admitting an outbreak of a pestilent disease carried the mark of a Third World country, entailing a loss of prestige for the notifying country.
The technical elites of the WHO soon realized that little could be done to stop these acts of noncompliance except the provision of technical aid and health resources to counter the diseases that motivated these actions themselves. As such, the WHO has abandoned regulatory activities because they were no longer compatible with its original goals, technical cooperation.\(^1\) What was needed was the provision of basic health services on an individual country basis. This has become the new guiding principle of the international health regime.

The explanation for this development lies in the growing acceptance amongst Western developed states that health care was a fundamental social right. As nation states began to realize that they had a responsibility for the health care of their individual citizens they transferred this belief to the international level. Within the society of nations it gradually became an accepted norm that the more advanced nations had a responsibility to improve the health of the less fortunate and less developed nations.\(^2\) This principle was not accepted unanimously. Most of the developed countries were not willing to provide the less developed countries with the aid needed to develop their health infrastructures. Large multinational firms have also grown suspicious of the WHO as it takes an increasingly critical stance towards some of their activities regarding the Third World. They are supported by some of the developed states, especially the United States, who
do not like the turn in direction the WHO has taken since a
decolonization in the 1960s added a large number of Third
World countries to the organization. The United States'
growing displeasure with this situation has been expressed by a
substantial reduction in its budget contribution, causing the
WHO great difficulties in meeting its responsibilities and
carrying out its programs. This action poses the largest
obstacle to the future of international health collaboration
for the WHO today.

The elite of the organization, and a few Western nations,
are sympathetic to the plight of the Third World. These
nations include: Sweden, Denmark, Norway, and the
Netherlands. It is the technical elites, however, who control
the agenda of this organization. As a result of an earlier
political compromise, established at the League of Nations,
members of the World Health Organization's Executive Board are
elected on the basis of their technical expertise and as their
own persons to represent the aims of the organization, not the
positions of their respective governments. This situation has
allowed these individuals to guide the organization along the
original path suggested by its progressive constitution.

Collaboration in the World Health Organization has
undergone an incredible evolution from the original aims of the
sanitary regulations and the health regime, designed to ensure
the prevention of the spread of disease and the free flow of
trade. Today the organization is more concerned with improving
the general level of health care for all of its members.

The obstacles to international health collaboration were the result of many factors: a lack of political will to collaborate; insufficient scientific knowledge of the etiologies of the pestilent diseases; the tendency of international health organizations to develop a bureaucratic mentality; a lack of economic and health care resources, and an unwillingness to provide these resources; fear of economic repercussions to trade and tourism; and, the intrusion of political conflicts into the health arena.

INTERNATIONAL RELATIONS THEORY AND INTERNATIONAL HEALTH COLLABORATION

The developments in international health collaboration have not occurred without opposition. From the beginning, states have been reluctant to collaborate in the area of international health. Even when the precedent of collaboration had already been well established, and the benefits realized, states continued to object or violate the terms of international agreements. The reasons for the development of international health collaboration, and for the reluctance of some states to participate, as well as for the evolution that this international regime has undergone, can best be understood with the assistance of International Relations Theory. Of the four themes outlined in the first chapter, two best explain the instigation and development of international collaboration, while the other two are useful in
explaining the obstacles and reluctance of states to participate in these ventures.

REALISM

Realism and Neo-realism are theories that concern themselves with the power of the nation state, either within the international system or in comparison to other states. Classical realism has little to say on the possibilities of collaborative efforts of states in the area of disease prevention. It is not generally an issue of survival or a factor of power for a state. This explains the disinterest states originally displayed towards health cooperation at the international level; it was not an issue of priority for them. In response to a threatening epidemic states would become concerned and take preventive measures, but as this crisis receded, the focus of states returned to more crucial issues, such as the attainment and preservation of power.

Neo-realism is more useful in explaining the development of international health collaboration. Neo-realism modifies classical realism, and considers the overall welfare of the state to be as important in guiding its actions as preserving its power. The state, for neo-realists, acts primarily in its self-interest, to protect its security or its standing in the international system. The security of a nation state depends upon more than its amount of power or military capability. Other factors, such as economic welfare, securing access to strategic resources, and ensuring the well-being of its
citizens become involved. Preserving the sanctity of the nation state, its cultural autonomy, or national sovereignty is also important, as these factors define what is a nation state. A state will take action against any development that threatens its security, be it a spreading epidemic or a harmful trade measure. It will cooperate with other states or in international arrangements when it is to its benefit, in increasing some aspect of its security. This collaboration cannot come at great cost to a state in terms of its sovereignty or economic welfare. If it does, a state will be reluctant to participate in the collaborative venture. If a state's interests change, or an international agreement it has committed itself to is no longer profitable or beneficial, a state will not hesitate to withdraw from collaborative efforts.

Within the framework of international health collaboration, neo-realism best explains the initial reluctance of states to collaborate, until it became clearly in their self-interest to do so -- to ensure trade liberalization and to control the spread of disease. Even after they had realized the value of collaboration, states would violate or fail to comply with health regulations they had once agreed to, or be reticent about further collaborative efforts.

Throughout the early sanitary conferences there was always a reluctance on the part of states to ratify a convention that would in some way limit their actions without ensuring that their interests were protected. Despite the general acceptance
of the idea to hold an international sanitary conference, it was to take almost twenty years before European states would even agree to meet. The French had suggested such a conference as early as 1834, yet the first conference was not held until 1951. Certain countries were ambivalent to the idea of a sanitary conference; Austria was reluctant to participate in a conference for which it saw no real need. As a landlocked country removed from the source of epidemics, it was relatively unaffected by their scourge. Britain, too, later expressed a great disdain for the entire conference system. It frequently had to be coaxed to attend conferences with promises that issues that were vital to its economic interests, such as imposing lengthier quarantine on ships passing through the Suez Canal, would not be discussed.

States were concerned with forging an international agreement that was favourable to their national interest. They were unwilling to compromise on any convention that would even partially harm this interest. This is best demonstrated in the fact that it took forty-one years before there was to be success in these collaborative ventures; it was not until the Seventh International Sanitary Conference in Venice that a limited convention was signed regarding the measures to be taken for ships destined for the Mecca pilgrimages. After this first success it was to take the participants a further ten years before a comprehensive convention on all relevant diseases and quarantines would be signed by the participating
nations. Even though collaborative efforts repeatedly met with failure, states continued to return to the conference forum, as they realized that an international solution was needed to solve the common problems of epidemic disease and the imposition of stringent and damaging quarantine measures against trade. Yet they were unwilling to compromise on a solution that would not be in their best interest.

The issues that most concerned states in the Sanitary Conference centered upon two items. The first was the national autonomy of a state, and the second was ensuring that their trading interests were not harmed. The issue of political sovereignty arose several times in the history of the conferences. Each time a measure was proposed that would restrict the traditional jurisdiction of a state there would be a large outcry. The best example of this occurred at the Fifth International Sanitary Conference when the United States' request for permission to be granted to their nationals to inspect all ships bound for US ports was greeted with an emphatic negative by other delegates because it would be a violation of their sovereignty. The European countries felt that such an action questioned the capability and honour of their medical facilities.

Prestige and status are aspects of international politics that are closely linked to national autonomy and sovereignty. Matters of prestige are usually issues that are unique or characteristic to one nation. For instance, at the sanitary
conferences all efforts to place restrictions on the Mecca pilgrimages were rejected by Turkey as an affront to its religion and a violation of its cultural autonomy and standing as a nation state. In fact, Turkey did not sign a single Sanitary Conference in the nineteenth century because almost all of them sought to impose special measures against the Muslim pilgrimages.

Protecting the interests of international trade was a constant concern in the early development of the international health regime. States with a large degree of trade traversing the Suez Canal had quite different goals to protect at the sanitary conferences than those with lesser trading interests. Countries with significant trade were the most supportive of the regulative aspects of this regime, while those closer to the apparent source of the epidemics felt psychologically at greater risk and preferred the security of strict quarantine measures. Each grouping of states advocated their respective views on this matter because these measures supported what was best for their national interest and security. The determining factor in a state's position regarding the imposition of quarantine was less a reflection of their belief in this method of prevention than it was a reflection of what would be in the state's long term interest. This point explains Britain's shifting opinions regarding the source of the cholera vibro. Britain initially accepted the general consensus expressed at the Fourth Conference that cholera originated in India, yet
denied this same fact twenty years later at the Sixth Conference. As time passed Britain grew more reluctant to participate in these conferences. This is evidenced by their rejection of a Permanent Commission on Epidemics where they expressed a "want of faith in the value of co-operative international sanitary work". This, no doubt, had a great deal to do with the fact that they were always in the minority, advocating the substitution of medical inspections for quarantine.

Even after a successful international health regime had been formed, states continued to obstruct collaboration by refusing to comply with measures that conflicted with their perceived self-interest. This was the case with failures to notify the outbreaks of reportable disease and compliance with the regulations concerning the imposition of excessive measures. States found themselves in a position where the question became whether to comply with the notification requirements of the regime and risk the imposition of damaging trade measures, or to avoid these measures by not reporting the breakout of a notifiable disease. As there was an established history of states imposing excessive measures upon learning of an outbreak, many states failed to notify the WHO, not wishing to risk economic losses to trade or tourism as a result of the imposition of excessive measures. This practice continues unabated even today and has recently been attracting new followers as a result of hysteria regarding the spread of the
AIDS pandemic.

States have been greatly concerned with protecting their security and self-interest throughout the formation of the international health regime. Although this has often disrupted or prevented collaboration when actions have not proven to be in a state's best interest, it has also encouraged collaboration for the same reason, when it serves a state's self-interest and enhances its position in the international system.

A health regulatory regime was formed to protect states from the spread of epidemic disease and to shelter their growing trade interests as much as possible from the increasingly damaging effects of quarantine. Yet, as the above examples demonstrate, a Neo-Realist perspective is perhaps best at explaining the failure of states to collaborate as opposed to providing an explanation for the instigation of collaborative efforts. Other theories of international relations are more useful in accounting for the positive developments in the international health regime.

LIBERALISM

Liberal theories of international relations, as expressed in the work of Edward Morse and Richard Cooper, predict increases in international collaboration will occur as a result of the modernization process initiated by the forces of industrialization. The world has become more interdependent, and this has caused a major change in the nature of the
international system. In order to enjoy the benefits of strong economic relationships, states must be willing to give up certain amounts of national independence and autonomy in achieving their economic objectives. States have moved beyond the traditional realist goals of power and security to more subtle ones such as the expansion of economic well-being and the provision of a more equitable distribution of wealth. As a result of modernization the norms of international behaviour have been enlarged. It is becoming the obligation of wealthy nations to redistribute some of the world's wealth to the poorer nations. 4

In order to improve economic welfare, states have been willing to reduce barriers to the free flow of trade. In explaining the development of the international health regime, liberalism accounts for states' gradual acceptance of the need for the coordination of regulations and the reduction of quarantine measures. States will surrender the autonomy they once guarded to ensure the provision of economic gains to their countries. This development was the major impetus behind international health collaboration.

Before states had extensive trading interests, quarantine was merely an inconvenience to travellers. With the development of efficient means of transportation, quarantine became a serious and costly impediment to trade. As their trading interests grew, states gradually came to realize this point and sanitary codes were finally concluded to alleviate
this financially harmful situation.

Britain, as the largest trading nation at that time, provided the strongest opposition to quarantine. Throughout the conferences, its position became more belligerent. Other countries came to accept Britain's position as their own trading interests grew. Those with a large degree of trade, mainly Northern European states and northern France, sided with Britain much earlier than those closer to the sources of the disease's spread, Mecca.

With the adoption of successful sanitary codes in the 1890s, the principles of the health regime were established. They were strongly suggested by liberalism, that the spread of disease should be checked by procedures which are not excessively harmful to the progress of international trade.

As international health development progressed, improving the economic potential of a state also became a part of this regime. Developed states were strong supporters of eradication programs, not only because they were to rid the world of a pestilent disease, thereby ensuring that these countries need never have to guard against them, but also because they made the world safe for international business and travel. Less developed countries were not able to instigate development programs until a sufficient amount of their population was free from disease. Also, epidemic diseases in these countries posed a serious economic drain in terms of the loss of a potential workforce.
Liberalism also explains the evolution of the health regime in the twentieth century. While the former principles have been retained, an addition has recently been made that there should be an equitable distribution of health welfare throughout the world. This entails a transfer of health resources from the developed states to the lesser-developed ones. The WHO has attempted to implement this new norm with programs of technical cooperation. Although these measures have not been well received by all states, they are, nevertheless, part of the modernization process which Morse describes. Conflict exists in this area of international cooperation because the changes to the international system that modernization has wrought are not yet complete. The significant changes that have already occurred as a result of this process include the loss of power by the European states and an increase in the total number of states. Both of these changes are reflected in the World Health Organization today, and provide explanations for the development of new programs in this organization that differ significantly from its previous goals, before modernization had changed the fundamental structure of the international system.

FUNCTIONALISM

As a theory in international relations, Functionalism is most useful in explaining the advances in health collaboration and the evolution within the health regime. This theory is based on the essential premise that as a result of the growing
complexity of the world, states will no longer be able to provide adequately for their citizens the benefits they have in the past. They will be forced to turn to international technical organizations to provide social welfare goals and to ensure that technical issues that cross national jurisdictions will be administered successfully. These international organizations are to be staffed by technical elites who are experts in the area of collaboration. They will, because of their technical training, be able to separate the political issues from the technical solutions that are required. As a result, collaborative ventures between states in technical areas will lead to greater levels of cooperation as states realize the success to be gained from these joint actions.

Preventing the spread of disease by developing standard health regulatory codes is an area that crosses the national jurisdiction of states and needs technical expertise to be achieved. With the growing amount of trade and travel that occurred in the nineteenth century, the spread of contagious diseases became more extensive throughout the world, especially in Europe. The Sanitary Conferences were an attempt at the international level to resolve this problem and to ensure the free flow of trade. Successful cooperation was not to occur until scientific discoveries had been made isolating the causes of epidemic disease. After this discovery, states realized the value and necessity of scientific and political cooperation in this area and institutionalized it in the formation of
international health organizations with technical goals. These organizations began to develop a life of their own, however, and have led to an evolution in the health regime and an increase in collaborative efforts.

As for the nature of technical cooperation itself, the health regime has shown some positive developments. The adoption of the contracting out procedure demonstrates the degree to which the former political aspects of the sanitary regulations have been reduced to mere technical issues, not requiring the implicit approval of states. The WHO is dominated by the medical profession: virtually every member of a country's delegation is a physician, and represents their country's ministry of health, rather than the more politically motivated departments that are responsible for foreign policy.

The successes of the international health regime have occurred as a result of technical cooperation. The eradication of smallpox came about largely because of the highly technical nature of its solution. A vaccine was already in existence. What was needed was an efficient way to inoculate a large enough percent of the population in an endemic area to stop the transmission of this disease. With international cooperation under the auspices of the WHO, the vaccine and method of injection were successfully modified and smallpox has become a disease of the past.

The WHO is motivated to fulfill the ideals of its Charter because physicians share the ambition of preventing unnecessary
sickness and disease, a belief which they bring with them when they represent their country at the international level. Despite the fact that government officials without their specialized training may not share their ideals, these health specialists have been remarkably successful in a few instances of ensuring collaboration on issues which are not in many of their country's perceived self-interest. A good example of this is the WHO/UNICEF code on Marketing of Breast Milk Substitutes, which was regarded by the foreign ministries of some states as adversely affecting international trade and the financial positions of multinational pharmaceutical corporations.

Yet despite the successes in international health collaboration, political issues still arise to interfere with the more technical and collaborative aspects of international health work. This is especially true in the World Health Assembly, where states are represented by the more political factions of governments. A spillover of the collaborative spirit from the medical aspect of the organization to the more political area is not yet evident.

FINAL COMMENTS - PROGNOSIS FOR THE FUTURE OF INTERNATIONAL HEALTH COLLABORATION

The evolution that has occurred within the health regime is the result of the special characteristics inherent in international health collaboration. Health is an area where states have collaborated to a much greater degree than in other, more political, areas of international relations. As
health care became an accepted social right in the developed nations of the world, this principle was transferred to the international level. All states were entitled to enjoy the benefits of good health, and the developed nations had an obligation to assist the less developed ones in achieving this goal. While this ideal has been subject to the same political forces as other social welfare issues at the international level, such as human rights, health collaboration has been more successful because of the nature of its technical elites. Medical personnel at the international level, working with their colleagues at the national level, have managed to push collaboration in this regime farther than nation states would like, and the repercussions to this action are now beginning to be felt by the organization, as funds and support are withdrawn.

Collaboration has increased within the International Health Regime, and each of the four theories of International Relations sheds light on a different factor to explain this development. Realism and Neo-Realism best explains the opposition to collaboration, while Liberalism and Functionalism suggest occasions when collaboration will be successful.

As for the future of international cooperation in this area, it appears that increased collaboration will be inevitable. As AIDS increasingly becomes a global problem, the developed states of the West will be faced for the first time this century with a threatening epidemic disease for which they
have no cure or treatment. This situation has not caused such a panic in the less developed states as AIDS for them is yet another disease striking their population. With its sudden appearance in an almost epidemic form, developed states are erecting barriers in an attempt to stop its spread. This is beginning to pose great difficulties for international traffic and commerce. As well, developing states have been fearful to notify the WHO of the existence of this disease, lest it cause repercussions to their tourist industries. Several cases of excessive measures regarding international travellers have already been reported. These incidents recall an earlier period when the international health regime was just being created. As AIDS threatens to bring about similar barriers as quarantine, with equally damaging results, states no doubt will enter into collaborative arrangements to ensure the free flow of international traffic. All the principles of the health regime will be strengthened, and the lessons learned from earlier health collaboration will be applied once again.
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Head, Canadian Delegation to the World Health Organization.

Dr. Jacques Lariviere - Senior Medical Advisor to the World Health Organization, Department of Health and Welfare, Ottawa.

Mr. Barney Miller - United Nations Directorate, Department of External Affairs, Ottawa.

Prof. Yves Beigbeder - Visiting Professor, Department of Political Science, UBC - Summer 1987. Past Administrative Official of the World Health Organization.

Prof. Nancy Morrisson - Department of Sociology, UBC