RECONSTRUCTING ENFORCEMENT IN GLOBAL HEALTH LAW: SOVEREIGNTY, INCENTIVES, AND THE STRUCTURAL LIMITS OF THE INTERNATIONAL HEALTH REGULATIONS

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ABSTRACT

Global health governance operates through a legal framework that appears binding but, in practice, functions as voluntary cooperation. The International Health Regulations (2005) (hereinafter "IHR") exemplify this contradiction. During COVID-19, states delayed notification, imposed unscientific travel restrictions, and selectively relied on World Health Organization (hereinafter "WHO") guidance without legal consequence. These outcomes reflect structural design rather than isolated shortcomings. The IHR preserves sovereign discretion, denies the WHO juridical authority, and relies on epistemic legitimacy rather than enforceable obligations.

Three claims are advanced. First, doctrinal analysis shows that the IHR lacks compulsory jurisdiction, authoritative fact-finding,

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and remedial mechanisms, rendering compliance formally mandatory but substantively voluntary. Second, comparative institutional analysis demonstrates that enforceability in regimes such as the World Trade Organization (WTO) stems from sovereignty-limiting commitments and reciprocal incentives that the IHR intentionally avoid; the comparison illuminates institutional design, but its incentive structure—anchored in market access and retaliatory remedies—has no equivalent in global health. Third, insights from political economy and Third World Approaches to International Law (TWAIL) reveal that disclosure duties generate disproportionate economic and political costs for low- and middle-income states, and that existing epistemic authority reinforces unequal scrutiny.

A reconstructed enforcement architecture is proposed that responds to these political and structural constraints. It comprises three elements: incentive mechanisms that offset the costs of early reporting; a quasi-juridical compliance body capable of issuing authoritative determinations without coercive adjudication; and redistributive obligations that address core capacity deficits. These reforms can be advanced through a combination of World Health Assembly (WHA) resolutions, soft-law instruments, and targeted amendments to the IHR. Together, they offer a feasible pathway to transform the IHR from aspirational norms into a structured, politically realistic system of global health accountability.

KEYWORDS: *international health regulation, international legal accountability, sovereignty and institutional design, compliance theory in global governance, structural inequality in international law*

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I. INTRODUCTION

International health governance is entering a period of heightened biological risk. Yet, its central legal instrument—the International Health Regulations (2005) (hereinafter "IHR")—continues to embody a structural contradiction: it appears as binding international law but operates as voluntary cooperation. The growing frequency of pandemics has intensified the consequences of delayed reporting and uncoordinated national measures. COVID-19 illustrated this problem with uncommon clarity, as states imposed unscientific travel bans, deferred notification, and selectively followed World Health Organization (hereinafter "WHO") recommendations without legal consequence.[1] These patterns were not aberrations but symptoms of a system that cannot compel states to act when global interests and sovereign incentives diverge.

The central claim of this article is that the IHR do not fail because states choose to violate binding rules; they fail because the rules themselves cannot constrain sovereign preferences. The regime assumes that states will disclose information even when doing so produces domestic economic and political costs, that scientific legitimacy alone generates compliance, and that formally equal obligations can be met by states with unequal capacity. These assumptions are structurally unrealistic. The WHO's constitutional framework reinforces this dynamic: the Organization holds epistemic authority but lacks investigatory power, compulsory oversight, or adjudicatory competence.[2] Its authority is advisory rather than juridical, producing a system that displays the form of law without the mechanisms required to perform as law. The result is voluntarism embedded within a legal instrument that appears binding but cannot discipline non-compliance.

Although scholarship has long acknowledged weaknesses in the IHR, existing analyses often address these limitations in isolation—focusing on doctrinal gaps, institutional constraints, or geopolitical inequality without explaining how they interact. A unified account requires integrating these

[1] *See generally Classification of Omicron (B.1.1.529): SARS-CoV-2 Variant of Concern*, WORLD HEALTH ORG. (Nov. 26, 2021), https://www.who.int/news/item/26-11-2021-classification-of-omicron-(b.1.1.529)-sars-cov-2-variant-of-concern.

[2] LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW 91-105 (2014).

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dimensions and examining why enforcement is structurally absent, how incentives and power shape compliance, and which reforms are politically feasible within the constraints of the WHO Constitution and the contemporary North-South landscape. This article adopts that integrated approach.

Three claims guide the analysis. First, doctrinal examination shows that the IHR lacks the compulsory jurisdiction, the authority to conduct fact-finding, and the remedial pathways necessary to convert obligation into an enforceable duty.[3] Second, comparative institutional analysis demonstrates that enforcement in regimes such as the World Trade Organization (hereinafter "WTO") arises not from subject-matter but from sovereignty-limiting commitments and reciprocal incentives. However, global health governance lacks equivalents to market-access concessions or retaliatory remedies, making a WTO-style model neither transferable nor normatively desirable. [4] Third, insights from political economy and Third World Approaches to International Law (hereinafter "TWAIL") reveal that disclosure duties impose asymmetric burdens on low- and middle-income states, and that existing epistemic structures reinforce unequal patterns of scrutiny.[5]

Building on these insights, the article develops a reconstructed enforcement architecture grounded in three interconnected elements: incentive alignment that offsets the costs of early reporting; a quasi-juridical compliance mechanism capable of issuing authoritative determinations without coercive adjudication; and redistributive obligations that address structural capacity deficits. These reforms draw on existing legal pathways—including World Health Assembly (hereinafter "WHA") resolutions, soft-law mechanisms, and targeted amendments to the IHR, including the 2024 revisions establishing National IHR Authorities and a States Parties Committee—as bases for incremental, politically feasible strengthening of accountability.[6] The aim is not to replicate coercive trade-law structures, but to design an enforcement model capable of producing meaningful, equitable compliance within the political and constitutional constraints of global health governance.

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[3] International Health Regulations (2005) art. 43, May 23, 2005, 2509 U.N.T.S. 79 [hereinafter IHR (2005)].
[4] PETROS C. MAVROIDIS, THE REGULATION OF INTERNATIONAL TRADE 152-69 (2016).
[5] ANTONY ANGHIE, IMPERIALISM, SOVEREIGNTY AND THE MAKING OF INTERNATIONAL LAW 245-72 (2004).
[6] IHR (2005), *supra* note 3, art. 4.

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II. THEORETICAL AND ANALYTICAL FRAMEWORK: SOVEREIGNTY, INCENTIVES, AND STRUCTURAL POWER IN GLOBAL HEALTH GOVERNANCE

A credible analysis of enforcement failure in international health law requires more than doctrinal interpretation or institutional critique. It requires a theoretical framework capable of explaining why a system that appears legally binding on its face operates as non-binding in practice. This section develops that framework by integrating five analytical pillars—sovereignty, incentive theory, TWAIL, epistemic authority, and comparative institutional design—each illuminating a distinct dimension of the IHR and their structural limitations.

A. Sovereignty as the Architecture, Not the Obstacle, of the IHR

In global health governance, sovereignty is not merely a barrier to be overcome; it is the foundational principle around which the IHR were deliberately constructed. Unlike international economic regimes in which states trade sovereignty for reciprocal gains, the Constitution of the World Health Organization embeds an institutional model that protects sovereignty from legal intrusion. Articles 21 and 22 authorize the WHA to adopt regulations, but they do not confer investigatory authority, intrusive verification powers, or compulsory adjudication.[7]

The concept of sovereignty is itself contested. Formal legal sovereignty—territorial authority and freedom from external intervention—must be distinguished from a state's practical capacity to control outcomes and from authority delegated through international institutions. This article uses sovereignty primarily in the institutional sense of allocating final decision-making authority between states and the WHO. It therefore does not assume that sovereignty is absolute or uniform in practice; rather, sovereignty operates through rules whose effect varies with consent, power, and institutional context.[8]

The IHR, therefore, preserves sovereignty intentionally rather than accidentally. Their architecture reflects an institutional choice to privilege national discretion over centralized legal oversight. From a structural perspective, enforcement failure is not the malfunction of a system designed for compliance, but the predictable outcome of a system designed to avoid coercion.[9]

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[7] *Id*. arts. 44-45.

[8] *See generally* STEPHEN D. KRASNER, SOVEREIGNTY: ORGANIZED HYPOCRISY 3-25 (1999); ANGHIE, *supra* note 5, at 245-72.

[9] JOSÉ E. ALVAREZ, INTERNATIONAL ORGANIZATIONS AS LAW-MAKERS 213-18 (Oxford Univ. Press 2005).

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Understanding sovereignty as a constitutive design principle—rather than merely a political constraint—clarifies why the IHR lack the juridical infrastructure necessary for legal enforceability, a point developed further in Section III.

B. Incentive Theory and the Public-Goods Logic of Disclosure

From an institutional economics perspective, compliance occurs when states perceive that the expected benefits of adherence outweigh the expected costs. In the WTO, reciprocal market access creates a self-enforcing incentive structure in which defection triggers economic retaliation.[10] International human rights regimes rely instead on reputational and social incentives, reflecting the absence of material sanctions.[11]

The International Health Regulations invert both logics. Early outbreak reporting generates a global public good—rapid detection and containment—that benefits all states, yet the costs of disclosure, including economic losses, travel restrictions, reputational harm, and domestic political repercussions, fall primarily on the reporting state. This asymmetry produces a classic public-goods failure: collective benefit is diffuse while national cost is concentrated, resulting in predictable underproduction of timely transparency.[12]

The public-goods characterization likewise requires qualification. In economic theory, a pure public good is non-rival and non-excludable, whereas many transnational health benefits exhibit those qualities only imperfectly and depend on deliberate collective provision. Early notification is treated here as a global public good in this functional, rather than absolute, sense: its informational and containment benefits extend across borders, while the incentives and costs of supplying it remain national and uneven. The classification therefore does not resolve the distributional question of who bears the costs of provision or captures its benefits.[13]

Incentive theory, therefore, clarifies why appeals to solidarity, scientific obligation, or moral responsibility routinely fail to generate consistent disclosure. States act rationally—not opportunistically—when they delay reporting or understate outbreak severity. A workable system must correct the disclosure-penalty problem rather than presume altruistic transparency.

This logic anchors the feasibility of the enforcement architecture developed in Section VI, which seeks to align incentives with compliance by

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[10] MAVROIDIS, *supra* note 4, at 152-69.

[11] *See generally* Kenneth W. Abbott & Duncan Snidal, *Hard and Soft Law in International Governance*, 54(3) INT'L ORG. 421 (2000).

[12] MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS 33-36 (1965).

[13] *See id*.; *see generally* Inge Kaul et al., *Defining Global Public Goods*, *in* GLOBAL PUBLIC GOODS: INTERNATIONAL COOPERATION IN THE 21ST CENTURY 2 (Inge Kaul et al. eds., 1999).

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reducing the costs of early reporting and creating tangible benefits for adherence.

C. TWAIL and the Structural Inequalities Embedded in Global Health Law

TWAIL offers a critical lens for understanding how global health regulation reflects and reproduces structural inequalities. TWAIL scholarship highlights that international legal regimes often universalize obligations while embedding hierarchies rooted in colonial legacies and uneven patterns of development.[14]

Applied to the IHR, this framework exposes two structural dynamics. First, formally uniform obligations generate unequal burdens: disclosure duties are framed identically for all states but impose disproportionate economic and political costs on low and middle income states with vulnerable economies and limited buffers against trade, mobility, and reputational shocks. Second, capacity deficits translate into apparent compliance deficits. Many instances of delayed reporting or incomplete data reflect chronic underinvestment in surveillance, laboratory capacity, and health-system infrastructure—conditions shaped by structural global inequality rather than sovereign indifference or bad faith.[15]

Contemporary TWAIL analysis extends this critique to global governance more broadly, showing that reporting, monitoring, and scrutiny mechanisms often operate asymmetrically, subjecting less powerful states to heightened external visibility while leaving underlying distributive inequities unaddressed.[16] This perspective is essential for Section V, which demonstrates that enforcement failure in global health law is inseparable from the political economy of inequality and cannot be resolved without addressing these structural conditions.

D. The Epistemic-Juridical Divide in WHO Authority

The WHO exercises profound epistemic authority: it defines health risks, synthesizes global evidence, and issues recommendations. Epistemic authority, however, is not juridical authority. The WHO lacks the power to compel compliance, determine legal breach, or impose consequences for violation.[17]

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[14] ANGHIE, *supra* note 5, at 245-72; *see generally* B.S. Chimni, *Third World Approaches to International Law: A Manifesto*, 8(1) INT'L CMTY. L. REV. 3 (2006).
[15] IHR (2005), *supra* note 3, arts. 5, 13.
[16] *See generally* Obiora Chinedu Okafor, *Newness, Imperialism and International Legal Reform in Our Time: A TWAIL Perspective*, *in* LEADING WORKS IN INTERNATIONAL LAW 145 (Donna Lyons ed., 2023).
[17] SHEILA JASANOFF, THE FIFTH BRANCH: SCIENCE ADVISERS AS POLICYMAKERS 61-90 (1990).

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The International Health Regulations rest on the assumption that epistemic legitimacy can substitute for juridical enforceability, but this assumption collapses when scientific assessments conflict with sovereign political or economic interests. The widespread imposition of travel restrictions during the COVID-19 pandemic illustrates this collapse: WHO guidance was clear, yet states disregarded it without legal consequence.[18]

This divide is not a technical gap but a constitutional design feature of the WHO system itself. Recognizing the epistemic–juridical distinction is therefore essential to the reform proposals advanced in Section VI, which seek to introduce a quasi-juridical compliance mechanism without transforming the WHO into a coercive institution.

E. Comparative Institutional Design: Why WTO Enforcement Illuminates, Not Dictates, Reform

This article draws on comparative institutionalism not to suggest that the IHR should replicate the WTO, but to illustrate why enforcement succeeds in one regime and collapses in the other. WTO members accept ex ante sovereignty constraints, compulsory jurisdiction, and credible remedies anchored in reciprocal market-access concessions.[19] These features create a self-enforcing environment in which non-compliance triggers material consequences by suspending equivalent trade benefits. The IHR reflects the opposite logic: no reciprocal concessions, no retaliatory remedies, and no compulsory jurisdiction. Their design rests on voluntarism, deference, and epistemic persuasion.

The comparison is therefore diagnostic rather than prescriptive. The WTO reveals structural conditions—sovereignty-limiting commitments and enforceable incentives—that make international obligations actionable, while the IHR exemplifies a framework deliberately structured to avoid such mechanisms.[20] Because global health governance lacks equivalents to market-access concessions and cannot rely on remedial retaliation, the institutional logic of the WTO is neither transferable nor normatively desirable. This contrast frames the analysis in Section IV and anticipates the enforcement architecture in Section VI, which seeks to build accountability without coercive sanctions.

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[18] *Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)*, WORLD HEALTH ORG. (Jan. 30, 2020), https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov).

[19] MAVROIDIS, *supra* note 4, at 152-69; *see generally* Appellate Body Report, *Australia — Measures Affecting Importation of Salmon*, WTO Doc. WT/DS18/AB/R (adopted Nov. 6, 1998) [hereinafter *Australia — Salmon* Appellate Body Report].

[20] GOSTIN, *supra* note 2, at 89-105.

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III. DOCTRINAL ANALYSIS OF ENFORCEMENT IN INTERNATIONAL HEALTH LAW

International health law presents itself as a body of binding obligations designed to protect collective security. Yet, when interpreted doctrinally and situated within its constitutional framework, it becomes clear that its enforcement architecture is structurally incapable of compelling state compliance. The problem is not episodic or operational but foundational: the IHR and the Constitution of the World Health Organization (hereinafter "WHO Constitution") constitute a regime of informational coordination rather than one of compulsory legal obligation. Enforcement failures arise not because states disregard the law, but because the law itself lacks mechanisms to constrain sovereign incentives during crises.

A. The Constitutional Design of WHO and the Legal Character of the IHR

Although the IHR were adopted pursuant to Articles 21 and 22 of the WHO Constitution—which authorize the WHA to issue regulations binding on Member States absent affirmative rejection—their formal binding status does not translate into a coercive legal regime. The IHR appear at first glance to resemble treaty-like obligations: they prescribe duties of surveillance, notification, core capacity development, and cooperation with the WHO. Yet textual analysis conceals a foundational limitation: the WHO possesses no independent authority to determine breach, no investigatory competence absent state consent, and no power to impose consequences for non-compliance.[21]

The WHO Constitution was drafted as an administrative and coordinating instrument rather than a regulatory charter. It establishes the WHO as a technical authority entrusted with generating knowledge, issuing recommendations, and coordinating expertise, not as an enforcement body capable of policing sovereign conduct. WHO authority is therefore epistemic rather than coercive: the Organization may classify events, issue temporary recommendations under the IHR, and convene emergency committees, but the constitutional text withholds mechanisms of compulsion. As a result, the IHR's binding language masks an institutional reality in which compliance depends entirely on states' willingness to act against their immediate political or economic interests.

[21] Constitution of the World Health Organization arts. 21-22, July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185; IHR (2005), *supra* note 3, arts. 5-13, 43-44, 56.

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B. Material Obligations of States: Due Diligence Without Adjudication

The IHR impose discrete duties on States Parties, including prompt notification of events that may constitute a "public health emergency of international concern," the maintenance of surveillance systems and core public-health capacities, and cooperation with the World Health Organization's risk-assessment processes. These obligations bear the doctrinal characteristics of due diligence duties: they require conduct rather than outcomes, vigilance rather than guarantees. The decisive flaw lies elsewhere. The IHR provides no forum for determining whether a breach has occurred, no compulsory dispute-settlement mechanism, and no remedial pathway.[22] A duty without an adjudicator is functionally equivalent to a recommendation.[23]

In classical international law, breach triggers responsibility only when a tribunal or an equivalent body can authoritatively determine non-compliance. The IHR contains no such structure. Although Article 56 contemplates dispute settlement, participation is voluntary, and the mechanism has never been invoked. The result is a legal vacuum: non-compliance remains politically contestable but legally indeterminate. States may fail to detect outbreaks, delay notification, or underreport events without ever facing a formal determination of breach.

The COVID-19 pandemic illustrates this structural defect. Independent review mechanisms concluded that numerous states—including powerful ones—failed to meet IHR expectations concerning timely notification, transparency, and proportionality of response measures. Yet no state was formally declared non-compliant under the IHR framework. The global public may perceive violations, but international health law provides no doctrinal mechanism for translating violations into legal responsibility. The lesson is not that states evade the law; it is that the law offers no institutional means for its authoritative application.[24]

C. Incentive Design and the Political Economy of Disease Reporting

A doctrinal appraisal of enforcement must account for the incentives embedded within the IHR framework. Early outbreak notification exposes

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[22] IHR (2005), *supra* note 3, arts. 5-13, 43-44, 56.

[23] Vienna Convention on the Law of Treaties art. 26, *opened for signature* May 23, 1969, 1155 U.N.T.S. 331.

[24] *See generally* World Health Organization [WHO], *WHO's Work in Health Emergencies: Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005)*, WHO Doc. A74/9 Add.1 (May 5, 2021); Joost Pauwelyn, *The Rule of Law Without the Rule of Lawyers? Why Investment Arbitrators Are from Mars, Trade Adjudicators from Venus*, 109(4) AM. J. INT'L L. 761, 772-78 (2015).

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states to economically harmful consequences—trade disruptions, flight cancellations, travel restrictions, reputational harms, and political backlash. Delay, concealment, or strategic ambiguity may yield short-term benefits. International health law requires states to act against their immediate interests without offering compensatory incentives or legal protections that offset those harms.[25]

This constitutes a systemic inversion of incentives. The IHR requires transparency, while the international system punishes transparency. The logical outcome is rational non-compliance.

The travel ban episode during COVID-19 provides a clear example. Under Article 43 of the IHR, additional health measures must be science-based and consistent with World Health Organization guidance.[26] The WHO repeatedly advised against blanket travel bans. Nevertheless, more than one hundred states imposed them, often in direct contradiction to WHO recommendations.[27] The WHO lacked authority to identify these measures as unlawful, compel reversal, or impose consequences. The episode demonstrates not merely disregard of WHO guidance, but the institutional reality that WHO's legal authority becomes ineffective when national interests diverge from global public health needs.

This failure is not the result of operational weakness but of doctrinal design: the IHR contains no mechanism capable of confronting a state whose sovereign interests run counter to compliance.

D. Compliance Mechanisms as Soft Oversight Without Legal Force

Although the IHR include procedures for reporting, evaluation, and expert review, these mechanisms function as instruments of cooperation rather than tools of compliance adjudication. Core capacity assessments create the appearance of oversight but carry no legal consequences for persistent deficiencies. Temporary recommendations during a public health emergency of international concern are non-binding, and review committees may critique state conduct without authority to determine whether a breach has occurred.[28]

The 2024 amendments maintain this structural orientation. They establish National IHR Authorities and a States Parties Committee to strengthen coordination, improve implementation, and facilitate peer support. [29] Yet both bodies are expressly designed as non-adversarial,

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[25] THE INDEPENDENT PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, COVID-19: MAKE IT THE LAST PANDEMIC 28-31 (2021).
[26] IHR (2005), *supra* note 3, art. 43.
[27] *Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)*, *supra* note 18.
[28] *See generally* WHO, *supra* note 24.
[29] IHR (2005), *supra* note 3, arts. 4, 53-56.

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promotive, and non-punitive mechanisms, with no investigatory mandate, compulsory access, or authority to issue binding determinations. Their role is advisory and facilitative, reinforcing the IHR's reliance on cooperation, persuasion, and capacity-building.

This reform trajectory confirms the IHR's institutional softness at its core. As long as compliance mechanisms lack juridical authority and rely on voluntary engagement, international health law will continue to function as a governance framework rather than a legal regime capable of enforcing obligations.

E. Why Enforcement Is Structurally Impossible Under the Current Regime

The enforcement failures of the IHR are symptoms of three deeper constitutional features.

1. WHO Is Not a Sovereign Competitor; It Is a Service Institution — The Constitution of the World Health Organization endows the Organization with authority to advise, coordinate, and disseminate knowledge, but not to conduct compulsory inspections, impose sanctions, suspend rights, or take enforcement action. This constitutional silence is deliberate: Member States did not create the WHO to regulate or police sovereign conduct.[30]

2. The IHR Are Drafted to Appear Binding While Remaining Unenforceable — The IHR adopts a treaty-like form and language, but they omit adjudication, remedies, and sanctions. Their binding character is therefore largely symbolic: they articulate duties without generating legal consequences for violation.[31]

3. State Sovereignty Is Preserved at Every Point of Potential Enforcement — States retain control over outbreak reporting, access to territory, data sharing, travel measures, and the scope of domestic responses. The IHR defers to national risk assessments even when they diverge from World Health Organization guidance, embedding the primacy of national interest within the global health regime.[32]

Taken together, these features render enforcement structurally impossible. Absent compulsory jurisdiction, independent verification, or penalties, international health law relies exclusively on persuasion and reputation—mechanisms that predictably collapse when national political or economic interests are at stake.

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[30] Constitution of the World Health Organization, *supra* note 21, arts. 1-2.
[31] IHR (2005), *supra* note 3, arts. 5-13, 43, 56.
[32] *Id.* arts. 6, 10, 43.

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F. Implications for the International Legal Order

A doctrinally grounded understanding of the IHR reveals a paradox. International health law aspires to global security but is built on a constitutional model that prioritizes sovereign autonomy. The system requires states to act rapidly and transparently yet provides no enforcement mechanisms or incentives aligned with those expectations. This leaves WHO accountable for outcomes it has no power to prevent, and states are insulated from responsibility for decisions that generate global harm.

This analysis establishes the baseline for comparing the WHO system to the WTO's enforceable dispute-settlement architecture in the subsequent section. Whereas trade law embeds binding adjudication, sanctions, and the suspension of benefits—making sovereignty surrender a precondition of participation—international health law depends on goodwill. That structural divergence is central to understanding why global health security repeatedly fails.

IV. COMPARATIVE ENFORCEMENT ARCHITECTURE: WHO'S NON-COERCIVE REGIME AND THE WTO'S LEGALIZED ACCOUNTABILITY

A structural comparison between the IHR and the WTO reveals not simply two institutional models but two incompatible philosophies of international law. Where the WTO constitutionalizes sovereignty surrender to enable binding adjudication, the WHO framework preserves sovereignty to prevent it. The result is an enforcement asymmetry so profound that it exposes the IHR's incapacity not as a flaw of implementation but as an inherent feature of their design. The core institutional differences between the WHO and WTO enforcement architectures are summarized in Table 1.

TABLE 1: Comparative Enforcement Architecture of the WHO and the WTO

Dimension	WHO / IHR	WTO
Legal nature	Regulations under WHO Constitution	Multilateral treaty system
Jurisdiction	Voluntary (Art. 56)	Compulsory
Fact-finding	State-controlled	Panel-based
Adjudication	None	Binding panels & Appellate Body
Remedies	None	Retaliation / suspension of concessions
Incentive structure	Disclosure punished	Compliance rewarded

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A. Sovereignty Surrender: The Foundational Divide

WTO membership requires states to relinquish unilateral authority over trade disputes. Under the Understanding on Rules and Procedures Governing the Settlement of Disputes (hereinafter "DSU"), members must submit all covered disputes to compulsory jurisdiction. They may not engage in unilateral determinations of compliance. This *ex-ante* commitment transforms consent into constraint: states accept external adjudication before controversies arise. The constitutional logic of the WTO, therefore, rests on sovereignty surrender as the price of participation.[33]

The IHR contain no comparable concession. Article 56 contemplates dispute settlement only on a voluntary basis and provides no mandatory adjudicatory forum. Sovereignty remains intact. Absent compulsory jurisdiction, no determination of breach can acquire legal finality. The WHO system, therefore, operates through sovereign discretion rather than sovereign constraint.

This divergence is not accidental. The WTO was designed as an enforcement-oriented institution; the World Health Organization as a coordinating one. Their respective constitutional texts consequently orient their enforcement architectures in fundamentally opposite directions.[34]

B. Adjudication and the Transformation of Obligation

WTO adjudication converts treaty norms into enforceable law. Panels and the Appellate Body issue authoritative interpretations of treaty provisions and apply them to contested facts. These rulings are not advisory; they bind the losing state, and persistent non-compliance may trigger authorized retaliation.[35]

Adjudication does more than resolve disputes—it transforms obligation into expectation. States internalize WTO norms because deviation carries predictable legal and economic consequences. This self-reinforcing cycle of interpretation, compliance, and expectation constitutes the juridical authority of WTO law.[36]

The World Health Organization lacks any analogue. The IHR create obligations without institutional mechanisms for authoritative interpretation or enforcement. Nobody is empowered to determine breach, no panel exists to adjudicate contested interpretations, and no mechanism authorizes

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[33] Understanding on Rules and Procedures Governing the Settlement of Disputes arts. 21-23, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 2, 1869 U.N.T.S. 401 [hereinafter DSU].
[34] IHR (2005), *supra* note 3, art. 56.
[35] *Australia — Salmon* Appellate Body Report, *supra* note 19, ¶¶ 199-207.
[36] MAVROIDIS, *supra* note 4, 645-78.

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consequences for non-compliance. The WHO therefore exercises epistemic authority—the power to generate and circulate expert knowledge—but not juridical authority, the power to enforce legal obligation. As a result, IHR norms remain suspended between text and practice, incapable of disciplining state conduct when national interests diverge from global public-health needs.[37]

C. The SPS Agreement: Enforceable Discipline in Health-Related Regulation

The Agreement on the Application of Sanitary and Phytosanitary Measures (hereinafter "SPS Agreement") provides a functional comparison because it regulates state measures justified on health-protection grounds. The SPS Agreement requires such measures to be science-based, proportionate, and grounded in international standards.[38] Failure to satisfy these requirements is justiciable, and states may be held legally accountable through the WTO dispute-settlement system.[39]

In Australia — Measures Affecting Importation of Salmon, the Appellate Body invalidated Australia's health measure for lacking an adequate risk assessment, finding it inconsistent with SPS obligations. The ruling compelled Australia to revise its domestic regulatory framework. The case illustrates how WTO enforcement mechanisms ensure that health-related justifications cannot shield scientifically unsubstantiated or protectionist policies from legal scrutiny.[40]

Under the IHR, by contrast, states that imposed sweeping COVID-19 travel bans in defiance of World Health Organization guidance faced no legal adjudication or sanction. The WHO could issue recommendations, but it lacked the authority to determine breaches, compel compliance, or impose consequences. Where the SPS Agreement disciplines state conduct through enforceable scientific standards, the IHR relies on non-binding guidance. One regime produces compliance through law; the other merely solicits it.

D. TRIPS and Enforceability in Health-Adjacent Rights

The Agreement on Trade-Related Aspects of Intellectual Property Rights (hereinafter "TRIPS") further demonstrates that states tolerate enforceable obligations even in politically sensitive, health-adjacent domains. While

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[37] DSU, *supra* note 33, arts. 21-22.

[38] Agreement on the Application of Sanitary and Phytosanitary Measures arts. 2-5, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1A, 1867 U.N.T.S. 493 [hereinafter SPS Agreement].

[39] *Id.*

[40] *See generally Australia — Salmon* Appellate Body Report, *supra* note 19.

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TRIPS incorporates flexibilities—including compulsory licensing and transition periods—disputes concerning compliance remain subject to binding adjudication under the WTO dispute-settlement system. What matters doctrinally is not the direction of the obligation but the existence of an institutional mechanism capable of transforming obligation into enforceable duty.[41]

The TRIPS regime reveals a philosophical point central to this analysis: states comply not because obligations are normatively attractive, but because non-compliance is costlier than adherence. Under TRIPS, the incentive structure aligns compliance with rational self-interest. Under the IHR, the inverse holds: early outbreak reporting imposes immediate political and economic costs on the reporting state, while delay or non-disclosure may generate short-term domestic advantage. The IHR thus inverts the compliance logic that sustains the WTO enforcement system.[42]

This inversion explains why the WHO enforcement cannot replicate the WTO legalization: one regime aligns incentives with compliance through adjudication and consequences, while the other structurally aligns incentives against compliance.[43]

E. Remedies as the Essence of Enforceability

A legal obligation becomes meaningful only when a breach produces consequences. Under the DSU, failure to comply with panel or Appellate Body rulings authorizes the suspension of concessions. This remedy mechanism creates a credible threat: states may face retaliatory measures that impose real economic harm.[44]

The IHR contain no comparable remedy system. They contemplate neither restitution, sanctions, nor the suspension of rights. Even flagrant violations—such as unscientific travel bans, refusal to share samples, or suppression of early outbreak data—yield no institutional consequences. This is not a failure of the WHO; it is a limitation imposed by the regime's constitutional architecture.[45]

A rule without a remedy is not enforceable law; it is an expectation. The IHR does not lose authority because states ignore it; it loses authority because it lacks a mechanism to defend its own norms when they are ignored.

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[41] Agreement on Trade-Related Aspects of Intellectual Property Rights arts. 7-8, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299 [hereinafter TRIPS].
[42] IHR (2005), *supra* note 3, arts. 6-13, 43.
[43] DSU, *supra* note 33, arts. 21-22.
[44] *Id.* art. 22.
[45] IHR (2005), *supra* note 3, arts. 43, 56.

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F. Normative Divergence: Contractual Law vs. Coordinative Governance

The WTO and WHO are governed by fundamentally different visions of international law.

1. Contractual vs. Coordinative — The WTO is a contractual regime: members exchange market access for legal constraint. The WHO is a coordinating institution: members exchange information for collective benefit, without ceding authority.

2. Juridical vs. Epistemic Authority — The WTO adjudicates truth; the WHO defines knowledge. WTO panels determine whether a state has violated obligations. WHO experts determine what constitutes a public health risk. One produces binding rulings; the other, guidance. The difference between juridical and epistemic authority explains why the WHO cannot compel compliance even when its scientific assessments are universally accepted.

3. Incentive Alignment vs. Incentive Inversion — WTO compliance is rational: violating trade law triggers retaliation. IHR compliance is irrational: revealing outbreaks triggers economic harm. The incentives that support WTO enforcement actively undermine IHR effectiveness.

These divergences are not anomalies; they reflect the philosophical core of each institution.

G. Why WTO Enforcement Cannot Simply Be Transplanted to Global Health

The WTO demonstrates that enforceable international law is possible when states accept ex ante sovereignty constraints, when compliance produces reciprocal benefits, and when remedies are credible. However, transplanting these mechanisms into international health law encounters insurmountable structural barriers:

1. States refuse external review of domestic health measures, viewing them as tied to national security and political legitimacy.
2. Global health law lacks reciprocal economic incentives; there is no equivalent of market-access concessions.
3. WHO's constitutional mandate excludes adjudication and coercion, and amending it would require political conditions that have never existed.

Thus, while the WTO model illustrates what "hard" international law looks like, the political and constitutional foundations necessary for such a model are absent in global health governance.

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H. Incentive Structures: WTO Reciprocity vs. IHR Disclosure Costs

The enforcement asymmetry between the WTO and the IHR is rooted not only in the adjudicatory design of each regime but also in the structure of incentives each regime generates. Reciprocal benefits sustain WTO law: members exchange market access for legal constraint, and non-compliance exposes them to the suspension of equivalent concessions. Compliance is therefore rational, because adherence preserves tangible economic advantages while defection triggers credible and measurable costs.[46]

The IHR inverts this logic. Early outbreak notification provides a global public good—rapid containment—that benefits all states, yet the immediate economic and political costs fall solely on the notifying state. There is no reciprocal benefit comparable to market-access concessions, and no remedial mechanism capable of imposing costs on those who disregard WHO guidance or delay reporting. The incentive structure, therefore, aligns rational state behavior against early disclosure: compliance is costly, while non-compliance may offer short-term domestic advantage.[47]

This divergence explains why the institutional logic of WTO enforcement cannot be transplanted into global health governance. The WTO model is anchored in reciprocity, adjudication, and enforceable remedies. The IHR framework lacks equivalent levers and, by constitutional design, cannot employ retaliatory or coercive tools. Effective accountability within the IHR must therefore arise from an alternative incentive configuration—one that offsets the disclosure penalty, offers conditional or compensatory benefits, and strengthens capacity where structural deficits drive non-compliance.

These considerations provide the conceptual foundation for the enforcement architecture developed in Section VI, which replaces reciprocity-based discipline with incentive alignment and redistributive support.

I. Enforcement as the Defining Distinction Between the Two Regimes

The WTO enforces compliance by making violations costly, ensuring authoritative adjudication, and making obligations reciprocal. The WHO system does none of these things. Its authority is epistemic, its norms are unenforceable, and its incentives encourage concealment rather than disclosure. What appears as WHO's "weakness" is, in fact, the result of a regime intentionally designed to preserve sovereignty rather than discipline it.

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[46] MAVROIDIS, *supra* note 4, at 152-69.
[47] OLSON, *supra* note 12, at 33-36.

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This comparison underscores the central thesis: the IHR fail not because they are ignored, but because they cannot be enforced within their existing legal and constitutional framework. The following section builds on this insight by examining how power dynamics and structural inequalities further entrench this enforcement vacuum.

V. POWER, INEQUALITY, AND THE STRUCTURAL LOGIC OF NON-COMPLIANCE IN GLOBAL HEALTH GOVERNANCE

While Sections III and IV establish the doctrinal and institutional limitations of the IHR, a purely legal explanation cannot account for persistent patterns of selective compliance, uneven scrutiny, and geopolitical shielding. International health law operates within a global order marked by profound asymmetries of political influence, economic resilience, and epistemic authority. These asymmetries shape not only how law is interpreted but whether it can meaningfully function as law at all. In the IHR regime, power—not obligation—determines compliance. The result is a system where the burdens of disclosure fall on those least equipped to bear them, while the costs of non-compliance often fall on those least able to impose them.

A. Agenda-Setting Inequality: Who Defines Global Health Emergencies?

Although the IHR formally impose equal notification duties, risk assessment in practice is dominated by states with strong surveillance systems, advanced laboratory capacity, and geopolitical weight. These states disproportionately influence whether events are deemed "public health emergencies of international concern" (hereinafter "PHEIC") and shape the WHO's risk framing. The voices of states with limited laboratory or genomic sequencing capacity carry less weight in global assessments.[48]

This epistemic hierarchy matters for compliance. When powerful states define threats and certify evidence, weaker states are positioned as sites of scrutiny rather than co-authors of global risk governance. Developmental disparities in public health infrastructure and data-generation capacity translate directly into unequal authority to set global agendas.[49]

The IHR thus operates through a hierarchy of voice: some states narrate emergencies; others are narrated. Compliance is shaped in advance by this

[48] *See generally* WHO, MANAGING EPIDEMICS: KEY FACTS ABOUT MAJOR DEADLY DISEASES (2018).
[49] *See generally* U.N. DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT (2022).

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asymmetry of agenda-setting authority rather than by formally equal legal obligation.[50]

B. The Political Economy of Disclosure: Transparency with Unequal Costs

Transparency is the core logic of the IHR, yet it carries vastly unequal consequences. States with diversified, resilient economies can afford early disclosure; reputational and economic losses are temporary. By contrast, states dependent on tourism, commodity exports, or fragile investment flows suffer immediate economic injury when outbreak information becomes public.[51]

A vivid illustration occurred in late 2021 when South African scientists identified the Omicron variant and disclosed it rapidly. Within days, over 30 states imposed sweeping travel bans targeting Southern Africa, despite WHO guidance against such measures.[52] The scientific openness of South Africa resulted in punitive restrictions, while states that later experienced widespread Omicron transmission imposed no such costs on themselves.

The IHR creates a uniform obligation—disclosure—while the global system attaches unequal harm to compliance. Rational states will hesitate, delay, or dilute transparency when the economic burden of honesty is asymmetric.

C. Selective Accountability: Why Equivalent Conduct Produces Unequal Consequences

The IHR lacks formal enforcement mechanisms, but informal accountability exists through WHO assessments, donor influence, and global media narratives. These mechanisms, however, operate unevenly. States with geopolitical leverage can resist WHO criticism, shape narratives, or redirect scrutiny onto procedural ambiguity. By contrast, lower-income states become subject to external monitoring, donor-imposed reporting conditions, and travel restrictions even when their conduct is indistinguishable from that of more powerful states.

During the 2014-2016 Ebola outbreak in West Africa, Guinea, Liberia, and Sierra Leone faced extensive scrutiny for delayed detection, even though the underlying cause was structural underinvestment linked to colonial and postcolonial economic patterns.[53] Meanwhile, high-income states that

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[50] *Classification of Omicron (B.1.1.529): SARS-CoV-2 Variant of Concern*, *supra* note 1.
[51] The INDEPENDENT PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, *supra* note 25, at 28-31.
[52] IHR (2005), *supra* note 3, art. 43.
[53] WHO, REPORT OF THE EBOLA INTERIM ASSESSMENT PANEL 7-15 (2015); *see generally* WHO, EBOLA SITUATION REPORT (2016).

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imposed scientifically baseless travel restrictions faced no comparable accountability.[54] This asymmetric response reveals that enforcement does not track legality but geopolitical vulnerability.

D. TWAIL Critique: The IHR as a Sovereignty-Preserving Regime for the Powerful

TWAIL provide a theoretical lens for understanding these disparities. TWAIL scholars argue that international law often reproduces rather than remedies structural inequities rooted in empire.[55] Within this framework, the IHR can be understood as a sovereignty-preserving arrangement for powerful states and a sovereignty-qualifying one for weaker states.

IHR obligations do not meaningfully constrain powerful states because the regime relies on voluntary disclosure and contains no mechanism to pierce sovereignty. Yet weaker states face a different reality: they are pressured to disclose, scrutinized for delay, and stigmatized for outbreaks, even when delays reflect structural underinvestment rather than negligence. TWAIL reveals that the IHR's architecture sustains a double sovereignty system: maximal autonomy for those with global leverage, diminished autonomy for those without it.

E. Capacity Deficits and the Fiction of Equal Ability to Comply

The IHR imposes uniform duties but ignores structural disparities in capacity. Surveillance systems, laboratory networks, and trained epidemiologic workforces require sustained financing. These capacities cannot be conjured through legal obligation alone. Yet the IHR treats compliance as an issue of political will rather than material feasibility. Articles 5-13 require states to develop "core capacities," but neither provides a financing mechanism nor imposes a redistributive obligation on high-income countries.[56]

This creates what can be described as a capability-compliance fiction: the law presumes that all states can comply, even as the global system ensures that many cannot. The fiction protects the regime's legitimacy but obscures the underlying injustice: states most vulnerable to health threats are judged by standards they lack the structural means to meet.

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[54] *Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa*, WHO (Aug. 8, 2014), https://www.who.int/news/item/08-08-2014-statement-on-the-1st-meeting-of-the-ihr-emergency-committee-on-the-2014-ebola-outbreak-in-west-africa.

[55] ANGHIE, *supra* note 5, at 245-72.

[56] IHR (2005), *supra* note 3, arts. 5-13.

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F. Epistemic Hierarchy and the Juridical Void

WHO's authority derives from its epistemic function—it defines outbreaks, issues scientific guidance, and synthesizes evidence. Yet epistemic authority alone cannot create compliance without a corresponding juridical structure. As Section IV demonstrated, the WHO cannot determine breaches, impose sanctions, or adjudicate disputes. The IHR therefore produces a paradox: powerful states selectively adopt the WHO's scientific outputs while weaker states are judged against them.

This epistemic hierarchy has legal consequences. When the WHO declares a PHEIC, powerful states may ignore the organization's recommendations without legal cost, while lower-income states face reputational and economic consequences for failing to comply. WHO's scientific authority thus interacts with geopolitical asymmetry to produce a system where knowledge disciplines the weak but does not constrain the strong.

G. Why Enforcement Reform Is Structurally Blocked

Efforts to revise the IHR or negotiate a pandemic treaty have sought to introduce compliance committees, enhanced reporting duties, and expanded monitoring mechanisms. Yet meaningful enforcement reform confronts entrenched structural barriers. First, states with the political and technical capacity to enforce compliance have little interest in being subjected to external scrutiny, particularly in domains implicated in national security. Second, states that would benefit from enforceable obligations lack the leverage to demand them, as global health negotiations operate through consensus and avoid majoritarian decision-making. Third, any system of sanctions or compulsory jurisdiction would risk reproducing geopolitical asymmetries by allowing powerful states to shape or weaponize enforcement mechanisms to their advantage.[57]

These constraints are not incidental; they reflect an international order in which health sovereignty is unevenly distributed and in which states with the most significant capacity to resist oversight will not authorize institutions capable of constraining them.[58] Within this environment, enforcement reform must be feasible rather than aspirational: it can function only through mechanisms that mitigate power asymmetries rather than amplify them. This is why the accountability model developed in Section VI relies on incentive

[57] *See generally* WHO, *Intergovernmental Negotiating Body to Draft and Negotiate a WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response*, WHO Doc. A77/10 (May 27, 2024).
[58] *See generally* Okafor, *supra* note 16.

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alignment, quasi-juridical determination, and redistributive support rather than coercive sanctions.

H. Unequal Power, Unequal Consequences, and the Limits of Legal Obligation

Compliance with the IHR is structured not by legal duty but by power, incentives, and global inequality. States disclose disease events not when the law requires it, but when transparency aligns with geopolitical and economic interests. Enforcement is selectively applied because accountability flows downhill: the weaker are scrutinized; the stronger are accommodated. WHO's authority is epistemic, not juridical, and epistemic authority cannot compel sovereign behavior in a world ordered by asymmetry.

The IHR, therefore, cannot function as a binding legal regime until its enforcement, financing, and epistemic structures are redesigned to address these power dynamics. Section VI outlines a reconstructed model of global health accountability capable of converting obligation into enforceable duty.

VI. RECONSTRUCTING GLOBAL HEALTH ACCOUNTABILITY: DESIGNING AN ENFORCEMENT ARCHITECTURE CAPABLE OF CONSTRAINING SOVEREIGN POWER

The preceding sections established two core propositions: first, that the IHR lack enforceability because their constitutional design deliberately excludes coercive authority; and second, that compliance is shaped less by formal obligation than by asymmetries of political economy, capacity, and epistemic power. As a result, international health law currently functions as a system of aspirational coordination rather than a regime capable of constraining sovereign incentives. The 2024 IHR amendments introduced new monitoring bodies—such as National IHR Authorities and the States Parties Committee—but did not alter this fundamental structure.[59]

Reconstruction must therefore be grounded in mechanisms that are both effective and institutionally feasible. Rather than mirroring the coercive adjudication model of the WTO, an enforceable global health regime must align incentives, strengthen compliance determination, and address structural inequality without exceeding the WHO's constitutional mandate. This Article develops a model organized around three interlocking pillars—incentive alignment, institutional authority, and redistributive capacity—each of which can be implemented through existing legal pathways, either by WHA resolutions or by IHR amendments under Articles 55-59. Together,

[59] IHR (2005), *supra* note 3, arts. 4, 53-56.

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these pillars aim to transform global health obligations into structured expectations while avoiding the reproduction of existing global inequities.

TABLE 2: Reconstructed Enforcement Architecture for Global Health Law

Pillar	Current IHR	Proposed Reform
Incentives	None	Compensation + access
Compliance determination	Informal review	Independent Compliance Determination Panel (ICDP)
Capacity building	Voluntary	Mandatory redistribution

A. Incentive Alignment: Making Compliance Rational Rather than Heroic

Early outbreak reporting under the IHR is often costly for the notifying state, and this structural reality shapes state behavior. As Section V demonstrated, disclosure can trigger economic loss, political pressure, and heightened scrutiny, particularly for low- and middle-income countries. An effective accountability system must therefore address the fact that transparency imposes immediate national costs while offering diffuse global benefits. Incentive alignment provides the most feasible pathway for reshaping this dynamic, because it works through support and reciprocity rather than coercion.

1. A Global Outbreak Solidarity Fund (hereinafter "GOSF") — A GOSF, financed through assessed contributions, would compensate states for documented economic losses associated with early notification. Compensation reduces the disclosure penalty and is politically acceptable because it preserves sovereignty while stabilizing states that bear the initial burden of transparency. It performs a function analogous to economic safeguards in other regimes: states accept constraints when compliance yields predictable and immediate benefits.

2. Conditional Access to Surveillance Resources — States that meet defined reporting thresholds would receive priority access to genomic sequencing support, vaccine-related technology transfer, diagnostics, and emergency-response assets. This approach strengthens core capacities while removing key barriers to timely reporting. By linking disclosure to tangible assistance, the mechanism makes compliance materially advantageous rather than politically risky.

3. Graduated Consequences for Concealment — Although coercive sanctions are neither feasible nor compatible with the WHO's constitutional mandate, procedural consequences can still alter state incentives. Measures such as temporary reductions in committee influence, delayed eligibility for

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specific funding mechanisms, or enhanced transparency obligations create reputational and institutional costs without replicating the punitive logic of trade law. These tools rely on political incentives rather than formal penalties and are therefore more acceptable within current global health politics.[60]

By embedding reporting obligations within an incentive structure rather than assuming sovereign altruism, this model makes early disclosure a rational choice. It offers a feasible basis for strengthening accountability within the constraints of the existing global health governance system.

B. Institutional Authority: Building a Juridical Core Without Replicating WTO Coercion

The IHR cannot function as enforceable law because the WHO lacks juridical authority: it has no compulsory investigatory power, no binding fact-finding, no adjudicatory body, and no remedy system.[61] A practical accountability framework must therefore introduce a limited juridical core—an institution capable of determining compliance—without transforming the WHO into a coercive tribunal. To address the reviewer's concern regarding feasibility, each component below indicates its required legal pathway: either an amendment under Articles 55-59 of the IHR or a WHA resolution adopted under Articles 21-23 of the WHO Constitution.[62]

1. Independent Compliance Determination Panel (hereinafter "ICDP") — Legal route: IHR amendment (Arts. 55-59)

A compliance body with quasi-juridical functions cannot be created solely by soft law.[63] Establishing an ICDP would require an amendment to the IHR, as it introduces an organ empowered to assess state conduct in relation to binding obligations. Once established, the ICDP would:

1. determine whether specific conduct constitutes non-compliance with the IHR;
2. issue written findings that, while non-punitive, carry legal weight and trigger procedural or financial consequences within the incentive system (e.g., GOSF adjustments);
3. Request relevant data or facility access, with refusal recorded as an adverse inference in compliance evaluation.

The ICDP would not adjudicate inter-state disputes, avoiding WTO-style adversarialism. Its function is limited to objective compliance assessment, which strengthens accountability without coercion.

2. Mandated Transparency for Travel and Trade Measures — Legal route: WHA resolution (Arts. 21-23)

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[60] *Id.* arts. 5-13.
[61] *Id.* arts. 4, 53-56.
[62] Constitution of the World Health Organization, *supra* note 21, arts. 21-23; *id.* arts. 55-59.
[63] Abbott & Snidal, *supra* note 11, at 421-56.

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The WHO has constitutional authority to adopt procedural reporting requirements through WHA resolutions. A resolution could require states invoking additional health measures under Article 43 to submit:

1. a scientific justification;
2. a proportionality analysis;
3. an assessment of the projected economic impact on affected states.

If a state fails to provide this documentation within a fixed period, the ICDP may classify the measure as non-compliant. This requirement does not impose sanctions; instead, it disciplines discretionary national measures by subjecting them to structured review.

Because this concerns documentation and procedural transparency, a WHA resolution is legally sufficient and avoids the political difficulty of treaty amendment.

3. Emergency Verification Missions —

1. Option A: Soft verification (WHA resolution)

A WHA resolution could authorize voluntary, non-binding verification missions, deployed at a state's request or with its consent. This approach aligns with the existing cooperative ethos and is politically feasible.

2. Option B: Limited compulsory verification (IHR amendment)

If verification missions are intended to operate without prior consent—activated by a WHA supermajority—they would require a formal amendment to the IHR. Compulsory investigatory authority cannot be introduced through soft law. States are unlikely to accept a strong inspection mandate, but a circumscribed mechanism focused on clarifying early outbreak information may be negotiable.

This institutional restructuring would not convert the WHO into a coercive adjudicatory body. Instead, it would introduce a narrowly tailored juridical core capable of issuing authoritative compliance determinations, subjecting discretionary measures to structured transparency, and clarifying factual uncertainties through verification missions. These tools preserve state sovereignty while adding an enforcement backbone currently absent from the IHR.

C. Redistributive Capacity: Correcting the Structural Inequality Embedded in the IHR

As Section V established, capacity deficits—not simply political will—drive many forms of non-compliance. A credible accountability framework must therefore incorporate redistributive obligations that shift the burden of capacity-building away from states least equipped to bear it and toward those with greater financial and technological resources. Without redistribution, expectations of universal "core capacities" remain normatively attractive but institutionally unachievable.

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1. Legally Mandated Financing Mechanism — Article 44 of the IHR encourages cooperation but does not impose binding financial obligations.[64] A reconstructed regime would require mandatory contributions, calibrated to national income and technological capability, to fund surveillance infrastructure, laboratory systems, epidemiological and genomic training, and digital detection platforms. This converts aspirational cooperation into a structured obligation and ensures that capacity-building becomes a predictable component of global health governance.

2. Technology Transfer Obligations — States with advanced genomic, diagnostic, and vaccine platforms would bear affirmative obligations to support technology transfer. While analogous to the flexibilities under the TRIPS Agreement, this mechanism extends beyond permissive exceptions by embedding a duty to expand scientific and production capacity in regions facing recurrent outbreak risk.[65]

3. Distributed Regional Surveillance Hubs — To reduce epistemic dependence on a small number of technologically dominant states, regional surveillance hubs under WHO oversight would decentralize laboratory and analytic capacity. This dispersal corrects structural asymmetries whereby powerful states define risk and weaker states are evaluated against standards they lack the means to meet.

4. Feasibility Through Redistribution — Redistribution is essential not only for equity but also for political feasibility. Low- and middle-income countries are far more likely to accept enhanced reporting duties, external review, and structured compliance mechanisms when these obligations are coupled with concrete support that offsets the material costs of transparency. Conversely, removing the capacity burden from peripheral states reduces North–South tension by grounding accountability in burden-sharing rather than discipline. In this way, redistributive obligations make enforcement politically viable and ethically coherent.

Redistributive capacity is not humanitarian; it is structural. Without it, the IHR remain formally equal but substantively unenforceable.

D. Integrating the Three Pillars into a Coherent Accountability Framework

A viable enforcement architecture must combine incentive alignment, limited juridical authority, and redistributive capacity into a coherent system that remains non-coercive, respects state sovereignty, and aligns with the institutional direction set by the 2024 IHR amendments.[66] These amendments introduced new mechanisms—such as National IHR

[64] IHR (2005), *supra* note 3, art. 44.
[65] TRIPS, *supra* note 41, arts. 7-8.
[66] IHR (2005), *supra* note 3, arts. 4, 53-56.

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Authorities and the States Parties Committee—that expand coordination and monitoring but stop short of creating enforceable obligations. The proposed model builds on this trajectory by strengthening accountability without departing from the WHO's constitutional constraints.

The integrated system would operate through three linked functions. First, early disclosure would automatically trigger compensation and priority access to surveillance support, correcting the structural incentive deficit that currently discourages transparent reporting. Second, compliance assessments issued by the Independent Compliance Determination Panel would introduce authoritative, non-adversarial determinations that carry procedural and reputational consequences, filling the juridical gap without reproducing the coercive litigation model of the WTO. Third, mandatory redistributive financing and technology transfer would reduce structural capacity disparities, transforming capacity-building from voluntary cooperation into a predictable institutional commitment.

This framework does not coerce states or impose sanctions. Instead, it reshapes the environment in which states make decisions by making compliance advantageous, procedurally visible, and materially supported. Sovereignty is preserved because participation remains voluntary and determinations do not compel specific actions. At the same time, the benefits of participation—financial protection, resource access, and institutional influence—become meaningfully tied to adherence.

Most importantly, the model reorients global health governance away from a formal equality that masks deep structural inequalities. By embedding redistribution, authority, and incentives within a single architecture, it creates an accountability system that reflects existing disparities and seeks to correct them rather than reproduce them.

E. Why This Reconstruction Is Both Necessary and Politically Realistic

Classic proposals for WTO-style adjudication in global health law misread the WHO's political and constitutional constraints. As Sections III-V demonstrated, powerful states will not accept a coercive enforcement regime in a domain closely tied to domestic legitimacy and national security. A viable reconstruction must therefore avoid coercion while still generating meaningful accountability.

The model proposed here meets that requirement. It reframes compliance as a structured bargain in which benefits flow to states that report early and procedural consequences apply to those that conceal. It preserves sovereignty while enabling external evaluation through non-adversarial compliance determinations. It reduces inequality by embedding redistributive obligations into the legal architecture. It strengthens the

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WHO's institutional role by adding quasi-juridical functions without requiring a constitutional amendment.

Crucially, the model is politically realistic because it can be implemented in stages. Phase one builds on existing reforms by expanding soft oversight through the States Parties Committee and strengthening reporting norms. Phase two deploys the Global Outbreak Solidarity Fund and conditional benefits to correct incentive structures once trust and predictability are established. Phase three introduces the Independent Compliance Determination Panel, but only after institutional legitimacy has grown and states have experienced the advantages of structured accountability. This sequencing addresses the reviewer's concern by grounding the proposal in a gradual, feasible pathway rather than in sudden institutional transformation.

This is not a utopian blueprint; it is a structural redesign grounded in the functional logic of international law and calibrated to the political realities of global health governance.

F. From Aspirational Norms to Structured Accountability

Reconstructing global health accountability requires abandoning the IHR's assumption that sovereigns will comply simply because they should. Compliance emerges when institutions align incentives, redistribute resources, and create authoritative mechanisms for determining when obligations are breached. A system built on these principles would transform the IHR from an architecture of hope into an architecture of enforceable expectation.

Crucially, this reconstruction is politically and legally feasible. Each component can be implemented through existing WHO constitutional authority—either through an IHR amendment or a WHA resolution—allowing the transition from aspirational norms to structured accountability without requiring a coercive overhaul of global health governance.

VII. CONCLUSION

The analysis developed in this article demonstrates that the IHR are structurally incapable of constraining sovereign behavior because their architecture was intentionally designed to avoid juridical authority, compulsory oversight, and enforceable remedies. The COVID-19 pandemic did not expose an accidental failure; it revealed a system functioning as constructed voluntarism presented in the form of binding international law. Recognizing this contradiction is essential for any effort to improve global health governance.

Three insights follow. First, doctrinal analysis shows that the absence of compulsory jurisdiction, authoritative fact-finding, and remedial

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mechanisms makes IHR compliance formally obligatory but practically optional. Sovereignty is not an obstacle to enforcement; it is the regime's constitutional baseline. Second, comparative institutional analysis—particularly with the WTO—illustrates that enforceability results from structural design rather than subject matter. WTO members accept reciprocal incentives and sovereignty-limiting mechanisms that global health governance was never mandated to, nor politically positioned to, adopt. Third, political-economy and TWAIL perspectives reveal that disclosure obligations impose asymmetric burdens, scrutiny is uneven, and compliance failures track underlying patterns of economic and epistemic inequality.

The way forward is neither the coercive imposition of WTO adjudication nor the preservation of the current voluntarist model. This article proposes an alternative enforcement architecture grounded in three pillars: (1) incentive alignment that makes early notification advantageous rather than harmful; (2) a quasi-juridical compliance mechanism capable of issuing authoritative determinations without destabilizing sovereignty; and (3) redistributive obligations that address the structural capacity deficits that make uniform compliance unattainable. These reforms are institutionally feasible: components such as enhanced reporting, transparency standards, and benefit-linked incentives can be advanced through WHA resolutions, while establishing a compliance determination panel or mandatory financing mechanism would require IHR amendments under Articles 55-59. Importantly, the model aligns with the trajectory of the 2024 IHR amendments, which introduced new monitoring bodies but did not establish enforceable accountability.

Meaningful global health security requires a legal framework capable of producing consistent and equitable compliance. The choice is not between coercion and voluntarism, but between maintaining a system that cannot work and constructing one that can. The enforcement architecture developed here offers a realistic and legally grounded pathway toward a global health order that is credible, politically viable, and structurally just.

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