GLOBAL HEALTH IN A TURBULENCE TIME: A COMMENTARY

Tsung-Ling Lee[*]

ABSTRACT

The emergence of the 2019 novel coronavirus—or COVID-19[1]*—outbreak has resuscitated global attention on the state of global health governance. Legal scholars and political scientists have long been fascinated by global governance of health, which had galvanized intellectual discourse that began almost two decades ago. Increasingly, global health operates in a complex, multipolar world, which is informed by pluralistic values. The ever-changing configuration of players, interests and values adds complexity to the global health landscape. It is timely to reexamine the landscape of global health, where new transnational challenges—such as galvanizing a global concerted effort towards international infectious disease control, financing global health activities in a sustainable manner, and achieving Universal Health Coverage—also inform new global health configuration. The article takes a historical view and traces the evolving of the global health landscape and examines the various of norms, processes and institutions that form global governance of health. The article also identifies the strengths and weakness of the International Health*

[*] Assistant Professor of Law. Taipei Medical University. I am grateful for the insightful feedback of the anonymous reviewer and the superb editorial efforts of the AJWH editorial team. All errors are my own. The research is supported by the Brocher Foundation and the Young Scholar Fellowship Program by Ministry of Science and Technology (MOST) in Taiwan, under Grant MOST108-2636-H038-002.The author can be reached at: tl265@georgetown.edu.

[1] *See generally Coronavirus Disease (COVID-19) Outbreak*, WORLD HEALTH ORGANIZATION [hereinafter WHO], https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last visited Feb. 14, 2020).

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Regulations—the international legal architecture for international infectious disease control—as the novel coronavirus outbreak unfolds.

KEYWORDS: *global governance of health, universal health coverage, World Health Organization, 2019 novel coronavirus, COVID-19, the right to health*

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I. INTRODUCTION

The emergence of the deadly coronavirus, the 2019 novel coronavirus—or COVID-19[2]—outbreak has resuscitated global attention on the state of global health governance. With the rapid outbreak of the novel coronavirus across the global, effective containment of the outbreak requires global concerted efforts. New transnational challenges—for instance, emergence and re-emergence of infectious diseases, containment of antimicrobial resistance, appropriate international governance of human genome editing—expose the collective vulnerability which is in need of concerted global efforts. Increasingly, global health operates in a complex multipolar world, informed by pluralistic values. The relationship between those who are governing and those being governed is often tense. The ever-changing configuration of players, interests and values add complexity to the global health landscape. Operations of global health exists in constant contestation within a multi-layer governance structure. Institutions with global health mandates or capable of delivering have multiplied since the turn of millennium.

However, mobilizing global solidarity remains challenging: in part because global health has become more political and less driven by humanitarian-focused missions, in part because insufficient resources and funding, and in part because global health agenda has been driven and shaped by divergent interests in an increased crowded landscape. Solving new transnational, collective action problems have become more difficult: governments often are reluctant to invest in public health infrastructure when these investments do not necessarily yield immediate and apparent political gains.

In an interconnected world, driven by an increased rate of economic globalization, global governance of health is a contentious field, often fought with ideological disagreements. Adding to the operational difficulties—lack of funding and resources, challenges over coordination, fragmented landscape—many of global health activities often operate against the background of increased skepticism on the World Health Organization (hereinafter "WHO"), which further undermines and undercuts the effectiveness of the organizations' public health programs and initiatives. Global governance of health is increasingly complex, with non-states actors exerting growing influences on global health policies. Governance challenges for global health has long fascinated legal scholars and political scientists.[3] With the recent COVID-19 outbreak it is timely to re-examine

[2] *See generally id*.

[3] *See generally* Allyn L. Taylor, *Global Governance, International Health Law and WHO: Looking Towards the Future*, 80(12) BULL. WORLD HEALTH ORG. 975 (2002), https://apps.who.int/iris/handle/10665/71663.

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the current landscape of international health cooperation, which is underpinned by various of legal norms, processes and institutions.

The paper sketches the recent key development in global health and offers some commentaries on some of these emerging trends. The paper takes a historical view and traces the evolution of the global health landscape *vis-à-vis* the right to health, the article demonstrates that despite the constantly shifting landscape—which takes shape against the backdrop of economic globalization and political turbulence—these emerging challenges also help contributing to innovative governance mechanisms, spur new configuration and arrangements in global health.

II. GLOBAL HEALTH: PROGRESS AND CHALLENGES

In the last six decades, the world's achievements in health have been remarkable: global life expectancy has increased more in the new millennium than any previous millenniums.[4] Most of the health progress are in low- and middle-income countries: average life expectancy was approximately forty years in 1950, five decades later, it has risen to about sixty-five years, a 60% increase.[5] Reduced health risks for young children contributes to most of the improvements in life expectancy: the number of children dying before age of five has been reduced from twenty million in 1960 to 9.2 million in 2007. Globally, the prevalence of human immunodeficiency virus (hereinafter "HIV"), tuberculosis and malaria epidemics have been reduced considerably, with child mortality and maternal mortality dropped 53% and 45% respectively since 1990.[6]

However, despite the remarkable progress in health, as the world marched into the new millennium, new anxieties arise. Concerns over the acquired immunodeficiency syndrome (hereinafter "AIDS"), the continuous challenges of malaria and tuberculosis, the re-emergence of Ebola, and new strains of influenza, and the growing prevalence of non-communicable diseases (NCDs), and most recently, the novel coronavirus originated from China, have again bought new anxieties and complexity to global health.[7] In 2019, the WHO listed air pollution and climate change, non-communicable

[4] *The US Commitment to Global Health: Recommendations for the New Administration, Progress in Global Health Can Be Achieved Now*, NAT'L CTR. BIOTECHNOLOGY INFO., https://www.ncbi.nlm.nih.gov/books/NBK32625/ (last visited Feb. 14, 2020); *see also World Population Prospects – 2017 Revision: Global Life Expectancy*, U.N. DEP'T ECON. & SOC. AFF., https://www.un.org/development/desa/publications/graphic/wpp2017-global-life-expectancy (last visited Feb. 14, 2020).

[5] U.N. DEP'T ECON. & SOC. AFF., *supra* note 4.

[6] *MDGs: Progress Made in Health*, WHO, http://www.who.int/topics/millennium_development_goals/post2015/en/ (last visited Feb. 14, 2020).

[7] *Coronavirus*, CTR. DISEASE CONTROL & PREVENTION [hereinafter CDC], https://www.cdc.gov/coronavirus/index.html (last visited Feb. 14, 2020).

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diseases, possibility of a global influenzas pandemic, antimicrobial resistance, Ebola and high-threat pathogens, weak primary care, and HIV as some of that top ten global threats in 2019.[8]

III. GLOBALIZATION OF PUBLIC HEALTH

Globalization of public health is not a new phenomenon.[9] Scholars interested in the governance of global health have turned to examine and understand how the various norms, interests, pathways, and processes have shaped the collective ways in addressing global public health issues.[10] In the past, focus have been on the former decision-making processes at the United Nations, as well as on the less formal processes that consist of private entities which also contribute in shaping behaviours of states.[11]

Central to the health norms development at the international level is the WHO, which functions as a global public health agency.[12] Established in the aftermath of World War II in 1948, the WHO is driven by a strong, collective recognition of the need to improve health worldwide.[13] Article 1 of the WHO Constitution explicitly recognizes that the purpose of the organization "shall be the attainment by all peoples of the highest possible level of health."[14] Despite the organization's reticence in global health leadership, the WHO remains the principal international organization charged with addressing threats of emerging and re-emerging infectious diseases, among other public health issues.[15] Upon the organization's establishment, member states granted the WHO an unparalleled law-making power to ensure the agency would fulfil its constitutional mandate. Specifically, the WHO Constitution and the United Nations Charter establish the organization as the specialized health agency within the United Nations (hereinafter "U.N.") system, tasked with coordinating and responding to international health activities.[16] However, with each passing decade, the WHO has become a shadow of its former glories.

The WHO has an unparalleled law-making power among the international organizations with lawmaking authority. With its amiable

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[8] *Ten Threats to Global Health in 2019*, WHO, https://www.who.int/news-room/feature-stories/ten-threats-to-global-health-in-2019 (last visited Feb. 14, 2020).
[9] Allyn L. Taylor & Douglas W. Bettcher, *International Law and Public Health*, 80(12) BULL. WORLD HEALTH ORG. 923, 923 (2002).
[10] LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW (2014).
[11] *See generally* David Stuckler et al., *Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed?*, 8(4) PLOS MED. e1001020 (2011).
[12] *Constitution of the World Health Organization*, 36(11) AM. J. PUB. HEALTH 1315, 1315-16 (1946) [hereinafter *Constitution of the World Health Organization*].
[13] GOSTIN, *supra* note 10.
[14] *Constitution of the World Health Organization*, *supra* note 12, art. 1.
[15] *Id.* art. 2.
[16] *Id.*

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power and authority, the agency has an unequivocal power to influence international health policies.[17] Article 19 of the WHO Constitution provides the Health Assembly the power to "adopt conventions or agreement" by a two-third vote.[18] A treaty would become binding upon a State Party once the government accepts it in accordance with its national constitutional processes. The World Health Assembly's (hereinafter "WHA") quasi-legislative powers is even far reaching than for conventions and agreements. Regulations adopted under Article 21 would automatically become binding upon its member states by a simple majority, unless member states have notified the WHO otherwise: countries wish to reject must formally file an objection within eighteen months after the convention's adoption by the WHO General Assembly. Such an arrangement is unique among international organizations.[19]

However, despite WHO's amiable legal power, to date, the agency has only adopted one health convention: Framework Convention on Tobacco Control and two regulations: Nomenclature with Respect to Diseases and Causes of Death and the International Health Regulations (hereinafter "2005 IHR"). [20] With the agency's visible reluctant to utilize its law-making power,[21] commentators have observed that the WHO is more contented to act as a technical agency then embracing a leadership role in global health.[22] Consequently, with the WHO's deliberate distance from its bestowed role in global health and avoidance to tackle deep-seated global health challenges, other key players have emerged. With each passing decade, pessimism over the diminishing political leadership of the WHO looms. However, such pessimism does not dwarf the need for the agency to generate and disseminate global health norms. Here the article turns to global governance of health.

As an expanding field of study, global governance of health is a subject of fascination for scholars across different intellectual fields and disciplines. Within the growing body of legal literature, a considerable intellectual effort has been undertaken to capture the dynamic relationships between the stakeholders, sketch the architecture of global health, and outline the appropriate rules and norms between those governing and been governed.

Insofar as global governance of health is a multi-layered enterprise, legal

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[17] *See id.*
[18] *Id.* art. 19.
[19] Allyn L. Taylor, *International Law and Public Health Policy*, *in* INTERNATIONAL ENCYCLOPAEDIA OF PUBLIC HEALTH 667, 675 (Kris Heggenhougen et al. eds., 2008).
[20] WHA, *Revision of the International Health Regulations*, at 7-66, WHA Doc. WHA58/2005/REC/1 (May 23, 2005).
[21] Lawrence O. Gostin et al., *The Normative Authority of the World Health Organization*, 129(7) PUB. HEALTH 854, 856, 858, 861 (2015).
[22] *Id.* at 861.

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scholars have proposed to study global health as a system of law.[23] Legal scholar Lawrence Gostin defines global health law as the "study and practice of international law both hard law (e.g., treaties that bind states) and soft instruments (e.g., codes of practice negotiated by states)—that shape norms, processes and institutions to attain the highest attainable standard of physical and mental health for the world's population."[24] Put differently, approaching the subject through the lens of law is to understand the various global health norms and practices that emerged from various international institutions and consider how they interact with each other. Professor Gostin's definition therefore places health as a human right at the centre of analysis, where health equity and justice are two fundamental principles that should inform the practice and operation of global health.

Most recently, the Lancet Commission on Global Health also reiterates the crucial role of law in achieving global health with justice.[25] Specifically, the Commission aims to advance population health equity through the rule of law, and to provide a clearer understanding of law, regulations, and the rule of law in creating healthier living conditions, beneficial for population health.[26]

On the global level, a legalized approach towards global health is not new. In the past, legal scholars have called for a Framework Convention for Global Health, which would establish a health financing mechanism to reduce global health inequalities.[27] The WHO defines health inequalities as systemic differences in the health status of different population groups, where the differences could be reduced by appropriate mix of government policies.[28] Evidence suggest that in developing countries, inequalities in health have been decreasing,[29] but within certain populations inequalities have been growing, partly due to a decline in health-service coverage among poor populations.[30]

Equally important to the realization of health equity is global investment in health: it is widely recognized that investment in global health is part of the poverty alleviation effort. The Millennium Development Goals (hereinafter "MDG") implicitly recognizes the importance of poverty

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[23] GOSTIN, *supra* note10, at 59.
[24] *Id*.
[25] Lawrence O. Gostin et al., *The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development*, 393 THE LANCET 1857, 1857 (2019).
[26] *Id*.
[27] *See generally* Lawrence O. Gostin et al., *Towards a Framework Convention on Global Health*, 91 BULL. WORLD HEALTH ORG. 790 (2013).
[28] *Glossary of Terms Used*, WHO, https://www.who.int/hia/about/glos/en/index1.html (last visited Feb. 14, 2020).
[29] Davidson R. Gwatkin, *Trends in Health Inequalities in Developing Countries*, 5 LANCET GLOBAL HEALTH e371, e371 (2017).
[30] *Id*.

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reduction.[31] 170 countries have pledged to "improve health systems in developing countries and those with economies in transition with the aim of providing sufficient health workers, infrastructure, management systems and supplies to achieve the health related Millennium Development Goals by 2015." The Sustainable Development Goals (hereinafter "SDG") succeeded the MDGs and explicitly recognizes the connection between health and international development, with a single unifying goal on health. Other SDGs goals are interrelated to health, which all contribute to the creation of healthy individuals and healthy communities. However, this is not to say that increased wealth for the individual would automatically lead to an improved health. Nor to say that wealthy countries would have healthy population. The Institute of Medicine Committee on the United States (hereinafter "US") Commitment to Global Health has long recognized that economic well-being is not a predictor of health status. Instead, technological innovation and diffusion of knowledge are the main vehicles that drive improvement in health status.[32]

Investment in global health cannot be solely determined by economics terms. Similarly, the Nobel laureate Amartya Sen succinctly argues that "the case for health care does not have to be established instrumentally by trying to show that good health may also help to contribute to the increase in economic growth."[33] Instead, as Professor Sen points out that investment in health concerns with enhancing lives through expanding freedom from avoidable ill-health and from escapable mortality.[34] Accordingly, Professor Sen argues that "the enhancement of health is a constitutive part of development." The ensuing section turns to health as human rights.

IV. HEALTH AS HUMAN RIGHTS

Health has an intrinsic value to the individual and to the society.[35] The preamble to the WHO Constitution embodies this aspiration.[36] Specifically, the preamble defines health as "a state of complete physical metal and social well-being and not merely the absence of disease infirmity," and it affirms that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."[37] The right to health is explicitly recognized in the Universal Declaration of Human Rights (UDHR),[38] in the

[31] G.A. Res. 60/1, ¶¶ 47, 57(a) (Oct. 24, 2005).
[32] NAT'L CTR. BIOTECHNOLOGY INFO., *supra* note 4.
[33] WHO, *Health in Development*, at 7, WHO Doc. A52/DIV/9 (May 18, 1999).
[34] *Id.* at 2.
[35] Norman Daniels, *Justice, Health, and Healthcare*, 1(2) AM. J. BIOETHICS 2, 3 (2001).
[36] *Constitution of the World Health Organization*, *supra* note 12, pmbl.
[37] *Id*.
[38] Article 25(1) of the Universal Declaration of Human Rights [UDHR]: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing,

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constitutions of 115 countries,[39] and in regional and international treaties.[40] Insofar as every country in the world is bound by at least one treaty containing a provision which gives recognition to the right to health, it can be argued that the right to health is universal. Yet despite its universal recognition, the normative content of the right to health remains highly contested.[41] Nonetheless, authoritative interpretation of the right done by treaty bodies, regional and national judicial bodies agree that the content of the right can be understood along the dimensions of the responsibility of the state (which is expressed through the provision of a robust health system), and through the realization of health-related human rights.[42]

Relevant to the discussion on a human right to health approach is Article 12 of the International Covenant on Economic, Social and Cultural Rights (hereinafter "ICESCR"), which provides the foundational expression of the right to health. Further, through its treaty body—The Committee on Economic, Social and Cultural Rights (hereinafter "CESCR"), a committee of eighteen independent experts that monitor state implement of the ICESCR—it has captured and provided an authoritative interpterion on the right to health in General Comment No.14. Importantly, the CESCR clarifies that the right to health does not mean the right to be healthy: as being health is partly contingent upon by healthcare, partly determined by genetic dispositions and a myriad of social factors.[43] Of particularly relevance to the discussion is the availability, accessibility, acceptability, and good quality (hereinafter "AAAQ") framework introduced by the CESCR. Simply put, the right to health requires the State to ensure conditions necessary for the realization of healthy lives, whether it is through regulated market or via government services.[44] In countries where the right to health is explicitly provided in their constitutions, the AAAQ framework further provides guidance on how to operationalize and utilize the law to protect and fulfil the right.[45]

Significantly, since the CESCR's interpretation of the right to health it

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housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." *See* Universal Declaration of Human Rights, art. 25(1), Dec. 10, 1948, G.A. Res. 217 A(III).

[39] Off. of the U.N. High Commissioner for Human Rights [hereinafter OHCHR], *The Right to Health, Fact Sheet No. 31*, June 2008, at 10-11, https://www.refworld.org/docid/48625a74 2.html.

[40] *Id.* at 9-10.

[41] Patrick Hayden, *The Human Right to Health and the Struggle for Recognition*, 38 REV. INT'L STUD. 569, 571 (2012).

[42] OHCHR, *supra* note 39, at 24-25.

[43] Committee on Economic, Social and Cultural Rights [CESCR], *General Comment No. 14 (2000): The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 9, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

[44] *Id.* ¶ 35.

[45] *Id.* ¶ 36.

臺灣大學學術期刊資料庫

has reoriented the discussion in the global health discourse. As the committee recognizes and clarifies the normative content and demonstrates how to operationalize a human rights approach to health at the population level, the interpretation also advances how domestic courts and governments can do in practice and theory. By drawing health as an entitlement and placing emphases on social and economic conditions that may result in systematic disadvantages to the vulnerable and marginalized population, the CESCR systematized attentions to these conditions. Moreover, the CESCR interpretation makes clear that to the extent possible (according to member state's health capabilities), individuals have the right to health and adequate public health services, where the state bears the primary obligations to fulfil these entitlements.[46]

V. THE ROAD TO UNIVERSAL HEALTH COVERAGE

The WHO's aspiration for health is further affirmed by the 1978 Declaration of Alma-Ata on Primary Health Care, which defines health as "a fundamental human right" and draws attention to the collective need to improve health: "the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."[47] Bold and ambitious, the Declaration of Alma-Ata was endorsed by 134 countries and sixty-seven international organizations, where the Declaration pledged to progressively develop primary healthcare system.[48]

However, with the Alma-Ata Declaration aimed to achieve health for all by 2000, its socialized medicine approach was widely perceived by the medical community as an attack on the medical establishment. [49] Furthermore, as the Declaration is associated with a Soviet city, its political undertone did not go unnoticed. To a certain extent, the promotion of primary care became the unlikely casualty caught between political and ideological battle: between liberalism and communism. [50] Suspicion arose with the political undertone of the Alma-Ata Declaration, which ultimately undermined its support in the midst of the Cold War. In a deeply polarized world, resistance towards primary health care grew as hostility towards communism deepens. In the subsequent four decades, along with the WHO's intentional neglect of human rights discourse, countries' diminishing

[46] *See generally id.*
[47] U.N. Int'l Children's Emergency Fund [hereinafter UNICEF] & WHO, *Declaration of Alma-Ata* (Sept. 1978), https://www.who.int/publications/almaata_declaration_en.pdf?ua=1.
[48] Zulfiqar A. Bhutta et al., *Alma Ata and Primary Healthcare: Back to the Future*, 363 BMJ 1, 1(2018).
[49] UNICEF & WHO, *supra* note 47.
[50] *Consensus During the Cold War: Back to Alma-Ata*, 86(10) BULL. WORLD HEALTH ORG. 745, 745 (2008).

臺灣大學學術期刊資料庫

political wills to tackle social determinants of health, and the lack of pragmatic plan to translate the goals set forth in the Declaration into actions, the Alma-Ata Declaration soon fell off countries' political radar and faded into obscurity.[51]

By the turn of the new millennium, it became apparent that without primary health care as a way to organize, finance, and deliver health services, global progress in alleviating poverty was limited: the out-of-pocket payments for essential medicine was driving households below the poverty line.[52] With the AIDS epidemic draining on health resources, and the inefficient use of health resources where overlapping diseases managed using different health initiatives, global health was in disarray. When the WHO attempted to resuscitate the global interest in primary health care beginning in 2007, it resonated well with the international community. A growing international consensus on a more effective way to use aid paved the way for the renewed focus on primary health care.[53] Universal health coverage (hereinafter "UHC"), a foundational principle of primary health care, became the focal point for the new millennium as a corrective strategy to the previous decades of intentional neglect on primary health care.

From an economic perspective, the march towards universal health coverage could ensure fairness and provide greater equality across and within countries.[54] The world's embrace of universal health coverage became widely accepted as an expression of support for fairness. Drawing from three decades of evidence, the WHO was able to confirm that well-trained community health workers contribute to sustained improvement in reductions in neonatal and maternal deaths.[55] Further research showed that integrating essential medicines, transport, supervision and public education could be part of comprehensive care. Perhaps unexpectedly, a robust health system can help safeguard countries from financial austerity: when the world economic order was disrupted by the 2008 financial crisis, even countries that had taken few financial risks and managed their economies responsibly were affected, adding to crisis in health care.[56]

Significantly, during a public health emergency of international concern, UHC can provide some social and economic protection that benefit global health security through various mechanisms. For instance, as UHC lowers financial barriers for health services it can facilitate early case detection which is essential during the early stage of an outbreak. Likewise, UHC may

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[51] Bhutta et al., *supra* note 48.
[52] *From Primary Health Care to Universal Coverage – The "Affordable Dream"*, WHO, http://www.who.int/publications/10-year-review/universal-coverage/en/ (last visited Feb. 14, 2020).
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *Id.*

臺灣大學學術期刊資料庫

protects individuals from financial catastrophe during an infectious disease outbreak, where high healthcare costs can push affected individual into poverty.[57]

Beginning in 2000, with the growing international consensus for primary health care, it became possible for the WHO to push for universal health coverage onto international development agenda again. The organization attempted to resuscitate the global interest in primary health care by commissioned a 2010 report on universal health coverage.[58]

This time, the medical community reciprocated the enthusiasm and strongly endorsed the idea. The Lancet published a series of articles, further confirmed the value of primary health care which contributes to the realization of social justice.[59] Mounting empirical evidence suggests that primary health care was the best way to reduce duplications of health initiatives, improve efficiencies in service delivery, and create the much-needed incentives for quality care in well-off countries, as well as cost-effective interventions in lower- and middle-income countries.[60]

In 2012, the United Nations General Assembly (hereinafter "UNGA") adopted a resolution on global health and foreign policy, which recognizes the pressing need to accelerate progress towards universal health coverage.[61] The resolution was sponsored by more than ninety countries; universal health coverage became an essential priority for international development. With the adoption of the resolution, the U.N. also formally recognizes the "need for further efforts to create a global policy environment supportive of global health."[62] Three years later in 2015, the UNGA adopted another resolution, "Transforming our world: the 2030 Agenda for Sustainable Development," which adopted target of universal health coverage. Importantly, the inclusion of a target for universal health coverage conveys a strong message of the development agenda: leave no one behind. In so doing, it recognizes that fairness would not be delivered without the recognition that health as a precondition for, or an outcome of all sustainable development. In 2017, the UNGA adopted a third resolution on global health and foreign policy, in which it recognizes that fairness would not be delivered without an inclusive society built on strong health system.[63] The

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[57] Vageesh Jain & Azeem Alam, *Redefining Universal Health Coverage in the Age of Global Health Security*, 2 BMJ GLOBAL HEALTH 1, 1 (2017).
[58] WHO, *supra* note 52.
[59] G.A. Res. 64/108, Global Health and Foreign Policy (Feb. 19, 2010), https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/64/108&Lang=E.
[60] WHO, *supra* note 52.
[61] G.A. Res. 67/81, Global Health and Foreign Policy (Mar. 14, 2013), https://undocs.org/A/RES/67/81.
[62] WHO Director-General, *Report of the Director-General of the World Health Organization on Global Health and Foreign Policy*, U.N. Doc. A/67/377 (Sept. 18, 2012), https://digitallibrary.un.org/record/737462?ln=en.
[63] G.A. Res. 72/139, Global Health and Foreign Policy: Addressing the Health of the Most

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2017 resolution thus echoed the WHO director-general's 2012 report submitted to the U.N., which reaffirms the central place of universal health coverage in international development agenda.

In 2019, the WHO has chosen universal health coverage as the World Health Day, recognizing the importance of affordable primary health care to development. However, for many countries achieving universal health care remains elusive. This is despite that the United Nations' SDG, which succeeded the MDG, explicitly recognizes that universal access to basic primary health care plays an important role in eliminating global inequalities. According to the United Nations, 100 million people are trapped in a cycle of poverty largely because of out-of-pocket expenses for basic health care. While the Sustainable Development Goals embody the universal aspiration to universal health care, as set forth in SDG 3.8, public investment remains critically low for most countries. Evidence suggests that public spending is a precondition for reaching universal health coverage.[64]

VI. GLOBAL HEALTH ASSISTANCE

Nonetheless, health development is now widely recognized as an essential component of nation-strengthening. With growing health disparities across and within countries, it also raises important question of international assistance on health. The first Special Rapporteur on the Right to Health, Paul Hunt, argues eloquently that "if there is no legal obligation underpinning the human rights responsibility of international assistance and cooperation, inescapably all international assistance and cooperation is based fundamentally upon charity. While such a position might have been tenable 100 years ago, it is unacceptable in the twenty-first century."[65] Article 2(1) of the ICESCR provides the legal basis for international health assistance, where member states "undertake to take steps, individually and through international assistance and cooperation, especially economic and technical" to progressively realize the right to health.[66]

Accordingly, the human rights approach to health has also reconceptualized international health assistance as a legitimate concern of the international community. Notably, Professor Gostin argues that international health assistance should not be conceptualized as aid, as it

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Vulnerable for an Inclusive Society (Jan. 15, 2018), https://undocs.org/A/RES/72/139.

[64] *See generally* WHO, WHO Symposium on Health Financing for UHC, Public Financing for UHC: Towards Implementation (WHO, Health Financing Working Paper No. 18.1, 2017), https://www.who.in t/health_financing/documents/towards-implementation/en/.

[65] *See generally* Human Rights Council, Rep. on Its Fourth Session, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainment Standard of Physical and Mental Health*, U.N. Doc. A/HRC/4/28/Add.2, Addendum (Feb. 28, 2007) .

[66] International Covenant on Economic, Social and Cultural Rights, art. 2(1), Dec. 16, 1996, 933 U.N.T.S. 3.

臺灣大學學術期刊資料庫

"masks the deeper truth that human health a globally shared responsibility, reflecting common risks and vulnerabilities—an obligation of health justice that demands a fair contribution from everyone."[67] In other words, according to Professor Gostin, international health assistance is as much as about assisting the weaker states as it is about securing a common future. Illustrative of this point is the recent erupted Ebola crisis, investment in cultivating weaker states' health capability in international infectious disease control would yield health dividends for the world.

Health financing is a critical, but often neglected, component of global governance of health. Health financing plays an important role in the progress towards universal health coverage, public investment in health is imperative in securing global health security; likewise, external funding sources help keep essential health services running in low-income countries.[68] According to the WHO's estimation, to provide a million more people with universal health coverage, protect a million more individuals from health emergencies, and improve a further billion people with better health and well-being, will require USD 14.14 billion. [69] However, investments in global health remain low compared to the needs, and it is continuing to dwindle. With the persistently low rate of global investment in health, it negatively impacts on individuals, particular those of vulnerable populations. Likewise, investment in health helps to promote and accelerate global development; achieving primary health care coverage can help countries to achieve other SDGs goals in poverty, hunger, education, gender equality, and reduce health and economic disparities. In addition to securing health finance for building a robust health system, governments must also ensure that health systems are equitable and sustainable.

At the international level, private philanthropic organizations have become major funding sources of global health. In 2017, the Bill & Melinda Gates Foundation provided USD 3.3 billions of the world's global health,[70] which tied the privately-funded organization in second with the United Kingdom for health assistance.[71] The Gates Foundation focuses on technical solutions to global health challenges, for instance, the Foundation invests in vaccines for HIV, polio and malaria, finds innovative solutions to family planning, nutrition, and maternal and child health. Other prominent private philanthropic organizations also preoccupy increasingly central places in the global health landscape. Each of the private philanthropy has a specific

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[67] GOSTIN, *supra* note 10, at 19.
[68] *See generally* WHO, *supra* note 64.
[69] *Investing for a Healthier World*, WHO, https://www.who.int/about/planning-finance-and-accountability/financing-campaign (last visited Feb. 14, 2020).
[70] Marlee Tichenor & Devi Sridhar, *Global Health Disruptors: The Bill and Melinda Gates Foundation*, BMJ OPINION (Nov. 28, 2018), https://blogs.bmj.com/bmj/2018/11/28/global-health-disruptors-the-bill-and-melinda-gates-foundation/.
[71] *Id*.

臺灣大學學術期刊資料庫

mandate: the Rockefeller Foundation focuses on universal health care, with a long philanthropic history in public health.[72] Bloomberg Philanthropies take a data-driven approach on tobacco control and livable cities,[73] and the Clinton Foundations work on HIV and AIDS.[74]

With the amicable financial resources these private actors also have the power to sway global health agenda. To that end, the proliferation of these actors also changes the configuration of global health: global health governance has been the provenance of states traditionally. The emergence of powerful private philanthropic organizations not only interject the much-needed findings sources to global health, but it also complicates the landscape. With these private organizations focusing on certain diseases, or conditions-specific vertical programs, these initiatives often overwhelmed the local need to develop robust health infrastructure in the receiving countries. Another common concern over these private organizations is the lack of regulatory oversight to ensure accountability of these actors. While it is true that these private organizations do not have the same obligations as states, commentators are concerned that with disproportionate influence on global health agenda, private organizations with their top-top approach to global health, can displace less powerful voices and bypass the basic democratic principles that should govern global health.[75]

Another major player with a considerable influence on global health is the US Since the end of World War II, the US have been the leading figure in shaping global health landscape and agenda. The establishment of new funding model of health assistance—for instance, the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative—contributes to the improvement of global health markedly. These funding initiatives reflect a long-held belief of the United States, where it is believed that investment in global health can help promote a more peaceful world, building stronger economies, enhance the US' reputation internationally, and advance US interests abroad.[76] In 2008, the Institute of Medicine even recommended the then-newly elected president, George W. Bush to "make a bold public statement that global health is an essential component of US foreign policy."[77] The US remains the largest funder of global health

[72] ROCKEFELLER FOUND., https://www.rockefellerfoundation.org/ (last visited Feb. 15, 2020).
[73] BLOOMBERG PHILANTHROPIES, https://www.bloomberg.org/ (last visited Feb. 15, 2020).
[74] CLINTON FOUND., https://www.clintonfoundation.org/home (last visited Feb. 15, 2020).
[75] *See generally* Stuckler et al., *supra* note 11.
[76] *See* INST. OF MED. (US) COMM. ON THE US COMMITMENT TO GLOB. HEALTH, THE US COMMITMENT TO GLOBAL HEALTH: RECOMMENDATIONS FOR THE PUBLIC AND PRIVATE SECTORS (2009).
[77] *A Prominent Role for Health in U.S. Foreign Policy*, NCBI, https://www.ncbi.nlm.nih.gov/books/NBK32621/#prominent.s2 (last visited Apr. 12, 2019).

臺灣大學學術期刊資料庫

programs worldwide; in 2018, the US have spent USD 10.8 billion in global health funding, a considerable increase from USD 5.4 billion in 2006. Despite the recent global health spending, the US remains the single largest contributor to WHO,[78] and serves as an executive board member.

Likewise, the US also serves as a central source for generating global health knowledge—many global health successes have stemmed from technological innovation and knowledge diffusion with research institutions such as the NIH and the National Science Foundation in providing scientific knowledge and know-hows.[79] Working in partnership with other countries, intergovernmental organizations, and the private sector the US has played an indispensable role and a major driver in expanding public health infrastructure and access to health inventions in many countries.[80]

However, the US's stance on its commitment to global health has much changed since the Trump administration took office. Consistent with President Trump's campaign promise, where the US's domestic economic interests would prevail over its international commitments, President Trump has notably reduced global health funding for 2019 and proposed funding cut in 2020.[81] This is not the first time that Trump administration's policies undermine global health, however. For instance, the expansion of the global gag rule—which prohibits non-US non-governmental organizations that are receiving US funding informing or education the public on safe abortion, or providing legal abortion services—many proponents argue that the gag rule undermines women's right to health, particularly those in low- and middle-income countries.[82]

VII. INTERNATIONAL HEALTH REGULATIONS AND THE CORONAVIRUS OUTBREAK 2019

The 2005 IHR is the overarching legal instrument for global health security.[83] Designed to enhance international health cooperation and provide an international legal framework, the 2005 IHR aims to "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public

[78] *The U.S. Government and the World Health Organization*, KFF (Jan. 24, 2019) https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-the-world-health-organization/.
[79] INST. OF MED. (US) COMM. ON THE US COMMITMENT TO GLOB. HEALTH , *supra* note 76.
[80] *Id*.
[81] *The U.S. Government and Global Health*, KFF (July 30, 2019), https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-global-health/.
[82] Edward Wong, *U.S. Expands Anti-Abortion Policies with New Overseas Funding Rules*, N.Y. TIMES (Mar. 26, 2019), https://www.nytimes.com/2019/03/26/us/politics/state-department-abortion-funding.html.
[83] WHO, INTERNATIONAL HEALTH REGULATIONS (2d ed. 2005), http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

臺灣大學學術期刊資料庫

health risks, and which avoid unnecessary interference with international traffic and trade."[84] The 2005 IHR was revised and updated after the accelerated outbreak of the 2003 Severe Acute Respiratory Syndrome (hereinafter "SARS") and the 2004 epidemic of avian influenza A (hereinafter "H5N1"). [85] The 2005 IHR was initially adopted as the International Sanitary Regulations in 1951,[86] under Article 21(a) and 22 of the WHO Constitution which confers the World Health Assembly to adopt regulations "designed to prevent the international spread of disease." Accordingly, the 2005 IHR is binding on all WHO member states except those that have affirmatively opt-out within a specified time period. Significantly, this binding power of regulations is unique amongst international organizations with international lawmaking authority. Equally important, the 2005 IHR also establishes the WHO as the directing and coordinating authority within the international health regime.[87] Under the 2005 IHR, countries are required to notify the agency of "events that may constitute a public health emergency of international concern (PHEIC)," [88] where the WHO may take into account of reports of outbreak submitted by non-state actors. This reporting mechanism provides an additional verification process for monitoring disease outbreak.[89]

In determining whether an event constitutes as a public health emergency of international concern (hereinafter "PHEIC"), the WHO Director-General shall consider a list of criteria provided in Article 12, in consultation with the State party in whose territory the event is allegedly occurring: the information provided by the State Party, the advice of the Emergency Committee, scientific principles as well as the available scientific evidence, assessments of the risk to human health, the risk of the international spread disease and of the risk of interference with international traffic.[90] A PHEIC would automatically expire after three months after their

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[84] *Id.*, forward.
[85] *See generally id*.
[86] David P. Fidler, *Revision of the World Health Organization's International Health Regulations*, 8(8) ASIL INSIGHTS (2004), https://www.asil.org/insights/volume/8/issue/8/revision-world-health-organizations-international-health-regulations.
[87] WHO, *supra* note 83, IHR Forward, where

> WHO is expected to cooperate and coordinate its activities, as appropriate, include the following: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and *Office International des Epizooties*.

[88] *Id.* art. 6.
[89] *Id.* art. 9.
[90] *Id.* art. 12.

臺灣大學學術期刊資料庫

issuance or modified/extended for additional periods of three months maximally. Once the Director-General has determined the event in question constitutes as a PHEIC, it must be accompanied by temporary recommendations which may include health measures and advices on international travel and traffics.[91] However, even in absence of declaring a PHEIC, the WHO can still issue influential guidance on trade and travel measures.[92] Likewise, state parties may impose trade and travel measures beyond those recommended by the WHO Director-General,[93] as these recommendations are not legally binding. As such, legal scholar David Fidler points out that the authority to issue a temporary advice is intended to give the WHO Director-General a normative power to "shape the political context in which state parties consider and implement trade and travel measures in response to specific outbreaks."[94] In other words, the legal power bestowed upon the WHO Director-General to declare an outbreak as a PHEIC is designed to encourage international cooperation and strengthen political leadership of the WHO during the outbreak. Accordingly, legal scholar Lawrence Gostin elaborates, a PHEIC provides a critical opportunity for WHO to set global norms and uphold principles as provided in the IHR during a public health emergency.[95] While there is no financial mechanism attached to the declaration of a PHEIC, it functions as a global signal to the international community for a concerted political action.

However, despite the transformative normative authority to declare a PHEIC during a disease outbreak, the WHO has exercised notable restraint. To date, the organization has only issued a PHEIC in six occasions: H1N1 (2009), Polio (2014), Ebola in West Africa (2014), Zika (2016), Ebola in the Democratic Republic of Congo (2019), and most recently, COVID-19 in China (2020). WHO's reluctance to utilize its normative power can be explained by its past where the organization has embroiled in wide global health controversies during previous outbreaks.[96] These incidents—non-compliance with the 2005 IHR, failure to declare a PHEIC in a timely manner, and the lack of transparency of the Emergency Committee, and most recently, the Chinese government's delay in sharing accurate and crucial information during the early stage of the COVID-19 outbreak[97]—separately

[91] *Id.* arts. 12, 15.
[92] David P. Fidler, *To Declare or Not to Declare: the Controversy over Declaring a Public Health Emergency of International Concern for the Ebola Outbreak in the Democratic Republic of the Congo*, 14(2) ASIAN J. WTO & INT'L HEALTH L. & POL'Y 287, 294 (2019).
[93] *See generally* Alexandra L. Phelan et al., *The Novel Coronavirus Originating in Wuhan, China: Challenges for Global Health Governance*, 323(8) J. AM. MED. ASS'N 709 (2020).
[94] Fidler, *supra* note 92, at 294.
[95] Phelan et al., *supra* note 93, at 710.
[96] Fidler, *supra* note 92, at 396.
[97] *See, e.g.*, Verna Yu, *If China Valued Free Speech, There Would Be No Coronavirus Crisis*, GUARDIAN (Feb. 15, 2020, 12:50 PM), https://www.theguardian.com/world/2020/feb/08/if-china-valued-free-speech-there-would-be-no-coronavirus-crisis; Matthew M. Kavanagh,

臺灣大學學術期刊資料庫

and collectively have inflicted sustained damages to the 2005 IHR and the reputation of the WHO as a normative agency for public health.

With the emergence of the COVID-19 outbreak global spot is again on the 2005 IHR and the WHO. The outbreak of the respiratory illness is first identified in Wuhan, Hubei Province, China in December 2019.[98] The fast-spreading epidemic in China has led the Chinese government to take extraordinary measure of locking down affected cities. Coronaviruses are a large family of viruses that causes illnesses which include the Middle East Respiratory Syndrome (MERS-CoV) and SARS; however, the COVID-19 is a new strain of coronavirus that has not been identified in humans previously.[99] Much remains unknown on the origin, transmissibility, severity, and other clinical features with COVID-19 as investigations are undergoing.[100] As 10 February 2020 (the time of this writing), there are over 42,638 confirmed cases of infection and 1016 deaths in mainland China, surpassing the death toll from the SARS outbreak in 2002 and 2003 in China.[101] Outside of China, the majority of the identified cases occur in a quarantined Diamond Princess cruise ship, with 135 confirmed cases as of February 10.[102] The ship has been under a two-week quarantine at the port of Yokohama since February 4, with had carried 3700 passengers and 1000 employees.

On January 23, the WHO called for a meeting of the Emergency Committee under the 2005 IHR, which the WHO Director-General Ghebreyesus declined to declare the outbreak as a PHEIC, after a split Emergency meeting.[103] Five days later, the WHO Director-General Tedros Adhanom Ghebreyesus met with Chinese President Xi Jinping in Beijing. Soon after, a second meeting was convened at the WHO's headquarter in Geneva on 30 January 2020 where the WHO Director-General declared the coronavirus a PHEIC,[104] following the advice from the same Emergency Committee.[105] Along with the declaration, the WHO also issued a temporary recommendation which advices countries not to unnecessarily restrict travel

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Authoritarianism, Outbreaks, and Information Politics, 5 LANCET PUB. HEALTH e135, e135 (2020).

[98] Phelan et al., *supra* note 93.

[99] WHO, *supra* note 1.

[100] CDC, *supra* note 7.

[101] *A Grim Landmark as Official Death Toll in China Tops 1,000*, N.Y. TIMES (Feb. 10, 2020), https://www.nytimes.com/2020/02/10/world/asia/coronavirus-china.html?action=click&module=Top%20Stories&pgtype=Homepage.

[102] *Id*.

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

[104] *Id*.

[105] *Id*.

臺灣大學學術期刊資料庫

or trade.[106] As aforementioned, these temporary recommendations are not binding on State Parties, where Article 43(1) explicitly provides that the 2005 IHR "shall not preclude State Parties from implementing health measures, in accordance with their relevant national law," provided that State Parties implementing additional public health measures provide to the WHO the public health rationales and relevant scientific information within 48 hours of implementation.[107] After receiving State Parties' public health justification, the WHO will conduct a review and may request State Parties to reconsider their measures.[108] The information about measures and the justification is then shared with other State Parties.[109]

Following WHO's declaration of the PHEIC, the United States declared the event a public health emergency on its territories the next day,[110] followed by Italy which imposes a six-month state of emergency,[111] Singapore, Britain, India and a number of countries soon stepped up their national disease outbreak responses.[112] The announcement of the PHEIC also triggered a cascade of temporary ban by countries which prohibits foreign nationals who visited China in the fourteen days prior to their arrivals to the implementing state.[113] Airlines also suspended flights to and from China.[114] As the outbreak accelerated, the US, South Korea, Japan, European Union, United Kingdom, Taiwan, Australia, New Zealand, French, Turkey, India and a number of countries also evacuated their citizens from Wuhan, the epicenter of the outbreak.[115] At the same time, the WHO has also activated a R&D Blueprint to accelerate diagnostics, vaccines, and therapeutics for the novel coronavirus.[116] After some negotiation with the

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[106] *Id.*

[107] WHO, *supra* note 83, arts. 43(3), 43(5).

[108] *Id.* art. 43(4).

[109] *Id.* art. 43(3).

[110] *Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus*, HHS.GOV (Jan. 31, 2020), https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html.

[111] Angelo Amante, *UPDATE 2-Italy Declares Coronavirus Emergency After First Two Cases Confirmed*, CNBC (Jan. 31, 2020, 09:51 AM), https://www.cnbc.com/2020/01/31/reuters-america-update-2-italy-declares-coronavirus-emergency-after-first-two-cases-confirmed.html.

[112] Chang Ai-Lien & Salma Khalik, *Coronavirus: Singapore Ups Outbreak Alert to Orange as More Cases Surface With No Known Links; More Measures in Force*, STRAITS TIMES (Feb. 7, 2020, 5:25 PM), https://www.straitstimes.com/singapore/coronavirus-outbreak-alert-upped-to-orange-as-more-cases-surface-with-no-known-links-more .

[113] *See, e.g.*, Ben Doherty & Naaman Zhou, *Coronavirus: Australia Extends Travel Ban on People Entering from China for a Week*, GUARDIAN (Feb. 14, 2020, 1:14 AM), https://www.theguardian.com/world/2020/feb/13/coronavirus-australia-extends-travel-ban-on-people-entering-from-china.

[114] *Airlines Suspend China Flights Due To Coronavirus Outbreak*, REUTERS (Feb. 12, 2020, 1:31 PM), https://www.reuters.com/article/us-china-health-airlines/airlines-suspend-china-flights-due-to-coronavirus-outbreak-idUSKBN2060H6.

[115] *Factbox: Countries Evacuating Nationals from China Virus Areas*, REUTERS (Jan. 31, 2020, 4:25 PM), https://www.reuters.com/article/us-china-health-evacuation-factbox-idUSKBN1ZU0TW.

[116] *World Experts and Funders Set Priorities for COVID-19 Research*, WHO (Feb. 12, 2020),

臺灣大學學術期刊資料庫

government of China, the WHO dispatched its international experts to China, fifteen days after the PHEIC declaration.[117] Much remains to be seen about the political leadership of the WHO and how well the 2005 IHR will function in this unprecedent scale of disease outbreak.

As a virus knows no borders nor nationalities, the coronavirus outbreak will again test different aspects of national and international public health resilience. In an effort to contain the international spread of the new coronavirus outbreak and protect vulnerable countries, the international community is also aiming to raise USD 675 million for a preparedness and response plan.[118] The WHO Director-General Ghebreyesus has warned that the spread of the coronavirus outside of China may indicate a more widespread transmission globally.[119] Following the PHEIC declaration, WHO also put forward an emergency action plan, which stresses that "all countries are at risk and need to prepare for 2019-nCoV."[120] The emergency action plan also introduces an international monitoring framework which includes indicators for global response in mobilizing financial support, capacity to deploy personal protective supplies to countries during the event, surveillance and rapid detection of the novel coronavirus cases and risk communication and community engagement, amongst other assessment criteria.

Notably, the revised 2005 IHR is supposedly to provide a radical transformation which connects global health with security and human rights.[121] However, with WHO's notable failings in containing previous disease outbreaks—for instance, during the 2014 Ebola outbreaks, the organization was notably slow to respond which is now widely seen as a failing of the WHO, where the delayed and poorly coordinated response had attributed to the unprecedent scale of the Ebola outbreak.[122] With the 2019 Ebola still constituting as a PHEIC, this is the first time in global health history where two PHEICs are occurring simultaneously.[123] Many legal

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https://www.who.int/news-room/detail/12-02-2020-world-experts-and-funders-set-priorities-for-covid-19-research.

[117] *World Health Organization: Coronavirus Must Generate 'Solidarity Not Stigma'*, U.N. NEWS (Feb. 14, 2020), https://news.un.org/en/story/2020/02/1057431.

[118] *US$675 Million Needed for New Coronavirus Preparedness and Response Global Plan*, WHO (Feb. 5, 2020), https://www.who.int/news-room/detail/05-02-2020-us-675-million-needed-for-new-coronavirus-preparedness-and-response-global-plan.

[119] Barbara Kollmeyer, *Coronavirus Spread Outside of China May Be 'Tip of The Iceberg,' Says WHO Chief*, MARKETWATCH (Feb. 10, 2020, 8:09 AM), https://www.marketwatch.com/story/the-coronavirus-spread-outside-of-china-is-at-the-tip-of-the-iceberg-says-who-chief-2020-02-10.

[120] WHO, 2019 NOVEL CORONAVIRUS (2019‑NCOV): STRATEGIC PREPAREDNESS AND RESPONSE PLAN 1 (2020), https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf.

[121] Fidler, *supra* note 92, at 293.

[122] Clare Wenham, *Public-health Experts Question Whether the WHO Has Been Too Deferential to China in Its Handling of the New Virus*, 372 PHIL. TRANSACTIONS ROYAL SOC. B 1, 1-2 (2017)

[123] *DR Congo Ebola Outbreak Still an International Public Health Concern*, U.N. NEWS (Feb. 12, 2020), https://news.un.org/en/story/2020/02/1057291.

臺灣大學學術期刊資料庫

scholars have commented that the extent to which the WHO is able to fulfil its mandate would be a function of its legitimacy.[124] With the WHO's apparent inadequacy in its global coordination in the previous infectious disease outbreaks, doubts about the ailing agency's ability to lead looms. Additionally, the WHO faces a number of governance challenges—underfunded surveillance team, regionalized governance structure, diminishing political space for the WHO to make independent decisions and the low compliance rate with the 2005 IHR, where many State Parties have yet to fulfil their obligations on strengthening core surveillance and response capacities. These governance challenges expose systemic flaws with the 2005 IHR specifically, and the lack of political leadership of WHO more broadly.

The revise 2005 IHR is designed to increase transparency and information sharing as historically countries have tendency to shy away from open communication about disease outbreaks in their territories, chiefly because of fear of economic repercussions. However, despite its improved design, the IHR proved to be futile in encouraging China to notify the WHO about coronavirus outbreak in a timely manner. This is not the first time where the Chinese government had failed to notify the WHO about a potential outbreak in its territories in a timely fashion. Previously, during the 2003 SARS epidemic China also downplayed the outbreak which resulted in three hundred deaths on its territories.[125]

Lack of transparency during a disease outbreak is concerning. In a rare, open criticism, one of the Emergency Committee members has expressed discontent over China's initial slow notification to the WHO about the coronavirus outbreak.[126] Information sharing is a core obligation under the 2005 IHR, Article 7 explicitly provides that "[i]f a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of origin or source, which may constitute a public health emergency of international concern, it shall provide to WHO all relevant public health information."[127] Moreover, following a notification a State Party should continue to communication with the WHO with all relevant public health information, in a timely and accurate manner.[128] Open

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[124] *See generally* Ilona Kickbusch et al., *Addressing Global Health Governance Challenges Through a New Mechanism: The Proposal for a Committee C of the World Health Assembly*, 38(3) J. L. MED. & ETHICS 550 (2010).

[125] *Summary of Probable SARS Cases with Onset of Illness From 1 November 2002 to 31 July 2003*, WHO, https://www.who.int/csr/sars/country/table2004_04_21/en/ (last visited Feb. 17, 2020).

[126] Primrose Riordan & Sue-Lin Wong, *WHO Expert Says China Too Slow to Report Coronavirus Cases*, FIN. TIMES (Feb. 5, 2020), https://www.ft.com/content/8ede7e92-4749-11ea-aeb3-955839e06441; Jeremy Page & Betsy McKay, *The World Health Organization Draws Flak for Coronavirus Response*, WALL STREET J. (Feb. 12, 2020, 11:33 AM), https://www.wsj.com/articles/the-world-health-organization-draws-flak-for-coronavirus-response-11581525207.

[127] WHO, *supra* note 83, art. 7.

[128] *Id*. art. 6(2).

臺灣大學學術期刊資料庫

communication between the WHO and the notifying party is particularly crucial during the early stage of a suspected disease outbreak, as necessary precaution can be implemented to limit the potential spread of the outbreak both domestically and internationally.[129] However, as the revised 2005 IHR is designed to encourage information-sharing, no penalty is attached even if a State Party fails to notify the WHO in a timely manner.

To China's credit, the country has taken extraordinary measures, such as sharing of genomic sequence of the virus, lockdowning of major cities, although public health experts have expressed doubts over the effectiveness over whether such a measure would reduce human-to-human transmission of the novel coronavirus.[130] China's "authoritarian advantage"[131] means the country can take a down-top, forceful approach during the disease outbreak, which has earned notable praises from the WHO.[132] Yet with the death of the coronavirus whistleblower and China's forceful quarantine measure in contradiction with the WHO's standard, WHO's deferential stance towards China have raised questions about the relationship between China and WHO.[133] Old debate about WHO's diminishing political space for independence reignited as the relationship between China and the WHO intensifies the scrutiny.[134] This is not the first time where the WHO is challenged over its independence and by extension, its legitimacy as a global health agency, however. Previously, international controversy over the sharing of H5N1 virus sample by the Indonesia government with the WHO had also drawn attention to the impartiality of the agency. A decade ago, scholars have noted that the WHO is expected to be "to act as a trusted natural broker. Any hint of lack of independence . . . can have serious repercussions for the work of the organization."[135] The WHO now walks a delicate tightrope between not affording China, a politically and economically powerful country, and retaining its moral and legal authority.

While the WHO builds its moral authority upon the universal aspiration for health for all, the agency has also found itself embodied in the geopolitics with the novel coronavirus outbreak: China has become more active in global health in part to exclude Taiwan, a democratically self-governed island, from participating at the World Health Assembly.[136] The exclusion

[129] Page & McKay, *supra* note 126.
[130] *Id*.
[131] Kavanagh, *supra* note 97, at 135.
[132] *WHO Director-General on IHR Emergency Committee on Novel Coronavirus (2019-nCoV)*, WHO (Jan. 30, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus-(2019-ncov). WHO Director-General Tedros Adhanom Ghebreyesus noting that "China is actually setting a new standard for outbreak response".
[133] Kavanagh, *supra* note 97, at 135.
[134] Page & McKay, *supra* note 126.
[135] *Id*.
[136] *Id*.

臺灣大學學術期刊資料庫

of Taiwan from the WHO has real consequences: the WHO cannot share information with Taiwan under the 2005 IHR. Likewise, there is no formal channel for Taiwan to share its proactive COVID-19 response with the world.[137] While a consensus exists that a global concerted effort is pertinent to international infectious disease control, such an effort builds upon trust which dangerously erodes with the WHO's apparent partiality.

Critically, as a normative agency, the WHO needs to uphold principles articled meticulously by signatories to the 2005 IHR and its commitments to human rights. Likewise, with the persist under-investment of health infrastructure in many parts of the world it creates surveillance loopholes, putting lower-resourced countries at a greater vulnerability due to a lack of access to basic health services. Neither are countries with strong health systems immune from the international spread of infectious diseases; if the current situation worsens with the novel coronavirus, considerable strains will be placed upon even the strongest health systems;[138] epidemiologists have warned that the COVID-19 outbreak may launch critical assault on health systems, even those with strong public health infrastructures.

While the 2005 IHR provides a legal architecture for improving global health security, compliance rate with the 2005 IHR remains markedly low. This is in spite that that 186 of 196 State Parties have submitted reports or have reported their progress at the WHA since 2010.[139] Without a formal mechanism for monitoring compliance, the WHO relies on the 2005 IHR monitoring and evaluation framework which consists of four components: self-assessment, after action review, simulation exercises, and voluntary external evaluation.[140] Although State Parties are obligated to report on their IHR implementation progress at the WHA annually, the evaluation framework is purposely not legally binding which further diminishes incentives for compliance. The voluntary nature of the evaluation framework is designed to foster a culture of transparency, trust and cooperation.[141] As of September 2018, eighty-two countries have voluntarily partaken a Joint

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[137] C. Jason Wang et al., *Response to COVID-19 in Taiwan: Big Data Analytics, New Technology, and Proactive Testing*, JAMA NETWORK (Mar. 3, 2020), https://jamanetwork.com/journals/jama/fullarticle/2762689.

[138] Patti Neighmond, *Would The U.S. Health System Be Ready For A Surge In Coronavirus Cases?*, NPR.ORG (Feb. 13, 2020, 13:43 PM), https://www.npr.org/sections/health-shots/2020/02/13/799534865/would-the-u-s-health-system-be-ready-for-a-surge-in-coronavirus-cases; Koh Ewe & Gutierrez Natashya, *Singapore Is the Poster Child for Handling the Coronavirus. Here's What Other Countries Can Learn from It*, VICE (Mar. 5, 2020, 3:49 PM), https://www.vice.com/en_asia/article/epgqda/singapore-containtment-coronavirus-lessons.

[139] *International Health Regulations (2005) Monitoring Framework*, WHO, http://www.who.int/gho/ihr/en/ (last visited Mar. 15, 2020).

[140] WHO, INTERNATIONAL HEALTH REGULATIONS (2005) IHR MONITORING AND EVALUATION FRAMEWORK, at 11, WHO/WHE/CPI/2018.51 (2018).

[141] WHO, MEETING REPORT: WHO TECHNICAL REVIEW MEETING OF THE JOINT EXTERNAL EVALUATION (JEE) TOOL AND PROCESS 15 (2017), https://apps.who.int/iris/bitstream/handle/10665/259206/WHO-WHE-CPI-2017.53-eng.pdf?sequence=1.

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External Evaluation (hereinafter "JEE") mission, a peer-to-peer assessment conducted jointly by the WHO and the requesting State. Findings and recommendations from the mission is published on the WHO website, contingent to the host country's agreement. It remains to be seen whether conducting a JEE would facilitate countries in building resilient public health systems during the COVID-19 outbreak. More specifically, whether the international infectious disease regime can elicit responsive and coordinated responses from State Parties in time of crisis, without enforcement mechanism to compel State Parties to take meaningful actions in line with the 2005 IHR.

As the COVID-19 outbreak unfolds, it also exposes additional weaknesses of the 2005 IHR, in particular to the protection afforded to whistleblowers in authoritarian regimes. While human rights principles guide the operation of the 2005 IHR, the WHO lacks investigatory power to examine reports or claims relating to the possible outbreak, nor can the agency hold State Parties accountable for human rights violations. The WHO has incorporated media reports as part of its disease surveillance system, but without extending whistle-blower protection to individuals on the ground that expose the potential danger from unfair treatment, disproportionate punishment and retaliation,[142] it can have devastating consequences for the whistle-blower and the containment of infectious diseases. Concealment of crucial information can exacerbate the spread of infectious diseases, impeding the collective response in disease containment.

The 2005 IHR needs to go beyond acknowledgment of human rights principles in the 2005 IHR and provide a mechanism for implementations. A starting point would be incorporating human rights impact assessment into the evaluation framework which require states to disclose the relevant human rights legislation in balancing individual and collective rights in the event of a PHEIC in their territories.

The coronavirus outbreak again underscores the interdependency and interconnectedness of countries in containing the spread of infectious disease; commentators have urged that "the pertinence of an orchestrated international response in times of health crisis becomes only clearer. The global medical community has the capacity to address extremely dangerous outbreaks. In isolation, most countries do not."[143] This suggests that an inclusive participation from stakeholders is essential to protect "all people of the world from the international spread of disease", a guiding principle of

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[142] *Report of the Special Rapporteur to the GA on the Protection of Sources and Whistleblowers*, OHCHR, https://www.ohchr.org/EN/Issues/FreedomOpinion/Pages/ProtectionOfSources.aspx (last visited Mar. 10, 2020).

[143] James Hamblin, *We Don't Have Enough Masks, Pandemics Will Require Deciding Who Needs Respirators and Surgical Masks, and Who Doesn't*, THE ATLANTIC (Jan. 30, 2020), https://www.theatlantic.com/health/archive/2020/01/viral-masks/605761/.

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the 2005 IHR.[144] Public health and legal scholars have noted that "[t]he WHO would be more effective by giving voice and representation to stakeholders."[145] Such could be achieved by broadening participation both at JEE missions and WHA to giving voice to those voices previously unheard. Currently, the JEE process is structured as a joint collaboration between governmental bodies and international experts, which excludes participation from civil society. While State Parties are required to report their implementation of IHR at the annual meeting of WHA, the Rules of Procedure of the World Health Assembly provides limited participation for civil society and non-Member States, which further weakens the effectiveness of the 2005 IHR. Broadening participation at the WHA can provide an additional oversight by holding governments accountable for their rhetoric and enables the WHO to leverage its technical and normative authority as a global health agency and improve evidence-based policy making. Insofar as infectious disease control requires a global concerted effort, there is a pressing need to move beyond a state-centric approach in the international infectious disease control, while acknowledging that governments remains the primary political actors responsible for the health of their people. With the unprecedent scale of the coronavirus outbreak, political responsiveness, democratic openness, inclusive participation are various ways in which the WHO can strengthen its political leadership in protecting public health.

Notably, the emergence and re-emergence of infectious diseases can expose current inadequacy in global health governance, but crises can also spur innovations in governance mechanisms. For instance, after the much criticism on the 2014 Ebola outbreak in West Africa it has resulted in important improvements: it led to the reform of the WHO emergency programmes, the creation of new finance mechanisms such as Contingency Fund for Emergencies at the WHO and the Pandemic Emergency Facility at the World Bank, and introduction of external evaluations of individual countries' core public health capacities.

It remains to be seen if the novel coronavirus will again catalyze another wave of governance reform at the WHO. The COVID-19 outbreak exposes the collective vulnerability against the invisible enemy that penetrate national borders with ease. The outbreak will again test the effectiveness of IHR specifically, and the moral and legal legitimacy of the WHO as a global health agency more broadly.

[144] WHO, *supra* note 83, art. 3(3).
[145] Gostin et al., *supra* note 21, at 860.

臺灣大學學術期刊資料庫

VIII. CONCLUSION

Global health has come a long way, with some notable achievements. However, as global governance of health is increasingly complex, where operations of global health are often intertwined with various interests of stakeholders, muddled in geopolitics and national interests. While a wide consensus exists that effective containment of COVID-19 outbreak requires a concerted global effort, an effective global response must also include inclusive participation, accountability, and transparency both at the national and international levels.

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