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Evaluating Sub-State Participation in the History of International Health Co-operation

Nikita Chiu[1]

Introduction

The Treaty of Westphalia is often referred to as the point of departure in the history of international relations. It was in 1648 that the modern state system was established and the concept of national sovereignty born. Today, these two concepts remain essential elements that govern interstate relations. Despite that the term *international relations* implies relations between nations instead of states, it has historically been taken for granted that IR is a discipline that focuses on the relations between sovereign states. For instance, Kenneth Waltz, in his *Theory of International Politics*, acknowledged that "states are not and never have been the only international actors."[2] Nonetheless, Waltz also disregarded other international actors, besides the state, arguing that so long as the international structure is defined by major states, other actors are thus non-consequential. Until recently, the predominant unit of analysis in the discipline has been sovereign states, though increasingly we see an expanding literature on non-state actors such as transnational organisations (re: the EU), NGOs (re: Amnesty International), armed groups (re: Al Qaeda), and multinational corporations (re: Microsoft).

Recently however, scholars have become increasingly interested in the role of sub-state units in international relations. Although literature on federalism, regionalism, cities and the politics of other sub-state entities are slowly expanding, sub-state actor remains underwritten when concerning their impact on international organisations, regimes and their promoted values. However, the argument that international organisations have always been the exclusive

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[1] Nikita Chiu is a doctoral candidate at the Graduate Institute of International and Development Studies (IHEID) in Geneva. Currently she also holds the position of Research and Teaching Assistant at the Political Science Department of IHEID. She may be reached at sze.chiu@graduateinstitute.ch. The author would like to personally thank Jamie Galbraith, Charles Chu and Cillian O Donoghue for their comments and supports in the course of completing this research.

[2] Kenneth Waltz, *Theory of International Politics*, (New York: McGraw-Hill Company, 1979), p. 94.

domain of sovereign states is incorrect. Indeed, one of the very first major international organisations, the League of Nations, did not limit its membership to sovereign states. At that time, India and the White Dominion, both not yet independent from the British Empire, were admitted as members to the League. London had its seat at the League (as the British Empire), representing the interests of other colonies that were not members. Also, it is noteworthy that the small, but sovereign, state of Liechtenstein was refused admission. Article 1 of the Covenant of the League of Nations set the criteria for membership stating that "any fully self governed State, Dominion or Colony […] may become a Member of the League if its admission is agreed to by two-thirds of the Assembly."[3] The emphasis here rested on the ability of potential members to self-govern, as well as been given recognition and acceptance from fellow members. This example illustrates that the membership policy of international organisations is not neutral, or based on an objective set of criteria; it is largely an exercise of political power.

To demonstrate the presence of sub-state actors in international co-operation, this article uses the example of international co-operation in international healthcare and traces changes and developments of membership policies, to health organisations, over the past century. International co-operation in healthcare has, possibly, the longest history when compared to other international regimes. As such, an examination of international efforts in resolving global health challenges over the past century could be indicative of the changes in attitude and trends regarding sub-state involvement within the international community more generally. The assumption is that these changes reflect the different dominant states that emerged in various periods in the past century. In particular, the exclusivity of sovereign state members in participating in most forum of international co-operation was a deliberate construction that emerged after the inception of the United Nations (UN). Its emergence was a result of the emphasis on sovereignty that became institutionalised due to huge pressure for decolonisation in the post-WWII environment.

Methodology & Research Design

This study involves researching secondary sources to outline the history of, and changes to, membership policy in the area of international healthcare co-operation as well as extensive exploration of primary sources available at the headquarters of the World Health Organisation (WHO). This work examines the list of participants in decision-making bodies, which include the annual World Health Assembly (WHA), over a selection of chosen time intervals.

[3] Art. 1, The Covenant of the League of Nations, See Oyvind Osterud, "The Narrow Gate: Entry to the Club of Sovereign States" in *Review of International Studies* (1997), 23, 167-184.

Two, ten-year intervals (1946-1956 and 1999-2009) will be examined in the case of the WHO.

This research adopts a broader definition of sub-state units, referring to all non-sovereign, non-centrally administered or governed units under a sovereign state as sub-state entities. When defining a sovereign state, I refer to the present legal definition: a sovereign state is one with a permanent population within a defined territory, whose government has the capacity to enter into relations with other states.[4] As such, sub-state units are governing or administrative units that are constitutionally subordinate to the ultimate sovereignty of their respective central governments that meet the above international standard for legal personality. This design excludes territories of contested sovereignty in general. If sovereignty of the territory in question is claimed by two competing authorities, then it is not a matter of state/sub-state relations, but one of civil conflict. This is the situation in the 1970s and 1980s between the communist regime of China and Taiwan. However, this is no longer the case as Taiwan has, in principle, accepted that it could no longer claim sovereignty over mainland China, and switched its priority to gaining recognition as a separate state instead. Failing to meet the above criteria means that the entity fails to constitute as a sovereign state. For example, though the Sovereign Order of Malta enjoys a certain legal personality, it does not constitute any permanent population within a defined territory. Thus, despite regularly attending international conferences alongside sovereign states, it is not considered a state, nor a sub-state unit in this study.

In terms of sub-state participation, there were various channels and manners in which sub-state interests were represented, and forms of participation in the two domains were subject to different membership regulations set within the two main organisations that were studied. Nevertheless sub-state participation could be generalised into three main forms:

P1. As *formal participants* (albeit with limited rights) that are represented separately from the national central authorities. For example, associate membership of non-self-governing units in the WHO that has a more limited set of rights than full members, but nonetheless through which sub-state officials were able to participate separately from their national delegation.

P2. As *observers* that are represented separately from the national central authorities. In this case, sub-states participate in the capacity as an *observer*, may be able to speak at conferences, but are denied voting rights and other forms of initiatives that may determine the agenda of the meetings. However, this form of participation has significant symbolic value, as the sub-state units will be present separately from their national delegations.

[4] Montevideo Convention, 1933.

P3. As *representatives integrated* within national delegations. In this case, sub-state units will not be represented separately from their sovereign authorities, but rather absorbed into the national delegations. Even within this approach there are varying levels of influence from the part of the sub-states. For example, while some countries did appoint sub-state officials as formal delegates, most others would include them as mere advisers at least, and alternates at best. Unfortunately, due to resource limitation, this research could only subsume all varying level of influence under one single form for ease of evaluation.

The status of many entities vary across different times over the past century, in particular British possessions that have international legal personalities such as South Africa, Australia and Canada posed considerable challenges to defining the exact year when these countries become fully sovereign states. For these countries, decolonisation was an ongoing process and sovereignty was gradually gained, recognised and exercised. Often agreements for increasing autonomy and legislative power concluded between the British government and these entities were not explicitly stated, making it a difficult task to determine when these entities become independent in making their own decisions in the international forums examined in this research. A decision was made to consider any British Dominions sovereign the year when the Statute of Westminster was formally adopted.[5]

History of International Cooperation in Healthcare

The Classical Regime – International Sanitary Conferences

International co-ordination and co-operation in international healthcare has a long history. According to Fidler, the earliest international initiative in the area dates back to 1851, when the first International Sanitary Conference was held in France. Together with numerous conferences that ensued, this series of International Sanitary Conferences (ISC) were the first international attempt to standardise international quarantine regulations against the threats posted by three epidemic diseases: cholera, the plague and yellow fever, all of which were considered to have travelled from foreign territories to Europe through trading routes. These conferences, according to Fidler, constitute the "classical regime"

[5] The Statute of Westminster was a treaty that established legislative equality between the British Empire and its various self-governing dominions. For a more detailed analysis on the judicial status of these dominions, see Kenneth Clinton Wheare, *The Statute of Westminster and dominion status*, (Oxford: Oxford University Press, 1953).

in the health arena, which paved way to the later development and institutionalisation of the internationally concerted effort in tackling health threats.[6] The classical regime aimed to ensure the following: first, that parties to the regime would notify each other of outbreaks of the three abovementioned diseases that erupted within their own territories; second, that restriction imposed on international trade and travel in the name of disease prevention would be limited and that these restrictions should be backed by scientific evidence and public health principles.[7] These regulations reflected the major concerns of European nations in the 19th century: the introduction of Asiatic diseases to the continent and governments' restrictions on trade in response to contain the spread of these diseases. Prior to establishing the classical regime, individual governments responded to threats of epidemics by closing its frontiers, an approach called *cordon sanitaire.* The (then) city-state of Venice was the first to impose quarantine regulation in 1348 in face of the potential spread of bubonic plague (the Black Death) from Asia.[8] Needless to say, most quarantine measures that developed since varied greatly from locality to locality. When the first International Sanitary Conference was convened in 1851, we can see that out of the thirteen countries that participated, most were maritime and imperial powers that saw the need to discuss obstacles to trade posed by restricting regulations due to the threat of contagious diseases. A reasonable representation of regional balance was only found as late as 1881 when the ISC was held in Washington, 30 years after the first event was convened. Progress in reaching consensus on a binding standard of quarantine regulations was slow. It had taken the ISC forty-one years of discussions to reach a very limited convention that obliged the signatories to quarantine westbound ships that are with cases of cholera.[9]

Towards Institutionalisation – l'Office International d'Hygiène publique

Despite being a pioneer in international healthcare, the ISC made little binding impact due to its *ad hoc* nature. Institutionalised forms of co-operation, with a permanent administrative body and standardised decision-making mechanism were yet to emerge. The conferences were not regularly convened, but rather only called when there were outbreaks of infectious diseases or

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6 See David Fidler, "From International Sanitary Conventions to Global Health Security: The New International Health Regulations" in *Chinese Journal of International Law* (2005), Vol. 4, No. 2, pp. 325-392.

7 Fidler, (2005) p. 328.

8 WTO, "The rise of international cooperation in health: Medical, social, political and economic history sheds light on the purpose and function of WHO" in *World Health Forum*, Vol. 16, 1995, pp. 388-93.

9 Milton I. Roemer, (1993)*, National Health Systems of the World: Volume II: The Issues,* (Oxford: Oxford University Press), p. 309.

when its existing regulations jeopardised the interests of the major powers at the time. For example, the Constantinople Conference was called because Egypt and Europe were beginning to see the spread of the forth pandemic of cholera; Russia called for the 1874 conference due to persisting cases of cholera found around the Black Sea and they found the harsh quarantine measures imposed on Russian ships unacceptable.[10] The first international endeavor to institutionalise health co-operation only came in 1907, when the powers present in Rome agreed to create a permanent body – *l'Office International d'Hygiène publique* (OIHP) to ensure better compliance to various conventions agreed at previous ISCs.[11] The office could be broken down into three main sections which aimed at achieving their corresponding objectives: a technical commission that aimed to further study epidemic diseases; a permanent administrative body to prepare the ISCs and administer the agreed conventions; and a centre to facilitate exchange of epidemiological information.[12] The twelve parties to the agreement decided to establish the office in Paris, and put the office under the control of the Permanent Committee.[13] The Permanent Committee was to compose of one technical expert from each participating state; voting rights however were allocated according to members' annual contribution rather than equal votes. For example, Great Britain and the USA, each paying 25 units of annual contribution, belonged to the first category and were entitled to six votes; Switzerland, on the other hand, contributing only 10 units, was put into the fourth category and was only entitled to three votes.[14] New, acceding parties to the agreement could choose to adjoin themselves to the six categories available, depending on the amount that they were willing to commit. It should be also noted that Committee members represented their respective countries rather than the general interest.[15]

Membership to the Committee was not exclusive to sovereign entities. As such, major empires enjoyed multiple representations. In addition to the delegate representing the British colonies, Britain also had another delegate separately representing India on the Committee. Moreover, as a first category country contributing 25 units to the Office's annual expense like Great Britain, British India was entitled to the same amount of votes in the body. In other

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10 Goodman, pp. 54-5, 58.

11 At the time of its creation, the main focus of its work was on issues relating to quarantine. See Goodman, pp. 70-1, 84-106.

12 Goodman, p. 84.

13 The twelve contracting parties were Belgium, Brazil, Egypt, France, Great Britain, Holland, Italy, Portugal, Russia, Spain, Switzerland and the USA. Romania was presented at the conference but was not a party to the agreement. Goodman, p. 87.

14 For details on categorization in accordance to units of annual contribution, see Annex: Statutes of Constitution of the International Office of Public Health, Art. 11, The Rome Agreement of 1907 Establishing the International Office of Public Health, translated from French to English in Goodman, p. 103.

15 Goodman, p. 87.

words, British India, as a sub-state unit to Great Britain, maintained *equal* rights and privileges as her sovereign counterpart. However, this equality between sovereign and sub-states was only a theoretical plausibility. In reality, this unprecedented system of voting power was never put into. In its almost half century of existence, no issues were ever brought to a direct vote.[16]

The Health Organisation of the League of Nations

With regard to the office's work, Goodman contends that the Office's impact was limited prior to the outbreak of war in 1914. During WWI, most of the Office's functions were halted except for the publication of a monthly bulletin that reported epidemiological information to contracting powers.[17] After the war, the League of Nations attempted to incorporate the Office into its Health Organisation, in accordance with Article 24 of the Covenant of the League.[18] A resolution was passed on 10th December, 1920 by the League to place the Paris Office under the League of Nations. However, according to the official record of the League, the "objection of the United States made it impossible […] to place the existing OIHP in Paris under the direction of the League of Nations."[19] The United States, having declined to join the League, could not send their delegate to the board of the Health Organisation. They did not think it to be in their interests to put the OIHP under the new organisation, as the US was entitled to substantial amount of votes at the OIHP due to its large financial contribution to the Office. The French government was also reluctant to give up influence in what they saw as essentially a French organisation (the only official language of the Paris Office was French), but the objection was mainly seen as coming from Washington.

The original proposal was that the OIHP was to join the Health Organisation through joining as part of the General Committee. The General Committee was to compose of one delegate from each of the League of Nations member states, and one delegate from each of the non-League of Nations members that was on the Permanent Committee of the OIHP. This plan was abandoned when the French government, along with the American, objected to proceed to elect a president for the General Committee.[20] The subsequent solution replaced the envisioned Health Organisation with the creation of a Provisional Health Committee composed of a majority of the delegates also on the Permanent

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16 Goodman, p. 87.
17 Ibid, p. 92.
18 Article 24, All international bureau previously established under international agreement shall, subject to the consent of the contracting States, be placed under the authority of the League of Nations." Covenant of the League of Nations.
19 League of Nations Official Journal, p. 1099, December, 1921.
20 Goodman, p. 110.

Committee of the OIHP.[21] The OIHP was set to only serve as an advisory body to the League of Nations, thus maintaining its independence from the League. This proposal was accepted by both parties after having examined that such an arrangement did not exceed the capacity granted to the OIHP in co-operating with other health agencies. This was ideal for Paris as it would not infringe on OIHP's autonomy.[22] The matter of merging the two existing bodies came up again at the Council of the League in 1923, where the Council decided to create a mixed commission of the League's Health Committee with the Permanent Committee of the OIHP to draft a constitution for the future of the health body of the League. The final output set the Permanent Committee of the Paris Office to be the General Advisory Health Council to the League Health Organisation. A Secretariat and a Health Committee were also created. However, differing from the Permanent Committee of the OIHP, the Health Committee of the League Health Organisation was meant to serve as a technical body that reported directly to the League's Council on the work that the Health Organisation was doing and other related health issues. The number of delegates on the Committee increased and decreased over the years, but the principle was to have them partly elected by the Permanent Committee of the OIHP; and the other part elected by the Council of the League. The president of the OIHP would be the *ex officio* vice-president of the Committee. Despite the fact that these officials were elected by the OIHP and the Council of the League, they were to serve the Health Organisation in their own personal capacity. In other words, these elected officials were not delegates that represent interests of their own countries.[23]

In theoretical terms, the power that was given to the League Health Organisation was limited. As the decision-making power remained in the hands of the Council of the League, the Health Organisation's role was expected to be mainly advisory and subordinate to the Council. In practice however, Dubin contends that the Committee was more powerful and that its work enjoyed a high level of autonomy. Since diplomats and politicians on the Council lacked the expertise to deal with health issues, they usually endorsed the Health Committee's suggestions without much doubts and rubber-stamped its recommendations.[24]

Before the reform of the Health Organisation in 1936, there had been an increase in the number of advisors introduced to the Committee. Dubin interprets this as the manoeuvre of imperial powers (re: Britain and France), to gain multiple representations through assigning colonial delegates in the League's organisation. However, in principle, nationalities of the members should not

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21 Nine out of thirteen, ibid, p. 110

22 Ibid.

23 Ibid, p. 112.

24 Martin David Dubin, "The League of Nations Health Organization" in (ed.) Weindling, *International Health Organization and Movements, 1919-1939*, (Cambridge: Cambridge University Press, 1995), p.63.

be a determining factor in decision-making given that members to the Health Committee should sit as officials in their own personal capacities rather than as representatives of their governments.[25] Nonetheless, and regardless of this principle, the empires tended to perceive that admission of colonial members to the OIHP, and hence, to the Advisory Council to the League's Health Organisation, would inevitably mean more influence and larger representation of the imperial interest. The record of a meeting of the Finance Committee of colonial Hong Kong aptly illustrates this point. In 1929, London approached the colonial government of Hong Kong and asked if it were willing to financially contribute to the annual subscription of joining the Permanent Committee, thus expanding British representation within the OIHP and the Health Organisation of the League of Nations. When queried about the contribution to OIHP, London explained their request,

> At present there is only *one* British member on the Health Committee of the League of Nations while on the Committee of the Office International, whether acting independently or as an advisory health council of the League the absence of representatives with experience of British colonial medicine and tropical diseases, tends to make the representation of the British Empire one-sided and deficient. There are strong arguments in favour of British representation. […] It was thought that the best arrangement would be to invite some of the larger colonies and those which are most likely to be interested in the work of the Office to contribute an equal share of the subscription. Promises of contributions of approximately Ł25 per annum have already been obtained from Ceylon, Nigeria, Straits Settlements and Kenya and the Secretary of State desires to know whether the Hong Kong Government will be prepared to contribute this sum or slightly more. [...][26]

In this case, sub-state participation to an international organisation was actively pursued and encouraged by the British Empire, hoping that an increase in colonial membership would advance its own imperial representation.

World Health Organisation

Another chance to redesign the architecture of international co-operation in international healthcare came after the Second World War, when the structure of the League of Nations was discussed and transformed into the newly established United Nations. The architecture of the United Nations, which emphasises the principle of self-determination and admits only sovereign nation-states, departs markedly from that of the League which largely reflected imperial dominance.

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[25] Ibid, pp. 61 and 63.

[26] "Item No. 84: Miscellaneous Services: - Office International D'Hygiene Publique, Paris, $302," *Proceeding of Hong Kong Legislative Council*, 31st October, 1929.

Originally there was no plan to renew the Health Organisation into a new body to deal with health issues in the United Nations Conference in 1945. As such, the existing Health Organisation was nearly abandoned instead of reinventing it in a new organisation as the League had done. Coincidentally, at the conference in San Francisco where the future of international institutions was discussed, three medical doctors found themselves in an international gathering of a group of world leaders that were almost exclusively diplomats and politicians. The three decided to get together for a medical luncheon, during which they agreed to discuss creating a new international health organisation on the conference agenda, oblivious to the fact that the British and US delegations had already decided, among themselves, that no health issues will be introduced to the agenda.[27] Regardless of the disinterest showed by Great Britain and the US, Dr. Sze Mingsze from China drafted a resolution proposing an international health conference to be held in order to discuss the establishment of an international health organisation. Subsequently Dr. Souza, representing the Brazilian delegation, and encouraged by Sze (but much to the latter's surprise), succeeded in including the word "health" in the UN Charter. The assumption was that once the word "health" was put into the Charter there would be an obligation to create a corresponding organisation.[28] Following the inclusion of the health aspect into the UN Charter, a declaration calling for the formation of a single health organisation was enthusiastically adopted and a resolution to establish a single health organisation and a preparatory committee was soon put to a vote in January 1946, at the Economic and Social Council (ECOSOC). It was passed by 11 votes, with 4 votes from Soviet countries opting against the resolution. Sze noted that Yugoslavia was unable to vote in favor of a resolution that they seconded due to their status as a Soviet satellite.[29] When the report of the Technical Preparatory Committee was submitted to the ECOSOC, along with other issues preparing the 1st International Health Conference, Sze noted again that the atmosphere turned political. The issue of which countries to invite to the conference dominated the discussions, and Sze pointed out that few of the delegations were uncertain about the status of countries like Yemen and the Trucial States.[30] In the end, invitations were sent to fifty-one members of the United Nations, and sixteen invitations were sent to non-UN members, three out of which did not send observers to the conference, namely Afghanistan, Romania, and Yemen.[31]

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27 Szeming Sze, *The Origins of the World Health Organization: A Personal Memoir 1945-1948*, (Florida, US: L.I.S.Z. Publications, 1982), p. 2.

28 WTO, "Forum Interview with Szeming Sze, WHO: from small beginnings" in *World Health Forum*, Vol. 9, 1988.

29 Ibid, p. 10.

30 Ibid, p. 16.

31 Goodman, p. 155.

The first International Health Conference opened on the 19th June, 1946 in New York. In addition to the presence of the (then) fifty-one UN member states and the thirteen non-UN member states, the only sub-governmental units present were from the post-war allied control authorities: the US Occupation Zone of Germany, occupied Japan, and occupied Korea all sent observers to the conference. Korea was represented by a local Director from the Bureau of Health-Dr. Y.S.S. Lee, but for US occupied Germany and Japan, they were represented by military officials; Major-General Morrison C. Stayer and Colonel Crawford F. Sams respectively. Moreover, the French and British delegations included one personnel working on colonial affairs: one official from the Ministry of the Colonies accompanied the French delegation, and one medical advisor from the Colonial Office served as an adviser to the British representation. Besides the abovementioned, no other sub-state authorities were present at the conference.[32] Observers to the conference were entitled to sit and speak at meetings upon invitations by the chair, but they had no rights to vote or to propose motions.

Membership to the New Organisation

Despite that most participants, including observers, were representing sovereign entities, considerable time was spent on debating membership eligibility, and quite controversially, on the matter of associate membership as proposed by the Technical Preparatory Committee. With regard to the criteria for membership, the general principle was that it should be open to all member states of the United Nations as long as they accepted the WHO constitution.[33] As for States that were not members of the United Nations, the United States proposed to accept them on condition that these countries accept the constitution. The argument was that "the fight against disease should outweigh any political considerations, since the absence of any states was bound to detract from the effective operation of WHO." Washington further pointed out that, according to international law, membership to an international organisation by no means affects recognition by other states of the admitted entities. As such, Washington saw no problems in admitting non-UN member states.[34] It appeared as a logical argument from Washington, considering that some years ago the United States wanted to be on the Health Organisation even though it was not a member to the League.

The US opinion on membership led the Soviet countries to introduce a counter-proposal that called for a two-thirds vote of the Health Assembly in order to admit non-UN States as members to the organisation.[35] The issue of

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[32] International Health Conference, 1946.
[33] WHO Official Records, Summary of the International Health Conference, 1946, p. 27.
[34] Ibid, p. 18.
[35] Ibid, p. 18.

membership is much less clear-cut as one would think. Seeing that the conference was set against a post-war backdrop, it was not surprising to find that Spain was excluded from the conference, and Germany and Japan were represented as territories under foreign control. Belarus went as far as to argue that the admission of Spain should not even be posted at the meeting. They recounted Spanish participation during the Second World War and Madrid's help to the Hitler's army. They charged that actions of the Fascist regime ran against the principle of peaceful progress and mutual understanding as in accordance to the Charter of the UN. The Soviet delegation backed the Belarus' claim and insisted on a two-thirds majority vote for admitting non-UN members. After much debate on the matter, the conference decided that non-UN States could be admitted to the organisation by a simple majority vote of the Health Assembly.[36]

Some delegates were displeased by the Soviet bloc's tendency to politicise issues at the conference. Among them included Brock Chisholm from the Canadian delegation, who was to become the first Director-General of WHO. He was against turning the forum of the new organisation into a political battleground. Coming from a medical background, he asserted, "It was important that health should be regarded as a world-wide question quite independent of political attitudes in any country in the world."[37]

Moreover, Chisholm, who was also on the Technical Preparatory Committee, was a major force behind the naming of the new organisation the *World Health Organisation* instead of *International Health Organisation*.[38] The concept behind labelling this organisation as a world organisation instead of an international organisation was the hope that this organisation could transcend national boundaries in order to collectively advance world health. The final consensus in accepting the preparatory committee's suggestion of the name came only after considerable debate. The UK wanted to call it the Health Organisation of the United Nations, but Iran, among several others, did not want membership of the organisation to be limited only to UN members, which at the time of inception, composed of only fifty-one states. Sze, representing China at the conference, explained the committee's choice of wording. He believed that the name is more universal than *United Nations* as efforts in the health domain ought to be "universal and cover a wider field than the United Nations organisation itself," and that the organisation would be one that belongs to the world as whole but not merely to nations.[39] It is important to take heed of the near idealistic vision that functionalism would trump politics that was shared by many members of the Technical Preparatory Committee. Tacitly, this shared belief of the group was transformed into practice through the committee's draft

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36 Ibid, p. 18.

37 Ibid, p. 70.

38 John Farley, *Brock Chisholm, The World Health Organization, & the Cold War,* (Toronto: UBC Press, 2008), p. 2.

39 International Health Conference, 1946, p. 48.

constitution. The committee sincerely hoped that the organisation could be as inclusive as possible. The suggested name of the organisation, and the proposal for a wider scope of membership admission, were indicative of the group's success.

Ironically, while the Soviet bloc politicised the issue of admission for certain members and thus posed problems to the goal of universal membership, the admission of Ukraine and Belarus was itself problematic. Their admission to the UN had long been seen as a political deal to accommodate more votes for the Soviet Union, and scholars have long challenged the autonomy of the two Soviet Republics in international forums.[40]

Associate Membership

Besides the matter of the politicalisation of membership admission, the other issue that dominated the debate was on associate membership. At the time of the conference, it was one of the first times when the concept of associate membership for non-sovereign entities in international organisations was publicly discussed in an international forum.[41] At first, Sze himself, one of those on the preparatory committee that backed the introduction of associate membership, had difficulty getting support from his own delegation. The proposal called for all territories that are "ineligible to separate membership in the United Nations, whose areas and populations are large enough, whose health problems are of world concern, and which have indigenous health administrations" be granted "all rights and privileges except voting and holding office" under Associate Membership.[42] The discussion showed that this type of membership was created to accommodate those non-self-governing territories ineligible for full

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[40] The definition of a sub-state is again put to test in the case of the two Soviet Republics – Ukraine and Belarus – which enjoyed full UN membership. Membership of the two Soviet states had long been interpreted as a political compromise made by Western powers in exchange for the Soviet's agreement to join the UN. However, sovereignty of these two entities was contested in both judicial and practical terms. In legal terms, scholars pointed out that the two republics could not be sovereign since the Federal Law of the USSR prevails over state law, constitutionally speaking. In practical terms, even though the constitution stated that member republics are sovereign states that were free to exercise their state power in establishing foreign relations, almost no diplomatic exercises were undertaken by Soviet member republics, except for Ukraine and Belarus who participated in international organizations. Originally the Soviet Delegation demanded admission of all sixteen republics into the UN at Dumbarton Oaks. The demand was subsequently rejected and the US instead promised three votes to the USSR at Yalta. See Edward Dolan, "The Member-Republics of the USS.R as Subjects of the Law of Nations" in *International and Comparative Law Quarterly*, Vol. 4, 1955, pp. 629-636; and Konstantyn Sawczuk, "The Ukraine: a Sovereign and Independent State? A Juridical Approach," in *European History Quarterly,* Vol. 1, No. 4, 1971, pp. 377-396.

[41] Sze, p. 17.

[42] International Health Conference, 1946, p. 48.

membership.[43] In particular, there were specific adjustments to the wording in the draft constitution proposed by the Technical Preparatory Committee in order for "Trust Territories, whether administered by a single Power or by the United Nations collectively, to be admitted to associate membership."[44] As such, the proposal of associate membership reflects the historical context of the time when the new international health organisation was being devised. It was an invitation to consider the representation of numerous post-war occupied areas and other regions under the UN Trusteeship Council. While debates on membership at the conference reflected and reaffirmed the United Nations' emphasis on sovereign membership, the conference also took note of the fact that many regions were yet to fulfill the UN sovereign criteria in the immediate post-war world order. A new trend developed that prioritised sovereignty as the main criteria in joining the international forum on the one hand, yet the acknowledgement of and subsequent accommodation for those territories that were yet to meet this new standard of statehood indirectly paved way for future participation of sub-state entities in international organisations. The reason being, that the wording of the final article regulating associate membership did not limit itself only to be applicable for trusteeship or occupied countries, although at the inception of the idea these type of territories were clearly the main concern. This specific attention to post-war non-self-governing territories is also reflected by the invitations to the conference that were extended to several territories occupied by the Allied Powers. The constitution governs Associate Membership as follows:

> Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as Associate Members by the Health Assembly upon application made on behalf of such territory or group of territories by the Member or other authority having responsibility for their international relations. Representatives of Associate Members to the Health Assembly should be qualified by their technical competence in the field of health and should be chosen from the native population […][45]

In the article, there was no reference to the non-self-governing nature of many post-war territories that were yet to attain full sovereignty. The categorisation of Associate Members in the constitution resembles the main attributes of sub-states that enjoy a certain level of autonomy in handling their own affairs. As the clause stipulates that application of membership should be made by the authorities on behalf of the concerning territories, it assumes that the ultimate residence of sovereignty of the territories in question is recognised, either by the territories themselves, or by the larger international community. As such, one can reasonably infer that Associate Membership is applicable not only to

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43 Ibid, p. 48.
44 Ibid, 19.
45 Article 8, Constitution of the World Health Organization, 1946.

occupied or trusteeship territories, but also to sub-state units whose sovereignty are understood to rest elsewhere - in the central authority that they belong to. In other words, Associate Membership does not apply to territories with contesting claims of sovereignty.

In practice, however, the intention of the Technical Preparatory Committee's introduction of Associate Membership in order to make the WHO be as inclusive as possible was hardly met. Over the course of its half century in operation, there have been very few instances when the window of participation through joining as an Associate Member were exploited. According to UN records, between 1945 to 1999, there have been over 90 non-self-governing territories under UN trusteeship or were administered under foreign powers.[46] Britain alone was responsible to assist the transition of near forty such territories to full statehood or other arrangements of decolonisation. During the discussion on associate membership, the UK, seeing the potentially large amount of additional members to the organisation, proposed to restrict the number of associate members to only twenty. The proposal did not pass, and in hindsight such a limitation seems unnecessary considering the small number of associate members that were eventually admitted to the system. Despite the staggering number of entities that were eligible to associate membership, which was devised to meet the goal of universal membership in the domain of international healthcare, only twenty-two associate members emerged since WHO's inception.[47] Furthermore, it was doubtful if these admitted members could exercise the level of autonomy that they were entitled to in voicing the needs of the local population, despite foreign rule. In 1952, France applied for Associate Membership on behalf of both Morocco and Tunisia. According to the six geographical regions that were established at the First Health Assembly, Morocco as a new associate member was put under the European region, in line with Paris' preference. In the wake of France's claim over Morocco, Spain made similar request and apply for associate membership for the Spanish Protectorate Zone in Morocco the following year. Madrid however, asked to put the protectorate zone under the African region, posing administrative difficulties in placing the same population under two regions.[48] In both cases, the deciding forces were the colonial powers and the role of local representatives of the newly admitted associate members was questionable.

Although Associate Membership was not limited to trusteeship territories, which were the major concern when this type of membership was devised,

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[46] UN, "Trust and Non-Self-Governing Territories, 1945-1999," *The United Nations and Decolonization,* 10 May, 2009, <URL=http://www.un.org/Depts/dpi/decolonization/trust2.htm>

[47] Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (London: Hurst & Company), p. 68.

[48] For politicization on the question of regional grouping, see Javed Siddiqi, "The Delineation of Regional Boundaries" in *World Health and World Politics: The World Health Organization and the UN System,* (Columbia: University of South Carolina Press, 1995) pp. 73-76.

admission of sub-state units as Associate Members almost completely died down in recent years since the Trusteeship Council ceased to exist. In the most recent 10 years that were studied, only Puerto Rico had participated twice at the annual World Health Assembly (see Fig. 1a & Fig. 1b below). Perhaps one of the obstacles for sub-states to formally participate through this type of membership was that application must be made by the central government. In this sense, even though it may be in the interest for sub-states to join, they may find it difficult to secure consent from the central authority to apply on their behalf. In fact, from studying associate members in selected years, we find that besides transitional countries, such as former colonies or protectorates that were expected to soon gain independence, there were hardly any other forms of sub-state entities.

Conclusion

The development of international co-operation in international healthcare reveals a history of tension between functionalism and politicisation. It is a struggle between technical experts' vision of a world health order contrasted against politicians' understanding of the international system. Membership policy in this struggle has never been neutral, but rather, reflects the power of dominating actors at different times. In the early twentieth century, the formation of the OIHP and its unique, weighted voting system that correlates with Contracting Powers' contributions defer from modern understandings of sovereignty, of which mutual recognition of equality was one crucial aspect. The OIHP however, was an organisation dominated by imperial powers which were the prevalent state form at the time. When the organisation was later incorporated into the new Health Organisation of the League of Nations, OIHP's major members, in particular the British Empire, was not content with the structure of equal participation, and attempted to recruit colonies into the organisation so that they could achieve what they perceived to be an expansion of British representation. The slow process of integrating the OIHP into the Health Organisation encapsulates the transition of the old imperial system into the new world order of equality that was envisioned by the founders of the League. It also marks the changing meaning of state – from imperial states slowly moving towards the conception of the nation-state.

At the creation of a new health organisation in 1946, medical experts were successful in convincing governments to adopt the clause for associate membership and a less politicised requirement in admitting non-UN members (requiring only a simple majority of approval is one of the lowest standards among UN-affiliated agencies in admitting non-UN members). Unfortunately, despite the adoption of these regulations that favour universal membership, such regulations were rarely utilised to the advancement in including local opinions of non-sovereign sub-state entities. The impractical proposals to place

French Morocco and Spanish Morocco under two different regional bureaus are indicative of the tension between governments' political decisions and the good intention behind an inclusive approach to membership policy. Furthermore, criteria for membership became a politicised debate between the West and the Soviet Union. Meanwhile, the new emphasis on sovereign membership was contradicted by the admission of Ukraine and Belarus whose empirical and judicial sovereignty was highly questionable. In the midst of the Cold War, terms of membership were determined by the two major powers in silent conflict. In other words, the new UN stress on sovereignty, as Krasner puts it, became mere 'organised hypocrisy.'

In recent years, membership to international organisations has more or less been fixed, leaving little room for change in admitting or expelling members. Colonial entities disappeared, and the main types of sub-states left are regional entities like provinces, federal states, or autonomous regions within national borders. The participation of these entities in international relations is largely confined to integration into national delegations. As such, the determining factor rests on the willingness of central authorities to incorporate sub-state officials into their delegations.

Based on the above findings, a prediction could then be made regarding future sub-state participation in international regimes or organisations. It is unlikely that sub-state units could join as members, albeit in a more limited capacity, to established UN-affiliated international organisations, even though in principle, as in the case of WHO, the policy of associate membership is applicable to sub-state actors. As mentioned above, the admission of non-sovereign sub-state entities as associate members or as observer were mostly an accommodation made for former colonies that were set to gain independence. It is more likely however, that sub-states seek representation through joining the national delegations. And, seeing the expansion of this practice across different geographical areas and types of regimes, it appears that states have become more open to the idea of incorporating sub-state officials into their own delegations. One reason behind this trend is that participation in international organisations, especially UN-affiliated ones, have become synonymous with displays of sovereignty. Before international organisations became the dominant form of global governance, we see that major powers, at times, could refrain from joining these organisations and still be able to yield influence (re: the US trying to influence work in the Health Organisation without joining the League of Nations). Currently however, membership to international organisations has essential symbolic value; as a way of demonstrating the unity of a given state. As such, even countries that are known for their highly-decentralised federal structures (re: Belgium), choose to refrain from having multiple international representations, but instead opt for incorporating sub-state representations under the umbrella of a single delegation. Due to this development, membership to international organisations has become even more politicised. Taiwan, for

example, was only granted observer status at the WHO in 2009, after almost a decade of blockage from Beijing to attend any World Health Assembly. Despite China's sensitivity to one single representation, China surprisingly scored highest in terms of number and in percentage of sub-state officials present within her national delegations in recent years in the WHA and WHO (see Fig. 1b below). However, almost all sub-state officials came from the special administrative regions of Hong Kong and Macao, and provincial officials from mainland China were usually limited to one per year at the WHA. Nonetheless the tacit acceptance of Beijing to Taiwan's admission as observer to the WHO is an encouraging gesture that signifies Beijing's tilt towards pragmatic consideration over political concerns.

References

Aldecoa, Francisco, and Michael Keating, (eds.) (1999*) Paradiplomacy in Action: The Foreign Relations of Subnational Governments*, Portland: Frank Cass.

Biersteker, Thomas, and Cynthia Weber (Eds.) (1996) *State sovereignty as social construct*, Cambridge: Cambridge University Press.

Biersteker, Thomas, (2002) "State, Sovereignty and Territory", [eds] Walter Carlsnaes, et al. *Handbank of International Relations*, London: Sage Publications.

Dolan, Edward, (1955) "The Member-Republics of the USS.R as subjects of the Law of Nations", *International and Comparative Law Quarterly,* Vol. 4: 629-636.

Dubin, Martin David, (1995), "The League of Nations Health Organization" [Ed]. Weindling, Paul, *International health organization and movements, 1919-1939,* Cambridge: Cambridge University Press.

Duchacek, Ivo D. "Perforated Sovereignties: Towards a Typology of New Actors in International Relations" [eds.] Michaelmann, Hans J. and Panayotis Soldatos, (1990)*Federalism and International Relations: The Role of Subnational Units,*Oxford, UK: Oxford University Press.

Duchacek, Ivo D. (1986) *The Territorial Dimension of Politics Within, Among, and Across Nations,* Boulder, Colorado: Westview Press, Inc.

Farley, John.(2008) *Brock Chisholm, The World Health Organization, & the Cold War,* Toronto: UBC Press.

Fidler, David, (2001) "The globalization of public health: the first 100 years of international health diplomacy", *Bulletin of the World Health Organization*, 79 (9):842-849.

(2005) "From International Sanitary Conventions to Global Health Security: The New International Health Regulations", *Chinese Journal of International Law*, Vol. 4, No. 2:325-392.

Goodman, Neville M.(1971) *International Health Organization,* London: Churchill Livingstone.

Haas, Ernst,(1964) *Beyond the Nation-State: Functionalism and International Organization*, Stanford, California: Stanford University Press.

Jackson, Robert H. (1993) *Quasi-States: Sovereignty, International Relations and the Third World,* Cambridge: Cambridge University Press.

Keating, Michael, (ed.) (2004) *Region and regionalism in Europe*, Cheltenham: E. Elgar.

Keating, Michael, (2001) *Nations against the state: the new politics of nationalism in Quebec,Catalonia and Scotland,* Basingstoke: Palgrave.

Krasner, Stephen D. (1999) *Sovereignty: Organized Hypocrisy,* Princeton, New Jersey: Princeton University Press.

Lachapelle, Guy, and Stéphane Paquin,(2005) *Mastering globalization : new states' governance and strategies*, London : Routledge.

Murphy, Craig, (1994) *International Organization and Industrial Change: Global Governance since 1850*, New York: Oxford University Press.
Mushtaq, Muhammad Umair (2009) "Public health in British India: A brief account of the history of medical services and disease prevention in colonial India" *Indian Journal of Community Medicine*, Vol. 34, Issue 1.
Osterud, Oyvind, (1997) "The narrow gate: entry to the club of sovereign states", *Review of International Studies,* Vol. 23:167-184.
Roemer, Milton I., (1993), *National Health Systems of the World: Volume I: The Countries,* Oxford: Oxford University Press.
Roemer, Milton I., (1993)*, National Health Systems of the World: Volume II: The Issues,* Oxford: Oxford University Press.
Rosen, George,(1958) *A history of public health,* New York: MD Publications, Inc.
Rusinow, Dennison, (1969) *Italy's Austrian Heritage: 1919-1946*, Oxford: Clarendon Press.
Sawczuk, Konstantyn, (1971) "The Ukraine: a Sovereign and Independent State? A Juridical Approach", *European History Quarterly,* Vol. 1, No. 4: 377-396.
Siddiqi, Javed, (1995) *World Health and World Politics: The World Health Organization and the UN System*, London: Hurst & Company.
Sze, Szeming,(1982) *The Origins of the World Health Organization: A Personal Memoir 1945-1948*, Florida, US: L.I.S.Z. Publications.
Waltz, Kenneth, (1979) *Theory of International Politics*, New York: McGraw-Hill Company.
Wheare, Kenneth Clinton, (1953) *The Statute of Westminster and dominion status*, Oxford: Oxford University Press.
WHO, (1989)"Brock Chisholm: words of wisdom from the past", *World Health Forum*, vol. 10: 70-73.
WHO, (1988) "Forum interview with Szeming Sze, WHO: from small beginnings", *World Health Forum*, Vol. 9: 29-34.
WHO, (1995) "The rise of international cooperation in health: Medical, social, political and economic history sheds light on the purpose and function of WHO", *World Health Forum*, Vol. 16: 388-93.
Wilde, Ralph (2008) *International Territorial Administration: How Trusteeship and The Civilizing Mission Never Went Away,* Oxford: Oxford University Press.

Primary Sources

WHO Library and Archive

Constitution of the World Health Organization, 1946.
Verbatim of World Health Assembly, WHO Official Records, 1945-1957, 1960, 1965, 1970, 1975, 1980, 1985, 1999-2009.

Minutes of the International Health Conference, WHO Official Records, 1946.

Hong Kong Legislative Council

Hong Kong Legislative Council, "Item No. 84: Miscellaneous Services: - Office International D'Hygiene Publique, Paris, $302," 31st October, 1929, *Proceeding of Hong Kong Legislative Council*, 3 July, 2009 <URL= www.legco.gov.hk/1929/h291031.pdf>

League of Nations Archive

League of Nations Official Journal, p. 1099, December, 1921.
Information Section, League of Nations Secretariat, *The Health Organisation of the League of Nations,* League of Nations Secretariat, Geneva, 1923.

Other UN documents

Montevideo Convention, 1933.
UN, "Trust and Non-Self-Governing Territories, 1945-1999", *The United Nations and Decolonization,* 10 May, 2009, <URL=http://www.un.org/Depts/dpi/decolonization/trust2.htm>