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## Realizing the International Human Right to Health: The Challenge of For-Profit Health Care

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# REALIZING THE INTERNATIONAL HUMAN RIGHT TO HEALTH: THE CHALLENGE OF FOR-PROFIT HEALTH CARE

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*Eleanor D. Kinney, J.D., M.P.H.\**

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## I. INTRODUCTION

Today, nation-states are struggling to maintain public health insurance coverage and public health protections. Even developed countries with generous programs are reviewing commitments toward health. For many developing countries, meeting the health care needs of their populations is beyond reach. The international human right to health is a useful tool to sort out the obligations that nation-states, regional and local governments, private organizations, and the international community owe individuals in terms of assuring access to health care services and public health protections.

From World War II until the 1990s, the world engaged in an ideological debate over governments' roles in providing basic economic and social rights to populations. The ideology of Communist countries maintained that the state had an obligation to provide these services. Capitalist ideology prevailing in liberal democracies of the West rejected the idea that governments had such affirmative obligations regarding social, cultural, and economic rights. The developing world, comprising primarily underdeveloped nations, was left to pick and choose among the patron nations and their prevailing ideologies.

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In the 1990s, global politics took on a different dynamic with the collapse of Communism. One development that arose from this collapse was a greater consciousness of the potential role that human rights jurisprudence could play in a world with a different political dynamic.

This article addresses the outstanding and critical issue in the realization of the international human right to health: how to reconcile the economic reality of providing and supplying health care goods and services through for-profit business modes. Included in this analysis is a critique of free trade agreements in the realization of the international human right to health.

## II. BACKGROUND

In the 1960s, the United Nations (UN) sponsored the development of two international covenants that articulate the human rights recognized in the UN Universal Declaration of Human Rights (UDHR). These two covenants are the International Covenant on Civil and Political Rights (ICCPR)<sup>1</sup> and the International Covenant on Economic, Social and Cultural Rights (ICESCR).<sup>2</sup> Together with the UDHR, these covenants comprise the International Bill of Human Rights.<sup>3</sup>

The ICESCR is the most important in terms of the human right to health. Article 12 states that the right to health includes “the enjoyment of the highest attainable standard of physical and mental health.”<sup>4</sup> The UN Committee on Economic, Social and Cultural Rights is responsible for the promotion, implementation, and enforcement of this covenant.<sup>5</sup>

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<sup>1</sup> International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI) A, U.N. Doc. A/6316 at 53 (Dec. 16, 1966).

<sup>2</sup> International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI) A, U.N. Doc. A/6316 at 49 (Dec. 16, 1966) [hereinafter ICESCR].

<sup>3</sup> *International Human Rights Law*, U.N. HUMAN RIGHTS, OFFICE OF THE HIGH COMM’R FOR HUMAN RIGHTS, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx> (last visited Sept. 17, 2010).

<sup>4</sup> ICESCR, *supra* note 2, at 51.

<sup>5</sup> Committee on Economic, Social and Cultural Rights, *Monitoring the Economic, Social and Cultural Rights*, OFFICE OF THE UNITED NATIONS HIGH COMM’R FOR HUMAN RIGHTS, <http://www2.ohchr.org/english/bodies/cescr/> (last visited Oct. 10, 2010).

**Figure 1**  
**MAJOR INTERNATIONAL HUMAN RIGHTS**  
**TREATIES RELEVANT TO THE RIGHT TO HEALTH**

- UN Declaration of Human Rights, 1948
- Constitution of the World Health Organization, 1946
- International Covenant for Civil and Political Rights, 1966
- International Covenant for Economic, Social and Cultural Rights, 1966
- International Convention on the Elimination of All Forms of Racial Discrimination, 1965
- Convention on the Elimination of All Forms of Discrimination Against Women, 1979
- Convention on the Rights of the Child, 1989

In 2000, the UN Committee on Economic, Social and Cultural Rights published General Comment 14 to ICESCR.<sup>6</sup> Comment 14 outlines the content of the international right to health and its implementation and enforcement. According to the General Comment, the right to health also has a core content, referring to the minimum essential level of the right.<sup>7</sup> Although this level cannot be determined in the abstract as it is a national task, key elements are set out to guide the priority setting process.<sup>8</sup> Included in the core content are “essential primary health care, minimum essential and nutritious food, sanitation, safe and potable water, and essential drugs.”<sup>9</sup> Another core obligation is adoption and implementation.<sup>10</sup> This plan must address “the health concerns of the whole population[,] . . . be devised[,] and periodically reviewed[,] on the basis of a participatory and transparent process[,] . . . [contain] indicators and benchmarks, by which progress can be closely monitored, . . . [and] give particular attention to all vulnerable or marginalized groups.”<sup>11</sup>

Today, there is a broad corpus of human rights treaties that recognize international human rights, as well as UN bodies that are responsible for the

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<sup>6</sup> OFFICIAL RECORDS OF THE ECONOMIC AND SOCIAL COUNCIL (ESCOR), U.N. COMM. ON ECON., SOC. AND CULTURAL RIGHTS, SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2004) [hereinafter ESCOR].

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* ¶ 12.

<sup>9</sup> *The Right to Health*, WORLD HEALTH ORGANIZATION (AUG. 2007), <http://www.who.int/mediacentre/factsheets/fs323/en/index.html>.

<sup>10</sup> ESCOR, *supra* note 6, at ¶ 43(f).

<sup>11</sup> *Id.*

monitoring and enforcement of these rights.<sup>12</sup> In addition to ICESCR, the human right to health is also recognized in numerous other international human rights authorities that establish prohibitions against government conduct that are detrimental to health. Such treaties include the International Convention on the Elimination of All Forms of Racial Discrimination of 1965,<sup>13</sup> the Convention on the Elimination of All Forms of Discrimination against Women of 1979,<sup>14</sup> the Convention on the Rights of the Child of 1989,<sup>15</sup> and the United Nations Principles for Older Persons.<sup>16</sup> Some treaties address the rights of individuals with HIV/AIDS and disabilities specifically.<sup>17</sup> Finally, in 1998, the UN adopted the Universal Declaration on the Human Genome and Human Rights to protect the human rights of individuals in light of new developments in the science of genetics.<sup>18</sup>

Further, there are regional human rights treaties that articulate the international human right to health. For example, under the auspices of the Organization of American States, there are two relevant treaties: the American Convention on Human Rights<sup>19</sup> and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights

<sup>12</sup> See *The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies*, Fact Sheet No. 30, U.N. HUMAN RIGHTS, OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, <http://www2.ohchr.org/english/bodies/docs/OHCHR-FactSheet30.pdf>; *International Law*, U.N. HUMAN RIGHTS, OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, <http://www2.ohchr.org/english/law/index.htm#core> (last visited Sept. 14, 2010).

<sup>13</sup> International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), U.N. GAOR, 20th Sess., Supp. No. 14, U.N. Doc. A/6014, at art. 5(e)(vi) (Dec. 21, 1965) (adopting 660 U.N.T.S. 195, 222) (entered into force Jan. 4, 1969).

<sup>14</sup> Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/36, at art. 12 (Dec. 18, 1979) (adopting 1249 U.N.T.S. 13) (entered into force Sept. 3, 1981).

<sup>15</sup> Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess. Supp. No. 49, U.N. Doc. A/44/49, at art. 24 (Nov. 20, 1989) (adopting 1577 U.N.T.S. 3) (entered into force Sept. 2, 1990).

<sup>16</sup> United Nations Principles for Older Persons, G.A. Res. 46/91, Annex, U.N. Doc. A/RES/46/91 (Dec. 16, 1991); ESCOR, *supra* note 6.

<sup>17</sup> Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, Annex, U.N. Doc. A/RES/S-26/2 (June 27, 2001); Standard Rules on the Equalization of Opportunities for Persons with Disabilities, G.A. Res. 48/96, U.N. Doc. A/48/49, at 208 (Dec. 20, 1993); Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. Res. 46/119, Annex, U.N. Doc. A/46/49 (Dec. 17, 1991); Declaration on the Rights of Disabled Persons, G.A. Dec. 3447 (XXX), U.N. Doc. A/10034 (Dec. 9, 1975); Declaration on the Rights of Mentally Retarded Persons, G.A. Dec. 2856 (XXVI), U.N. Doc. A/8429 (Dec. 20, 1971).

<sup>18</sup> The Human Genome and Human Rights, G.A. Res. 53/152, U.N. Doc. A/RES/53/152 (Mar. 10, 1999) (endorsing United Nations Educational, Scientific, and Cultural Organization Records of the General Conference, Oct. 21–Nov. 12, 1997, *Universal Declaration on the Human Genome and Human Rights*, 41, 29 C/Resolution 31 (Nov. 11, 1997)).

<sup>19</sup> American Convention on Human Rights, Nov. 22, 1969, 1144 U.N.T.S. 123 (entered into force July 18, 1978), *reprinted in* INTER-AMERICAN YEARBOOK ON HUMAN RIGHTS 1996A, 48–102 (Organization of American States ed., 1998).

(Protocol of San Salvador).<sup>20</sup> For the European Union, there is the Convention for the Protection of Human Rights and Fundamental Freedoms.<sup>21</sup> The regional treaty for Africa is the African Charter on Human and Peoples' Rights.<sup>22</sup>

Also, the World Health Organization (WHO) has responsibilities for realizing the international human right to health. The WHO Constitution states a right to the "highest attainable standard of health" and defines health broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>23</sup> Also, WHO has a vibrant human rights program that works toward realizing the international human right to health.<sup>24</sup> WHO sees its work as the advancement of the human right to health by strengthening "the capacity of WHO and its Member States to integrate a human rights-based approach to health," advancing "the right to health in international law and international development processes," and advocating "for health-related human rights."<sup>25</sup>

#### A. *The Rights-Based Approach and its Evolution*

In the 1990s, with the end of the Cold War, the UN made a concerted effort to revive human rights discourse and make human rights advancement a more prominent approach to and the promotion of economic development and peace. Many forces moved the UN towards greater commitment to human rights during this period. The HIV/AIDS pandemic highlighted the need for greater coordination of health care services and human rights enforcement.<sup>26</sup> WHO developed an HIV/AIDS program that greatly emphasized human rights as an important strategy for addressing the problems HIV/AIDS patients have in getting the care and services they need in often hostile circumstances.<sup>27</sup> Also in

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<sup>20</sup> Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights "Protocol of San Salvador," art. 10, Nov. 17, 1988 (entered into force Nov. 16, 1999), *reprinted in* INTER-AMERICAN YEARBOOK ON HUMAN RIGHTS 1996A, 128–51 (Organization of American States ed., 1998).

<sup>21</sup> Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, E.T.S. 005.

<sup>22</sup> African Charter on Human and Peoples' Rights art. 16, June 27, 1981, 21 I.L.M. 58.

<sup>23</sup> Constitution of the World Health Organization, *opened for signature*, July 22, 1946, 62 Stat. 6279, 14 U.N.T.S. 185 (entered into force Apr. 7, 1948).

<sup>24</sup> *Human Rights*, WORLD HEALTH ORG., [http://www.who.int/topics/human\\_rights/en/](http://www.who.int/topics/human_rights/en/) (last visited Sept. 10, 2010).

<sup>25</sup> *Health and Human Rights*, WORLD HEALTH ORG., <http://www.who.int/hhr/en/index.html> (last visited Sept. 10, 2010).

<sup>26</sup> Sofia Gruskin, Edward J Mills & Daniel Tarantola, *History, Principles, and Practice of Health and Human Rights*, 370 LANCET 449, 449–50 (2007).

<sup>27</sup> See WHO, *Global Strategy for the Prevention and Control of AIDS*, Res. WHA40.26, 40th World Health Assemb. (May 15, 1987). See also Jonathan M. Martin & Daniel Tarantola, *Responding to HIV/AIDS: A Historical Perspective*, 2 HEALTH HUM. & RTS. 5, 5–8 (1998).

the late 1990s, a renewed interest in the international human right to health emerged with the fiftieth anniversary of the adoption of the UDHR.<sup>28</sup>

There were several milestones of UN reform in this direction.<sup>29</sup> Specifically, beginning with a major conference in Vienna, Austria, in 1993, the UN held global conferences on human rights around the world to emphasize linkages between human development and human rights.<sup>30</sup> Preliminarily, the 1993 Vienna Declaration and Programme of Action (Vienna Declaration) enunciated an enhanced role for human rights in the work of the UN. Specifically, the Vienna Declaration provided:

The promotion and protection of all human rights and fundamental freedoms must be considered as a priority objective of the United Nations in accordance with its purposes and principles, in particular the purpose of international cooperation. In the framework of these purposes and principles, the promotion and protection of all human rights is a legitimate concern of the international community. The organs and specialized agencies related to human rights should therefore further enhance the coordination of their activities based on the consistent and objective application of international human rights instruments.<sup>31</sup>

The Declaration also emphasized the fundamental interrelatedness of political and civil human rights and economic social and cultural human rights.<sup>32</sup> The Vienna Declaration specifically provides:

All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural sys-

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<sup>28</sup> See George J. Annas, *Human Rights and Health: The Universal Declaration of Human Rights at 50*, 339 *NEW ENG. J. MED.* 1778 (1998).

<sup>29</sup> *Human Rights in the Context of U.N. Reform*, UNITED NATIONS DEV. GRP. (Sept. 10, 2010), <http://www.undg.org/index.cfm?P=531> (information accessible through the "CLP HRBA Presentation" hyperlink at the bottom of the cited page).

<sup>30</sup> *World Conference on Human Rights*, OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, <http://www.ohchr.org/EN/ABOUTUS/Pages/ViennaWC.aspx> (last visited Oct. 10, 2010).

<sup>31</sup> *World Conference on Human Rights*, June 14–25, 1993, *Vienna Declaration and Programme of Action*, ¶ 4, U.N. Doc. A/CONF.157/23 (July 12, 1993).

<sup>32</sup> *Id.* ¶ 5.

tems, to promote and protect all human rights and fundamental freedoms.<sup>33</sup>

This recognition of the universal, indivisible, interdependent, and interrelated nature of all human rights is a fundamental precept of the human rights-based approach. In addition, the Vienna conference recommended the establishment of a High Commissioner for Human Rights for the promotion and protection of all human rights.<sup>34</sup>

<b>Figure 2</b> <b>UN MILLENNIUM DEVELOPMENT GOALS</b>
<ul style="list-style-type: none"> <li>▪ Goal 1: Eradicate extreme poverty and hunger</li> <li>▪ Goal 2: Achieve universal primary education</li> <li>▪ Goal 3: Promote gender equality and empower women</li> <li>▪ Goal 4: Reduce Child Mortality Rate</li> <li>▪ Goal 5: Improve maternal health</li> <li>▪ Goal 6: Combat HIV/AIDS, malaria, and other diseases</li> <li>▪ Goal 7: Ensure environmental sustainability</li> <li>▪ Goal 8: Develop a global partnership for development</li> </ul>

In 1997, UN Secretary-General Kofi Annan announced the UN Reform Agenda.<sup>35</sup> One major reform was the creation of the UN Development Group, which unites the thirty-two UN funds, programs, agencies, departments, and offices “to deliver more coherent, effective and efficient support to countries seeking to attain internationally agreed development goals, including the Millennium Development Goals.”<sup>36</sup> Another major reform of Annan’s agenda was an emphasis on human rights and a rights-based approach to UN development and other activities. Annan’s report called on the UN to “mainstream” human rights in all activities of the UN.<sup>37</sup>

The next major UN step in the realization of the international human right to health was the development of the Millennium Development Goals. At the 2000 Millennium Development Summit, 189 UN member states established

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* ¶ 18.

<sup>35</sup> U.N. Secretary-General, *Renewing the United Nations: A Programme for Reform, Rep. of the Secretary-General*, U.N. Doc. A/51/950 (July 14, 1997).

<sup>36</sup> *Fact Sheet: United Nations Development Group*, UNITED NATIONS DEV. GRP., [http://www.undg.org/docs/10350/UNDGFactSheet\\_August2009.pdf](http://www.undg.org/docs/10350/UNDGFactSheet_August2009.pdf) (last visited Sept. 10, 2010).

<sup>37</sup> See U.N. Secretary-General, *supra* note 35, at 8; *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies*, [http://www.hreoc.gov.au/social\\_justice/conference/engaging\\_communities/un\\_common\\_understanding\\_rba.pdf](http://www.hreoc.gov.au/social_justice/conference/engaging_communities/un_common_understanding_rba.pdf) (last visited Sept. 10, 2010).



eight Millennium Development Goals to improve life for the world's poorest people by 2015.<sup>38</sup> These goals were presented in the Millennium Declaration.<sup>39</sup> These goals are also presented in Figure 2. In 2005, the independent advisory body, chaired by Professor Jeffrey Sachs of Columbia University, presented its final recommendations to the Secretary-General.<sup>40</sup> At the 2005 Millennium Summit, the Secretary-General reaffirmed the UN's commitment to a human rights approach to fulfill the Millennium Declaration.<sup>41</sup>

In July 2005, the UN Secretary-General established an initiative for a better understanding of the role of business in the realization of human rights and appointed Professor John G. Ruggie of Harvard University to be Special Representative of the UN Secretary-General on Business and Human Rights.<sup>42</sup> The mandate for this office includes "identifying and clarifying standards of corporate responsibility and accountability with regard to human rights."<sup>43</sup> The mandate also required the submission of reports on the work of the Special Representative.<sup>44</sup>

The transition to a human rights-based approach to UN development and other activities represents an important shift in the paradigm of the conception of service to the people of the world. Rather than the paradigm of charity, which has predominated in the past, this paradigm is one of entitlement. This paradigm shift and its importance are aptly described by the Danish Institute for Human Rights:

Rights-based development starts from the ethical position that all people are entitled to a certain standard in terms of material and spiritual wellbeing. It takes the side of people who suffer injustice by acknowledging their equal worth and dignity; it removes the charity dimension of development by emphasising

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<sup>38</sup> *Millenium Development Goals*, THE WORLD BANK, <http://go.worldbank.org/JQ9Z4PTBY0> (last visited Sept. 11, 2010).

<sup>39</sup> United Nations Millennium Declaration, G.A. Res. 55/2, ¶¶ 11–23, U.N. Doc. A/Res/55/2 (Sept. 18, 2000).

<sup>40</sup> See U.N. MILLENNIUM PROJECT, REPORT TO THE U.N. SECRETARY GENERAL, INVESTING IN DEVELOPMENT: A PRACTICAL PLAN TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS 2 (2005) available at <http://www.unmillenniumproject.org/documents/MainReportComplete-lowres.pdf>.

<sup>41</sup> Millennium Summit Outcome, G.A. Res 60/1, U.N. Doc. A/Res./60/1 (Oct. 24, 2005).

<sup>42</sup> Press Release, Sec.-Gen., Secretary-General Appoints John Ruggie of United States Special Representative on Issue of Human Rights, Transnational Corporations, Other Business Enterprises, U.N. Press Release SG/A/924 (July 29, 2005), available at <http://un.org/News/Press/docs/2005/sga934.doc.htm>.

<sup>43</sup> *Id.*

<sup>44</sup> *Id.* See Special Representative of the UN Sec.-Gen. on Bus. and Human Rights, *Mapping International Standards of Responsibility and Accountability for Corporate Acts*, Human Rights Council, U.N. Doc. A/HRC/4/035 (Feb. 9, 2007); Special Representative of the UN Sec.-Gen. on Bus. and Human Rights, *Promotion and Protection of Human Rights*, Comm. on Human Rights, U.N. Doc. E/CN.4/2006/97 (Feb. 22, 2006).

rights and responsibilities. It recognises poor people not as beneficiaries, but as active rightsholders and establishes corresponding duties for states and other actors against whom claims can be held. The concept of rights-holders and duty-bearers introduces an important element of accountability into development work and moves the focus where it should be: development by people—not for people.<sup>45</sup>

### B. *International Economic and Free Trade System*

Given that the manufacture, sale, and delivery of health care services and products are primarily economic activities, it is important to understand the world economic system. This system was established under the auspices of the UN after World War II to address world economic issues. The trade system does not now, but could, play an important role in the efforts to realize the international human right to health.

In 1944, forty-four countries signed the Bretton Woods Agreement, which was intended to prevent the formation of national trade barriers and thereby avoid economic depression, which was a key factor in the cause of World War II.<sup>46</sup> The Bretton Woods Agreement set up rules and institutions to regulate the international political economy, including the International Monetary Fund (IMF) and the International Bank for Reconstruction and Development, which was later divided into the World Bank and Bank for International Settlements.<sup>47</sup>

In 1947, twenty-three countries agreed to the General Agreement on Tariffs and Trade (GATT) to promote free trade in the world.<sup>48</sup> Initially, GATT addressed trade in goods; however, since the Uruguay Round in 1994, it also addresses trade in services, capital, and intellectual property.<sup>49</sup> The structure

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<sup>45</sup> JAKOB KIRKEMANN BOESEN & TOMAS MARTIN, *APPLYING A RIGHTS-BASED APPROACH: AN INSPIRATIONAL GUIDE FOR CIVIL SOCIETY*, 4 (2007), available at <http://www.humanrights.dk/files/pdf/Publikationer/applying%20a%20rights%20based%20approach.pdf>.

<sup>46</sup> See Articles of Agreement of the International Bank for Reconstruction and Development art. 1, Dec. 27, 1945, 60 Stat. 1440, 2 U.N.T.S. 134; Articles of Agreement of the International Monetary Fund art. 1, Dec. 27, 1945, 60 Stat. 1401, 2 U.N.T.S. 40; Terry Cone, *General Agreement on Trade in Services*, 23 INT'L BUS. L. 529, 529 (1995) (noting that GATS came out of the Uruguay Round of trade negotiations); WTO, *WORLD TRADE REPORT 2007, SIX DECADES OF MULTILATERAL TRADE COOPERATION: WHAT HAVE WE LEARNED?* 179–80 (2007), available at [http://www.wto.org/English/res\\_e/booksp\\_e/anrep\\_e/world\\_trade\\_report07\\_e.pdf](http://www.wto.org/English/res_e/booksp_e/anrep_e/world_trade_report07_e.pdf).

<sup>47</sup> See sources cited *supra* note 46.

<sup>48</sup> General Agreement on Tariffs and Trade art. 1, Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194.

<sup>49</sup> *Id.*

and mandate of the new World Trade Organization (WTO), founded in 1994, was also negotiated during the Uruguay Round.<sup>50</sup>

The General Agreement on Trade in Services (GATS) emerged from the Uruguay Round and went into effect in 1995.<sup>51</sup> The treaty, which covers health care, financial services, and insurance, has important implications for domestic health sectors.<sup>52</sup> National governments must take “such reasonable measures as may be available” to ensure that regional and local governments, among others, observe GATS provisions.<sup>53</sup> The major international trade agreements are presented at Figure 3.

<b>Figure 3</b> <b>RELEVANT INTERNATIONAL FREE TRADE</b> <b>AGREEMENTS</b>
<ul style="list-style-type: none"> <li>▪ World Trade Organization (WTO) (in force Jan. 1, 1995)</li> <li>▪ General Agreement on Tariffs and Trade (GATT) (1947)</li> <li>▪ General Agreement on Trade in Services (GATS) (1994)</li> </ul>

Also important are regional trade agreements establishing free trade in goods, services, capital, and even people among different countries. Two of the most important of these regional trade agreements are the treaties establishing the European Union (EU)<sup>54</sup> and the North American Free Trade Agreement (NAFTA).<sup>55</sup>

Since the 1980s, there has been much controversy over the impact of free trade on social policy intended to protect public health, the environment, and human rights.<sup>56</sup> Free trade agreements disfavor government provision of goods and services. In the 1990s, the World Trade Organization (WTO) had an affirmative policy of promoting privatization of public social welfare programs and facilitating free trade in privately held social services.<sup>57</sup> In the early years of

<sup>50</sup> Final Act Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, Apr. 15, 1994, 33 I.L.M. 1125. See *THE WTO AS AN INTERNATIONAL ORGANIZATION I* (Anne O. Krueger, ed., 1998).

<sup>51</sup> General Agreement on Trade in Services, Apr. 15, 1994, 33 I.L.M. 1167.

<sup>52</sup> General Agreement on Tariffs and Trade art. 1, Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194.

<sup>53</sup> *Id.* art. 1.3(a), at 1169.

<sup>54</sup> Consolidated Version of the Treaty Establishing the European Community art. 39, Dec. 24 2002, O.J. C 325.

<sup>55</sup> North American Free Trade Agreement, U.S.-Can.-Mex., Dec. 17, 1992, 32 I.L.M. 289.

<sup>56</sup> See, e.g., F. J. Garcia, *Global Justice and the Bretton Woods Institutions*, 10 J. INT'L ECON. L. 46 (2007); G. M. Meier, *The Bretton Woods Agreement-Twenty-Five Years After*, 23 STAN. L. REV. 235 (1971).

<sup>57</sup> Allyson M. Pollock & David Price, *Rewriting the Regulations: How the World Trade Organisation Could Accelerate Privatisation In Health-Care Systems*, 356 LANCET 1995, 1995 (2000);

the WTO, for example, many companies successfully challenged national public health measures as trade barriers.<sup>58</sup> In response to objections from national governments and nongovernmental organizations engaged in public health advocacy, the international bodies administering free trade agreements have become more sensitive to public health concerns.<sup>59</sup> Recently, the WTO and the WHO have worked together to identify important issues in trade and health that need analysis and resolution.<sup>60</sup> Nevertheless, the WHO has recognized the importance of working with private health care providers and insurers to achieve health reform and public health advances in developing countries.<sup>61</sup>

Free trade agreements are predicated on the assumption that the free market in goods and services is preferable to any other method for the distribution of goods and services. However, this assumption has proven problematic in efforts to promote the realization of human rights, which are economic and social in nature. Private competitive markets for health care, in particular, have proven unable to provide affordable and high quality health care for all people. Throughout the world, governments have assumed part of the burden of providing or financing health care services for their populations.

### III. FOR-PROFIT HEALTH CARE AND THE INTERNATIONAL HUMAN RIGHT TO HEALTH

Also throughout the world, private, for-profit enterprises are engaged in the development, manufacture, and delivery of health care goods and services. Yet little attention has been given to the role of for-profit enterprise in the realization of the human right to health. Declarations and treaties of the UN and other international and regional bodies recognize an international human right to health that governments of bound nations are required to respect, protect, and fulfill.<sup>62</sup> These treaties clearly assume that the financing and delivery of health care is an appropriate function of government. However, these treaties do not specifically address the obligations and/or roles of private actors, including for-profit enterprise, in the realization of the international human right to health.

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David Price, Allyson M. Pollock & Jean Should, *How the World Trade Organisation is Shaping Domestic Policies in Health Care*, 354 LANCET 1889, 1890 (1999).

<sup>58</sup> Ellen R. Shaffer, Howard Waitzkin, Joseph Brenner & Rebeca Jasso-Aguilar, *Global Trade & Public Health*, 95 AM. J. PUB. HEALTH 23, 24 (2005); Ellen R. Shaffer & Joseph E. Brenner, *International Trade Agreements: Hazards to Health?* 34 J. HEALTH SERV. 467, 473 (2004).

<sup>59</sup> See WHO & WTO, WTO AGREEMENTS AND PUBLIC HEALTH 1 (2002), available at [http://www.wto.org/english/res\\_e/booksp\\_e/who\\_wto\\_e.pdf](http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf); C. M. Correa, *Implementing National Public Health Policies in the Framework of WTO Agreements*, 34 J. WORLD TRADE 89, 90 (2002).

<sup>60</sup> See WHO & WTO, *supra* note 59.

<sup>61</sup> WHO, *Working with the Non-State Sector to Achieve Public Health Goals: Consultation on Priorities and Actions* 1 (Feb. 20–21, 2006), available at <http://www.who.int/management/background.pdf>.

<sup>62</sup> ESCOR, *supra* note 6.

The major players in the health care sectors of most countries of the world—health care providers, health insurers, and manufacturers and suppliers of medical products—are private enterprises in business whose goals are to maximize revenue and/or profit. Physicians, hospitals, and other providers—even if operating under a not-for-profit type of corporate control—seek to maximize profits and/or revenues as they provide health care service for people in need. Throughout the developed world and increasingly in the developing world, for-profit health insurers and HMOs finance and/or deliver health care services to mostly non-elderly and non-disabled people.<sup>63</sup> Health care pharmaceuticals, medical device manufacturers, and suppliers all operate as for-profit corporations and make considerable profits as major global corporations.<sup>64</sup> In sum, for-profit enterprise is an important component of the global health care sector. It must be incorporated into the health care effort to realize the international human right to health.

There is no question that providers, insurers, manufacturers, and suppliers have, through the conduct of their business, contributed greatly to meeting the health care needs of the people of the world. However, for-profit health care enterprises have garnered profits in ways that have not necessarily been helpful in the realization of the international human right to health in terms of promoting access to affordable health coverage for all people. In this respect, for-profit enterprise has worked at cross-purposes with the realization of the international human right to health.

Perhaps the most remarkable indicator of this failure is that collectively, health care providers and insurers have not been able to provide a full range of health care services to all people, nor have health insurers been able to provide affordable health care services or insurance for all people. In most developed countries of the world, governments have assumed a role of either providing or insuring health care services—at least to the most vulnerable populations in the country.<sup>65</sup> Even in poorer developing countries, governments have programs to provide health care services.<sup>66</sup> According to the WHO, expenditures for social

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<sup>63</sup> See ALEXANDER S. PREKER, PETER ZWEIFEL & ONNO P. SCHELLEKENS, GLOBAL MARKETPLACE FOR PRIVATE HEALTH INSURANCE: STRENGTH IN NUMBERS 42, 82, 175, 197, 277, 280 (2010).

<sup>64</sup> See Aaron K. Chatterji, *Spawned with a Silver Spoon? Entrepreneurial Performance and Innovation in the Medical Device Industry*, 30 STRATEGIC MGMT. J. 185, 189 (2008); F.M. Scherer, *The Pharmaceutical Industry—Prices and Progress*, 351 N. ENGL. J. MED. 927, 927 (2004).

<sup>65</sup> See *OECD Health Data 2010—Frequently Requested Data*, OECD (June 2010), [http://www.oecd.org/document/16/0,3343,en\\_2649\\_34631\\_2085200\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html) (information accessible through hyperlink “Download this Excel file”); David M. Cutler, *Health Care and the Public Sector*, in HANDBOOK OF PUB. ECON. 2143, 2146 (Alan J. Auerbach & Martin Feldsteins., 2002).

<sup>66</sup> See Andrew Cassels, *Health Sector Reform: Key Issues in Less Developed Countries*, 7 J. OF INT’L DEV. 329 (1995).

insurance constituted 25% of world health care expenditures of \$5.3 trillion.<sup>67</sup> In addition to social insurance, governments paid another 35% of global health care expenditures.<sup>68</sup>

Increasingly, developing countries have been privatizing public health insurance plans and turning their management over to private corporations in the financial business. The private stewards of the privatized plans have charged fees and taken risks to the detriment of the funds.<sup>69</sup> This financialization of public health insurance programs in developing countries has been detrimental to the stability of public programs and their mission of promoting access to health care.<sup>70</sup>

Nevertheless, private health insurance plays an important role in assuring access to health care services for younger and more affluent individuals. In both developed<sup>71</sup> and developing countries,<sup>72</sup> private health insurance is prevalent and an important source of health care financing. In 2007, the WHO reported that private health insurance constituted 18% of global health expenditures, compared to 25% for social health insurance.<sup>73</sup>

As discussed, nearly all countries of the world support the provision of health care services and insurance through government subsidies for public programs and/or tax expenditures that support corporate sponsorship of employee health insurance.<sup>74</sup> Further, the funds from donor nations to poor and middle income countries, particularly in Sub-Saharan Africa and South Asia, are substantial and have more than tripled between 2001 and 2008, rising from \$7.6

<sup>67</sup> *Composition of World Health Expenditures*, WHO, [http://www.who.int/nha/use/pie\\_2007-full.pdf](http://www.who.int/nha/use/pie_2007-full.pdf) (last visited Sept. 22, 2010).

<sup>68</sup> *Id.*

<sup>69</sup> See Sheena Sumaria, *Social Insecurity: The Financialisation of Healthcare and Pensions in Developing Countries*, BRETTON WOODS PROJECT, 11–12 (July 2010), available at <http://www.brettonwoodsproject.org/doc/private/socialinsecurity.pdf>; Maureen Mackintosh & Meri Koivusalo, COMMERCIALIZATION OF HEALTH CARE: GLOBAL AND LOCAL DYNAMICS AND POLICY RESPONSES 3–21(2005).

<sup>70</sup> Sumaria, *supra* note 69.

<sup>71</sup> ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT (OECD), THE OECD HEALTH PROJECT: PRIVATE HEALTH INSURANCE IN OECD COUNTRIES 11 (2004); Francesca Colombo & Nicole Tapay, *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems* (OECD, Working Paper No. 15, 2004), available at <http://www.oecd.org/dataoecd/34/56/33698043.pdf>.

<sup>72</sup> Denis Dreschler & Johannes Jutting, *Scope, Limitations, and Policy Responses*, in PRIVATE VOLUNTARY HEALTH INSURANCE IN DEVELOPMENT: FRIEND OR FOE? 181, 205 (A. S. Preker, R. M. Scheffler & M. C. Bassett eds., 2007); *but see* Mark V. Pauly, Peter Zweifel, Richard M. Scheffler, Alexander S. Preker & Mark Bassett, *Private Health Insurance in Developing Countries: Voluntary Private Insurance Could Fill in the Gaps that Limited Public Resources Cannot Cover*, 25 HEALTH AFF. 369 (2006).

<sup>73</sup> *Composition of World Health Expenditures*, *supra* note 67.

<sup>74</sup> VITO TANZI AND LUDGER SCHUKNECHT, PUBLIC SPENDING IN THE 20TH CENTURY: A GLOBAL PERSPECTIVE 35–38 (2000).

billion to \$26.4 billion, an increase of 248.7%.<sup>75</sup> From a human rights perspective, the necessity of these public subsidies in a sector in which private actors can be profitable in addressing the needs of some, but not all, is problematic.

Private health insurance also influences physician practices and access to health care for the poor. Physicians and other health professionals raise challenges to the realization of the human right to health as their fees and charges are higher in order to gain more payment from private health insurance programs thus posing barriers to access to care for lower income people and those with no or inadequate health insurance.<sup>76</sup> In many countries, physicians will not participate in public programs because they pay too little and often require physicians to work in poor working conditions.<sup>77</sup> Further, physicians and other health professionals can and do move across borders for professional opportunities that are more generous than domestic public programs.<sup>78</sup> Also, free trade agreements often have specific provisions that facilitate the movement of physicians and other medical professionals across borders to the detriment of poorer countries.<sup>79</sup>

In addition, the growing phenomenon of medical tourism poses challenges to the realization of human rights. Treating medical tourists can be quite lucrative for hospitals, physicians, and other providers in developing countries as medical tourists are likely to have health insurance or funds to pay for health care.<sup>80</sup> In developing countries, hospitals and medical practices that cater to

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<sup>75</sup> JEN KATES, ADAM WEXLER, ERIC LIEF & VIDAL SEGOBIN, U.S. GLOBAL HEALTH POLICY: DONOR FUNDING FOR HEALTH IN LOW- & MIDDLE-INCOME COUNTRIES, 2001–2008, 1 (The Henry J. Kaiser Family Foundation) (2010), available at <http://www.kff.org/globalhealth/upload/7679-04.pdf>.

<sup>76</sup> See generally Steven Simoens & Jeremy Hurst, *The Supply of Physician Services in OECD Countries* (OECD, Working Paper No. 21, 2006), available at <http://www.oecd.org/dataoecd/27/22/35987490.pdf>.

<sup>77</sup> *Id.*

<sup>78</sup> See generally OECD & WHO, *International Migration of Health Workers: Improving International Cooperation to Address the Global Health Workforce Crisis*, OECD (Feb. 2010), available at <http://www.oecd.org/dataoecd/8/1/44783473.pdf>; Amy Hagopian, *Recruiting Primary Care Physicians From Abroad: Is Poaching From Low-Income Countries Morally Defensible?*, 5 ANNALS FAM. MED. 483, 484–85; Fitzhugh Mullan, *The Metrics of the Physician Brain Drain*, 353 NEW ENG. J. OF MED. 1810 (2005).

<sup>79</sup> U.S. Dept. of Health and Hum. Serv., *National Center for Health Workforce Analysis > Globalization and the Physician Workforce in the United States*, BHPR (April 25, 2002), <http://bhpr.hrsa.gov/healthworkforce/reports/gpw.htm>; Mélanie Bourassa Forcier, Steven Simoens & Antonio Giuffrida, *Impact, Regulation and Health Policy Implications of Physician Migration in OECD Countries*, HUMAN RES. FOR HEALTH (July 16, 2004), <http://www.human-resources-health.com/content/2/1/12>.

<sup>80</sup> Annette B. Ramirez de Arellano, *Patients Without Borders: The Emergence of Medical Tourism*, 37(1) INT'L J. HEALTH SERV. 193, 193 (2007); Percivil M. Carrera & John F. Bridges, *Globalization and Healthcare: Understanding Health and Medical Tourism*, 6 EXPERT REV. PHARMACOECONOMICS & OUTCOMES RES. 447, 447 (2006).

medical tourists are deflected from participating in local health care delivery settings and public programs, particularly those that serve the poor.<sup>81</sup>

With regard to for-profit health insurers, there are several challenges. The most important issue is the degree to which for-profit insurers affect government sponsored health care services and health insurance programs. Government programs cannot be successful if a significant proportion of the affluent are able to opt-out of public programs and seek private coverage. When the affluent have more generous private coverage, physicians and other providers are more attracted to serving them because payments are likely to be more generous and working conditions better than with public programs.<sup>82</sup>

Further, international trade policy has also worked at cross purposes with the realization of the international human right to health. In free trade agreements, some health care providers and insurers have sought to make inroads into markets for health care goods and services at the expense of government programs using free trade agreements. For example, currently there is a suit from a for-profit American health care provider challenging the entire Canadian health insurance program as a trade barrier under the NAFTA.<sup>83</sup> This action by a health care provider is indicative of the potential damage to public programs that can be accomplished by pressing free trade agreements. In recent years, policy makers and scholars have begun to explore some of the issues related to for-profit enterprise, free trade, public health services, and insurance programs.<sup>84</sup>

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<sup>81</sup> Prashant K. Nanda, *Medical Tourism is Waste of Resources if Poor Not Treated: Health Secretary*, THAI INDIAN NEWS (March 30, 2008), [http://www.thaindian.com/newsportal/world-news/medical-tourism-is-waste-of-resources-if-poor-not-treated-health-secretary\\_10032693.html](http://www.thaindian.com/newsportal/world-news/medical-tourism-is-waste-of-resources-if-poor-not-treated-health-secretary_10032693.html) (last visited Aug. 20, 2010); Ramirez de Arellano, *supra* note 80, at 197.

<sup>82</sup> Simoens & Hurst, *supra* note 76.

<sup>83</sup> Revised Amended Statement of Claim at 4, *Mervin J. Howard, Centurion Health Corp. & Howard Family Trust v. Gov't. of Can.*, (filed Feb. 2, 2009), available at <http://www.international.gc.ca/trade-agreements-accords-commerciaux/assets/pdfs/CenturionvCanadaRevised.pdf>, dismissed by *Mervin J. Howard, Centurion Health Corp. & Howard Family Trust v. Gov't. of Can.*, [2010] PCA Case No. 2009-21 (Can.), [http://www.international.gc.ca/trade-agreements-accords-commerciaux/assets/pdfs/order\\_award\\_aug2010.pdf](http://www.international.gc.ca/trade-agreements-accords-commerciaux/assets/pdfs/order_award_aug2010.pdf). See *Suit Seeks to Open Canadian Health Care to Privatizers*, WINNIPEG FREE PRESS, Sept. 24, 2008, at A13, available at <http://www.winnipegfreepress.com/historic/33080179.html>; *Melvin J. Howard's Determination vs. Canada's Ambivalence*, WELLSPHERE, (Nov. 6, 2008), <http://www.wellsphere.com/healthcare-industry-policy-article/melvin-j-howard-s-determination-vs-canada-s-ambivalence/470246>.

<sup>84</sup> CHANTAL BLOUIN, NICK DRAGER & RICHARD SMITH, *INTERNATIONAL TRADE IN HEALTH SERVICES AND THE GATS: CURRENT ISSUES AND DEBATES* (2010); UNITED NATIONS UNIVERSITY, *DEVELOPING COUNTRIES AND THE WTO: POLICY APPROACHES* (2008); Kelly Lee, Devi Sridhar & Mayur Patel, *Bridging the Divide: Global Governance of Trade and Health*, 373 LANCET 416 (2009); Allyson M. Pollock & David M. Price, *The Public Health Implications of World Trade Negotiations on The General Agreement on Trade in Services and Public Services*, 362 LANCET 1072 (2003); Elisa R. Shaffer, Howard Waitzkin, Joseph Brenner & Rebecca Jasso-Aguilar, *Global Trade and Public Health*, 95 AM. J. PUB. HEALTH 23, 23–24 (2005); Richard D. Smith, Kelly Lee & Nick Drager, *Trade and Health: An Agenda for Action*, 373 LANCET 768 (2009);



The issues with the pharmaceutical and medical device industries are legion. There has been much controversy over the patent protection of essential medicines for HIV/AIDS and other conditions afflicting the poor in developing countries.<sup>85</sup> The protection of intellectual property interests of multi-national corporations for pharmaceutical products has become quite controversial and intellectual property protections make the cost of needed pharmaceutical products expensive for low and middle income countries.<sup>86</sup> Specifically, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS),<sup>87</sup> negotiated as part of the treaty establishing the WTO, has established protections for intellectual property rights as a cornerstone of international trade policy.<sup>88</sup> In 2001, the WTO issued the Declaration on the TRIPS Agreement and Public Health of 2001, known as the Doha Declaration, articulating the flexibility available to states under TRIPS to protect public health.<sup>89</sup>

As indicated above, the crucial issue from a human rights perspective is the degree to which profits should be realized especially when for-profit enterprises contribute little added value and operate in ways that threaten access to health care products and services for many. Such profit-taking should not be allowed or, in the alternative, should be allowed only if the for-profit enterprise takes other steps to mitigate the consequences of its deleterious profit-taking. Such strategies include taxing profits and using proceeds to address gaps in access to care. Another strategy is regulation in ways that prohibit or mitigate undesirable practices. For example, under the recently enacted health reform legislation in the United States, the Patient Protection and Affordable Care Act (PPACA),<sup>90</sup> insurers will be forbidden to use or invoke pre-existing exclusion clauses in health insurance contracts<sup>91</sup> and are limited in the exercise of contract

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Richard D. Smith, Rupa Chanda & Viroj Tangcharoensathien, *Trade in Health-Related Services*, 373 LANCET 593 (2009).

<sup>85</sup> John H. Barton, *TRIPS and the Global Pharmaceutical Market*, 23 HEALTH AFF. 146, 146 (2004); Bernard Pécoul, Pierre Chirac, Patrice Trouiller & Jacques Pinel, *Access to Essential Drugs in Poor Countries: A Lost Battle?*, 281 J. AM. MED. ASS'N, 361, 364–65 (1999).

<sup>86</sup> JOHN R. THOMAS, CONGRESSIONAL RESEARCH SERVICE, RL 31066, HIV/AIDS DRUGS, PATENTS AND THE TRIPS AGREEMENT: ISSUES AND OPTIONS 13–15 (2001); Sean Flynn, Aidan Hollis, & Mike Palmedo, *An Economic Justification for Open Access to Essential Medicine Patents in Developing Countries*, 37 J.L. MED. & ETHICS 184, 185 (2009); F. M. Scherer & Jayashree Watal, *Post-TRIPS Options for Access to Patented Medicines in Developing Nations*, 5 J. INT'L ECON. L. 913, 913 (2002).

<sup>87</sup> Agreement on Trade-Related Aspects of Intellectual Property Rights, Dec. 15, 1993, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 33 I.L.M. 81.

<sup>88</sup> *Id.*

<sup>89</sup> WTO, Ministerial Declaration of 14 November 2001, WT/MIN(01)/DEC/2, 41 I.L.M. 775 (2002).

<sup>90</sup> Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-48, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

<sup>91</sup> PPACA § 2704.

rescission after an insured person is sick.<sup>92</sup> Also, the PPACA prohibits not-for-profit hospitals from engaging in aggressive pricing and collection practices with respect to the low income and uninsured.<sup>93</sup>

Another important strategy is to engage the for-profit enterprises in the health care sector in the affirmative protection, promotion, and fulfillment of the international human right to health. As discussed in Part II.B of this article, the UN has launched an initiative to involve business as a general matter in realization of human rights.<sup>94</sup> The WHO and other human rights authorities should apply the mandate of this initiative (“identifying and clarifying standards of corporate responsibility and accountability with regard to human rights”)<sup>95</sup> to the for-profit enterprises of the health care sector. Already, the example of the pharmaceutical industry and its voluntary provision of essential medicines indicates that the for-profit sector can be responsive to such efforts.<sup>96</sup> Clearly, an appropriate strategy is to solicit the cooperation of for-profit enterprises in maximizing the good contributions and eliminating and/or minimizing the practices that impede the realization of the international human right to health. As part of this effort, there must be a greater appreciation of the impact of trade policy on the realization of the right to health.

In closing, this article offers several principles that might assist private, for-profit enterprises in this effort.<sup>97</sup> These principles pertain to the conduct of the insurance industry in a context of market failure, the consequences of health professional migration in the disparately developed world, and access to essential medicines and medical products for all people in need throughout the world.

### **Principle I**

If a nation-state or a state or province of a nation-state establishes a publically funded and administered health coverage plan for any or all residents of the relevant geographic jurisdiction in a democratic process, then trade agreements should protect the right of the political authority operate and expand the health coverage plan.

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<sup>92</sup> *Id.* § 2712.

<sup>93</sup> *Id.* § 9007, amending IRC § 501(c)(3) (2006).

<sup>94</sup> See Press Release, *supra* note 42.

<sup>95</sup> *Id.*

<sup>96</sup> See Sarah Joseph, *Pharmaceutical Corporations and Access to Drugs: The Fourth Wave of Corporate Human Rights Scrutiny*, 25 HUM. RTS. Q. 425, 436 (2003); *The Index 2010*, ACCESS TO MEDICINE INDEX, <http://www.accessstomedicineindex.org/content/index-2010-0> (last visited Oct. 10, 2010).

<sup>97</sup> The author has proposed earlier versions of these principles in Eleanor D. Kinney, *Realization of the of the International Human Right to Health in an Economically Integrated North America*, 37 J.L. MED. & ETHICS 807, 814 (2009), and Eleanor D. Kinney, *Health Care Financing and Delivery in the U.S., Mexico and Canada: Finding and Establishing Intentional Principles for Sound Integration*, 26 WIS. INT’L L.J. 935, 962–63 (2009).

**Principle 2**

If a private health care provider or payer seeks the protection of a free trade agreement to engage in business within another state party, the host nation has the right to ascertain whether any profit or excess revenues over expenses will be earned from public programs and take measures such as taxation to the degree necessary to protect public programs.

**Principle 3**

To facilitate the protection of individuals as they travel and move to other parties to a free trade agreement, universal access to affordable and portable health coverage should be a domestic policy goal and promoted as a condition of participation in international treaties for economic integration.

**Principle 4**

While respecting the right of physicians and other health professionals to pursue economic and other opportunities in other countries, those countries that are the beneficiaries of such immigration should appropriately subsidize educational institutions in the home countries of the immigrant health professionals and take other strategies to address the shortage of health professionals in the home countries.

**Principle 5**

While respecting the need for pharmaceutical and medical device manufacturers and suppliers to make a reasonable return in their business, these manufacturers and supplies should work with developing countries in meeting the demand for essential medicine and work for implementation of the WTO Declaration on TRIPS and Public Health.

#### IV. CONCLUSION

Current human rights theory focuses predominantly on the government as a provider or guarantor of health care services or the financing of the same. In human rights work, there has been less focus on the role of private, for-profit entities in the provision and insurance of health care goods and services. Clearly, the provision and insurance of health care in the world today can only be accomplished through the cooperative work of both public and private actors. The key for success is figuring out a set of rules, based on a human rights approach, which will create an environment in which both public and private actors can succeed in bringing accessible and high quality health care goods and services to all people in the world.