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Introduction

Human rights standards have been employed as a leading force for global justice. In confronting the insalubrious ramifications of globalization, human rights scholars and activists have argued for greater national and international responsibility pursuant to the human right to health.[1] Codified seminally in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to health proclaims that states bear an obligation to realize the "highest attainable standard" of health for all. [2] However, in pressing for the highest attainable standard for each individual, the right to health has been ineffective in compelling states to address burgeoning inequalities in underlying determinants of health, focusing on individual medical treatments at the expense of public health.[3] As a result, this limited right to health has hampered efforts to operationalize the right to health through public health systems and to respond to the societal harms resulting from economic globalization.[4]

Globalization has had fundamental implications for individual and public health. Implementation of neoliberal economic policies has resulted in the exacerbation of endemic diseases and the rapid proliferation of infectious and chronic diseases.[5] As a consequence of the monetary and regulatory changes engendered by these processes, globalization has transformed health and disease, diminishing individual control over health status while magnifying the impacts of societal determinants of

1. *E.g.*, Audrey Chapman, *Core Obligations Related to the Right to Health*, *in* CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL, AND CULTURAL RIGHTS 185, 185 (Audrey Chapman & Sage Russell eds., 2002); BRIGIT C.A. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW 284 (1999); HENRIK KARL NIELSEN, THE WORLD HEALTH ORGANISATION: IMPLEMENTING THE RIGHT TO HEALTH 63 (1999); Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 MD. L. REV. 20, 101 (2004); Aart Hendriks, *The Right to Health in National and International Jurisprudence*, 5 EUR. J. HEALTH L. 389, 394 (1998); Eleanor D. Kinney, Lecture, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1464 (2001); Allyn L. Taylor, *Governing the Globalization of Public Health*, 32 J.L. MED. & ETHICS 500, 505 (2004); Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT'L L.J. 325, 336 (2003); U.N. Econ. & Soc. Council [ECOSOC], Comm. on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur*, ¶ 51, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003) (*prepared by* Paul Hunt), *available at* http://www.unhchr.ch/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2003.58.En?Opendocument (follow "PDF" hyperlink) [hereinafter *Report of the Special Rapporteur* (Feb. 13, 2003)].

2. International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, art. 12.1, 993 U.N.T.S. 3, 8 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

3. *Infra* Part II.A-B.

4. *Infra* Part II.C.

5. *Infra* Part I.

health.[6] With the worsening of underlying societal determinants of health and the weakening of the public health systems necessary to meet these health challenges, broad changes in the global economy have left states without the public health infrastructures necessary to prevent disease and promote health.[7] As a result of these changes, disparities in health have widened both within and among nations.

While human rights have the capacity to bolster state public health responses, current human rights discourse has been largely incapable of speaking to these changing global conditions and responding to damaging underlying determinants of health.[8] With the right to health set out as an individual positive right, anachronistic notions of curative health continue to pervade human rights discourses, stymieing the development of state responses to public health dilemmas.[9] This Article contends that the paradigm of individual health, focused on a right to individual medical care, is no longer applicable to a globalizing world, compelling a renewed focus on the societal factors that facilitate the spread of disease and promote poor health. Examining and addressing these health determinants fall not within the purview of medicine but within public health systems.

Controlling these diseases of globalization will require a set of rights commensurate to combating the insalubrious effects of neoliberal economic policies. Through an emphasis on underlying societal determinants of health, it becomes clear that the human right sought to be protected is a collective right. Rather than relying solely upon an individual right to medical care, envisioning a collective right to public health—employing the language of human rights at the societal level—would alleviate many of the injurious health inequities of globalization. Thus, in securing health in the context of globalization, health policies must encompass topics ranging from economic development and gender equality to agricultural sustainability and cultural practice, employing a collective right to public health to give meaning to health rights.

In an earlier attempt to analyze the nature and discursive value of a right to public health,[10] no precise legal framework for such a right was created. What this analysis did was to clarify what a right to public health is not: the individual right to health, a right inapplicable to societally-driven harms. As a result of this circuitous definition, others have justly criticized the idea of a right to public health as being so broad as to be unworkable. The purpose of this Article is to circumscribe this right in human rights jurisprudence and to detail the programmatic state public health actions necessary for its realization.

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6. *Infra* Part II.C.

7. *Infra* Part I.B, D, E.

8. *Infra* Part II.

9. *Infra* Part II.A-B.

10. Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101 (2005).

The present analysis proceeds in three parts. Beginning with an acknowledgement of globalization's challenges to disease prevention and health promotion, Part I attempts to frame the difficulties in addressing public health in a globalized world. In Part II, this Article analyzes the role of public health in responding to globalization. Specifically, this Part looks to the difficulties in state fulfillment of the right to health pursuant to Article 12 of the ICESCR. While the right to health can be shown to have evolved in international discourse over time, such an evolution of an individual right to health cannot be shown to address the harmful ramifications of economic globalization. Based upon the conceptual weaknesses of the individual human right to health in responding to globalization, Part III of this study proposes the development of a collective right to public health as a means of responding to the societal effects of globalization, laying out the theoretical constructs and programmatic frameworks necessary to operationalize this right.

By examining modern changes to underlying determinants of health, this Article concludes that responding to globalized health threats requires a collective right to public health. This right is both recognized in jurisprudential discourse surrounding the individual right to health and justified through globalization as a collective human right. In creating a framework for discussing public health as an independent human right, this research finds that international legal bodies could derive measurable public health indicators for government programs and assure that these governments are held accountable for realizing the highest attainable standard of health.

I. Globalization Reframes Health Debates

While globalization is not new,[11] the present wave of globalization is unique in its rate, speed, and volume of interaction.[12] The processes of globalization,[13] referring broadly to the increasing interconnectedness

11. Julio Frenk et al., *The Globalization of Health Care*, *in* INTERNATIONAL CO-OPERATION IN HEALTH 31, 44 (Martin McKee et al. eds., 2001); Ilona Kickbusch & Kent Buse, *Global Influences and Global Responses: International Health at the Turn of the Twenty-First Century*, *in* INTERNATIONAL PUBLIC HEALTH: DISEASES, PROGRAMS, SYSTEMS, AND POLICIES 701, 706 (Michael H. Merson et al. eds., 2001) (noting that since the outbreaks of plague in the Middle Ages and the waves of indigenous deaths after Europeans colonized America, globalization has long threatened health through trade, travel, war, and migration). For analyses of and comparisons with earlier forms of economic globalization, see generally PAUL HIRST & GRAHAME THOMPSON, GLOBALIZATION IN QUESTION: THE INTERNATIONAL ECONOMY AND THE POSSIBILITIES OF GOVERNANCE (1996); PAUL KRUGMAN, THE RETURN OF DEPRESSION ECONOMICS (1999).

12. DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 14 (1999); David Dollar, *Is Globalization Good for your Health?*, 79 BULL. WORLD. HEALTH ORG. 827 (2001) (noting that the pace of globalization has accelerated with trade, foreign asset ownership, international travel, and internet usage); Lincoln C. Chen et al., *Health as a Global Public Good*, *in* GLOBAL PUBLIC GOODS: INTERNATIONAL COOPERATION IN THE 21ST CENTURY 284, 289 (Inge Kaul et al. eds., 1999) ("Globalization is not simply accelerating long-term trends but is ushering in contextual changes that are qualitatively and quantitatively different in disease risk, health vulnerability and policy response.").

13. The use of the term "globalization" as a rhetorical monolith should not be seen as a denial of the complexity of the myriad facets of globalization and the globalized

among states that began, in its most recent form, in the early 1980s, have resulted in heightened cross-border flows of goods, services, money, people, information, and culture.[14] These changes have denied states the sovereignty necessary to control and sustain their own development and health.[15]

Modern processes of globalization impact public health through myriad proximal and distal mechanisms. Although modernization has led to many improvements in health,[16] it has, through multiple, overlapping processes,[17] also served to exacerbate disparities in health between rich and poor.[18] Despite neoliberal globalization's rhetorical homage to indi-

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economic order. Although this Article begins its discussion of globalization by focusing on the core economic interconnectedness between states, this focus is intended neither to exclude, *inter alia*, the relevance of interactions of goods, individuals, technologies, or ideas, nor to preclude this Article's later consideration of globalization as a means to improve health through international legal mechanisms.

In this sense, the present Article does not seek to challenge globalization but rather to employ globalization's beneficial effects while ameliorating its harmful sequelae, existing within the stream of scholarship addressing the contentious dialectic between "globalization-from-above" (capital formation) and "globalization-from-below" (human rights). *See* Richard Falk, *Interpreting the Interaction of Global Markets and Human Rights*, *in* GLOBALIZATION AND HUMAN RIGHTS 61, 63 (Alison Brysk ed., 2002) [hereinafter Falk, *Interpreting the Interaction of Global Markets and Human Rights*] (noting that "globalization from-below activists are becoming more committed to a different, broader idea of human rights, which directly challenges globalization-from-above"); Richard Falk, *The Making of Global Citizenship*, *in* GLOBAL VISIONS: BEYOND THE NEW WORLD ORDER 39 (Jeremy Brecher et al. eds., 1993) [hereinafter Falk, *The Making of Global Citizenship*]. Within this globalization-from-below framework, this Article advances a broader conception of human rights that encompasses economic, social, and cultural rights at both an individual and collective level.

14. JAGDISH BHAGWATI, THE WIND OF THE HUNDRED DAYS: HOW WASHINGTON MISMANAGED GLOBALIZATION 138 (2000); THOMAS L. FRIEDMAN, THE LEXUS AND THE OLIVE TREE 86-87 (1999); Joseph E. Stiglitz, *Globalism's Discontents*, AM. PROSPECT, Jan. 1-14, 2002, at A16, available at http://www.prospect.org/print-friendly/print/V13/1/stiglitz-j.html.

15. *See* Stephen Gill, *Globalisation, Market Civilisation, and Disciplinary Neoliberalism*, 24 MILLENNIUM: J. INT'L STUD. 399, 406 (1995); Branko Milanovic, *The Two Faces of Globalization: Against Globalization as We Know It*, 31 WORLD DEV. 667, 668 (2003).

16. A.J. McMichael & R. Beaglehole, *The Changing Global Context of Public Health*, 356 LANCET 495, 495 (2000) (noting the beneficial effect of increased literacy, sanitation, and nutrition, among other factors, on public health); Milton Roemer & Ruth Roemer, *Global Health, National Development, and the Role of Government*, 80 AM. J. PUB. HEALTH 1188, 1189 (1990) (identifying the three major determinants of improved health in developing countries since the Second World War to be social and economic development, international and cross-national influences, and the maturation of national health systems).

17. *See* Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 81 (1995) (noting that the "focus on the connection of social conditions to single diseases via single mechanisms at single points in time neglects the multifaceted and dynamic processes through which social factors may affect health and, consequently, may result in an incomplete understanding and an underestimation of the influence of social factors on health").

18. Sarah Macfarlane et al., *Public Health in Developing Countries*, 356 LANCET 841, 841-42 (2000) ("There are widespread inequalities in health status, life expectancy, and in access to health care between rich and poor countries, between rich and poor people, and between poor men and women everywhere." (citations omitted)); Joyce V. Millen et al., *Introduction: What Is Growing? Who Is Dying?*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR 3, 6-7 (Jim Yong Kim et al. eds., 2000) ("[S]pecific

vidualism,[19] globalization, in tragic irony, has taken responsibility for health out of the control of the individual, predetermining harm at the societal level and robbing individuals of the autonomy necessary for individual health.[20] Thus, while globalization has resulted in improvements in technology and health services for some in the developed world, various globalized economic processes are correlated with widening health gaps within states and among states in the developed and developing world.[21] Through increased vulnerability to infectious and chronic disease, the deterioration of the built environment, weakening of public health infrastructures, the increasing power of transnational corporate interests, and the preeminence of trade regimes over health, individuals have lost the ability to exercise health rights, and governments, the strength to fulfill them.

A. Global Interconnectedness Highlights Shared Health Dilemmas

Global trade and travel allow infectious diseases to spread rapidly throughout the world, disregarding national and regional boundaries.[22]

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growth-oriented policies have not only failed to improve living standards and health outcomes among the poor, but also have inflicted additional suffering on disenfranchised and vulnerable populations.").

Rather than accepting aggregated data as evidence of improved health conditions in the developing world, this Article will focus on globalization's exacerbation of health disparities. In doing so, the author accepts U.N. Special Rapporteur Paul Hunt's admonition that "[f]rom the human rights perspective, the average condition of the whole population is unhelpful and can even be misleading: improvements in average health indicators may actually mask a decline for some marginal groups." *Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 51 (examining, through the prism of the right to health, poverty reduction, neglected diseases, impact assessments, relevant World Trade Organization Agreements, mental health, and the role of health professionals).

19. *See* Robert E. Mazur, *Realization or Deprivation of the Right to Development Under Globalization? Debt, Structural Adjustment, and Poverty Reduction Programs*, 60 GEOJOURNAL 61, 64 (2004) (noting globalization policy's emphasis on individualism and limited government (citing Tony Evans, *Citizenship and Human Rights in the Age of Globalization*, 25 ALTERNATIVES 415 (2000))).

20. *See* Richard Parker, *Administering the Epidemic: HIV/AIDS Policy, Models of Development, and International Health*, *in* GLOBAL HEALTH POLICY, LOCAL REALITIES: THE FALLACY OF THE LEVEL PLAYING FIELD 39, 41 (Linda M. Whiteford & Lenore Manderson eds., 2000).

> This basic understanding [of oppression and inequality as the most powerful forces shaping the HIV/AIDS epidemic . . .], has pushed us away from our early preoccupation with diverse forms of risk behavior, understood in largely individualistic terms, toward a new understanding of vulnerability as socially, politically, and economically structured, maintained, and organized.

Id.

21. *See generally* IS INEQUALITY BAD FOR OUR HEALTH? (Joshua Cohen & Joel Rogers eds., 2000). This correlation is not due solely to improvement in the developed world but also to worsening conditions in the developing world, especially among the poor and marginalized.

22. FIDLER, *supra* note 12, at 5 ("Sovereignty and borders are irrelevant to the microbial world, as microbes easily pass through the physical and jurisdictional barriers that demarcate peoples and governments."); Rim Prothero, *Problems of Human Mobility and Disease in Demography and Vector-Borne Diseases*, *in* DEMOGRAPHY AND VECTOR-BORNE DISEASES 2 (Michael W. Service ed., 1989) (noting "that the movements of people have been a factor in disease diffusion"); Allyn L. Taylor, *Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 33 HOUS.

Through the traffic of infected individuals and products, the globalization of commerce has allowed diseases to spread quickly and escape detection.[23] This has led longstanding infectious diseases such as tuberculosis and malaria, once thought to be on the brink of eradication, to spread at exponential rates, killing millions in the developing and developed world.[24] Although many of these existing infectious diseases have long been preventable and treatable with simple technologies, infectious diseases remain the top cause of morbidity and premature mortality worldwide.[25] In addition to the threat posed by existing diseases, emerging infectious diseases force states to contend with new risks often outside their research capacity and beyond treatment with existing technologies.[26]

Under this new, globalized risk of disease, divisions among regions and governments no longer guarantee protection.[27] Where once quarantines and other public health measures were thought to be effective in safeguarding a state from infectious disease,[28] infectious diseases have since reemerged in force through globalization, crippling even the most advanced national health controls.[29] As seen most recently with AIDS, SARS, BSE (mad cow disease), and avian influenza, infectious diseases can no longer be relegated to the developing world. Where nations have responded feebly to diseases, their inadequate medical responses have led to the emergence of various drug-resistant mutations.[30] Because of frequent, rapid, and unrestricted international means of transport, the transmission of

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L. REV. 1327, 1328 (1997) ("Advances in and widespread accessibility to rapid transportation and international commerce have obliterated former national reliance on the geographic isolation of microbial hazards." (footnote omitted)).

23. *See* LAURIE GARRETT, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE 69 (1994).

24. *See* THE GLOBAL BURDEN OF DISEASE: A COMPREHENSIVE ASSESSMENT OF MORTALITY AND DISABILITY FROM DISEASES, INJURIES, AND RISK FACTORS IN 1990 AND PROJECTED TO 2020 19 (Christopher L. Murray & Alan D. Lopez eds., 2000).

25. *Id.* at 15 (2000) (noting that one in three global deaths is from an infectious disease).

26. Ralph T. Bryan et al., CDC, U.S. Dep't of Health & Hum. Servs., *Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States*, 43 MORBIDITY & MORTALITY WKLY REP.: RECOMMENDATIONS & REPS., No. RR-5, at 1 (1994) (defining "emerging infectious diseases" as "diseases of infectious origin whose incidence in humans has increased within the past two decades or threatens to increase in the near future").

27. *See* ANTHONY GIDDENS, THE CONSEQUENCES OF MODERNITY 125 (1990) ("The global intensity of certain kinds of risk transcends all social and economic differentials.") (citing ULRICH BECK, RISIKOGESELLSCHAFT: AUF DEM WEG IN EINE ANDERE MODERNE 7 (1986)).

28. J.C. ALARY, FROM INTERNATIONAL QUARANTINE TO INTERNATIONAL HEALTH REGULATIONS: ROLE OF WHO 2-4 (1995). For a detailed assessment of early international quarantine controls, see CHARLES OLKE PANNENBORG, A NEW INTERNATIONAL HEALTH ORDER: AN INQUIRY INTO THE INTERNATIONAL RELATIONS OF WORLD HEALTH AND MEDICAL CARE 177-204 (1979).

29. *See, e.g.*, Ruth L. Berkelman et al., *Infectious Disease Surveillance: A Crumbling Foundation*, 264 SCIENCE 368, 369 (1994) (noting public health failures in preventing the emergence of infectious diseases in the United States).

30. Fred C. Tenover & John E. McGowan, *Reasons for the Emergence of Antibiotic Resistance*, 311 AM. J. MED. SCI. 9 (1996).

infectious disease among populations cannot be stymied at the local, or even the national, level. Through the interconnectedness of peoples brought about by globalization, "a health problem in any part of the world can rapidly become a health threat to many or all."[31]

Compounding the threat of infectious disease, chronic non-infectious diseases such as cardiovascular disease, cancer, and diabetes, once seen predominately in developed countries, are on the rise in developing countries.[32] As economic reform takes shape in these developing states, tobacco use, obesity, and other risk factors for disease increase, with the resulting mortality from chronic disease declining only once very high levels of social and economic development have been achieved—levels of development seen in only a few developing states.[33] While recognized as a major global problem,[34] few states in the developed or developing world have made any concerted effort to focus resources away from infectious disease to fight this silent pandemic of chronic disease.[35]

Through globalization, this "double disease burden"[36] of both infectious and non-communicable diseases has risen to unprecedented levels, creating a heightened need for expanded national health responses. Paradoxically, however, just as the burden of disease is reaching its apex, national public health systems are being downsized to meet the requirements of international financial institutions. As discussed below in the context of structural adjustment programs, states cannot address the plight of disease and ill-health while simultaneously eviscerating national health care and public health systems.

B. Structural Adjustment Programs - Weakening National Health Infrastructures

Global financial institutions disadvantage public health structures.

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31. Jonathan M. Mann, *Preface* to LAURIE GARRETT, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE xi, xii (1994).

32. World Health Organization, *Chronic Conditions are Escalating* (2004), http://www.who.int/chronic_conditions/conditions/en/print.html. *But cf.* Christopher J. L. Murray & Lincoln C. Chen, *Understanding Morbidity Change*, 18 POPULATION & DEVELOPMENT REV. 481, 493-95 (1992) (noting that the rise in chronic illness may be nothing more than a secondary effect of infectious disease eradication, which has led to longer life expectancy at birth—and the concomitant expression of chronic disease—in many developing states).

33. Derek Yach et al., *The Global Burden of Chronic Disease*, 291 J. AM. MED. ASS'N 2616, 2617-18 (2004); *see also* Chen et al., *supra* note 12, at 288-89 (noting that globalization of advertising has contributed to exponential increases in the developing world in the array of chronic diseases correlated with smoking).

34. *See, e.g.*, World Health Organization, *supra* note 32; WORLD HEALTH ORGANIZATION, WHO TECHNICAL REPORT SERIES 916, DIET, NUTRITION AND THE PREVENTION OF CHRONIC DISEASES (2003), *available at* http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf.

35. *See also* William T. Blackstone, *On Health Care as a Legal Right: An Exploration of Legal and Moral Grounds*, 10 GA. L. REV. 391, 391 (1976) (discussing American medicine's inertia in changing medical research and health care delivery to meet the needs of the chronically ill).

36. Macfarlane et al., *supra* note 18, at 841.

Through what has become known as the "Washington Consensus,"[37] international economic organizations began in the early 1980s to adopt lending policies mandating fiscal austerity, privatization, and market liberalization among loan recipients, imposing these processes on developing states through the harbinger of the ills of globalization: Structural Adjustment Programs (SAPs).[38] Whether created by the International Monetary Fund (IMF), the World Bank, or trade agreements,[39] these "neoliberal" policy changes—requiring states to implement, *inter alia*, fiscal adjustment, private property institutions, and exchange rate reform—aim to free developing economies from the guidance of state governments, turning over control of economic systems (and by extension, social justice programs) to the whims of international markets.[40] However, such market-oriented policy changes, taken without regard to economic and social rights,[41] have acted to weaken state sovereignty, eliminate the welfare state, and limit public action to provide for health care and other basic life-sustaining resources.[42]

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37. John Williamson, *Democracy and the "Washington Consensus,"* 21 WORLD DEV. 1329 (1993).

38. *See generally* Charles Gore, *The Rise and Fall of the Washington Consensus as a Paradigm for Developing Countries*, 28 WORLD DEV. 789 (2000). Gore defines the Washington Consensus broadly to include development policy changes intended for states to "(a) pursue macroeconomic stability by controlling inflation and reducing fiscal deficits; (b) open their economies to the rest of the world through trade and capital account liberalization; and (c) liberalize domestic product and factor markets through privatization and deregulation." *Id.* at 789-90.

39. In order to manage the growth of early globalization, First World countries established the International Monetary Fund (IMF), World Bank, and General Agreements on Tariffs and Trades (GATT) to promote a liberalized trade agenda in an age of booming industrial expansion. The missions of the IMF and World Bank (collectively known as the Bretton Woods Institutions) were originally designed for balance of payments transactions following the Second World War. However, in the wake of the debt of the late 1970s and early 1980s, the role of these organizations changed to resolving the "Debt Crisis" of the Third World, with the intent of helping Third World economies to "'return to growth' and, most importantly, to continue making interest payments." John Gershman & Alec Irwin, *Getting a Grip on the Global Economy*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR, *supra* note 18, at 11, 20. For detailed explanations of the differential roles of the IMF and World Bank in development discourses, see JOSEPH E. STIGLITZ, GLOBALIZATION AND ITS DISCONTENTS 17-25 (2002).

40. MANUEL CASTELLS, THE RISE OF THE NETWORK SOCIETY 137 (2d ed. 2000) (describing the foundational policies of economic globalization); SUSAN STRANGE, THE RETREAT OF THE STATE 13, 14 (1996) (recognizing that the accelerated integration of national economies into one single global market economy has led to a reversal of the state-market balance of power and brought on a growing asymmetry between the larger states with structural power and weaker ones without it).

41. JACK DONNELLY, UNIVERSAL HUMAN RIGHTS IN THEORY & PRACTICE 233 (2d ed. 2003); *see also* Mazur, *supra* note 19, at 64 ("[A]ccording to the neo-liberal conception of citizenship . . . civil and political rights must be prioritized in order to provide the condition for wealth creation.").

42. *See* Falk, *Interpreting the Interaction of Global Markets and Human Rights*, *supra* note 13, at 72 ("The neoliberal ideological climate of opinion induces the social disempowerment of the state, shifting responsibility for human betterment increasingly to the private sector."); *see also* Leo Panitch, *Rethinking the Role of the State*, *in* GLOBALIZATION: CRITICAL REFLECTIONS 83 (James H. Mittelman ed., 1996). This denial of life-saving

These SAPs—IMF loans conditioned upon the implementation of market-liberalizing economic and social policies by loan recipients—have left many developing states without the health resources and infrastructures necessary to respond to the majority of the world's disease burden.[43] Through these SAPs, the IMF is able to "demand cuts in government expenditure, including axing or abolishing programmes for education, health, housing and public sector development, like sewage disposal and public housing."[44] The IMF presses these structural changes on developing states, often prescribing the same cuts in government expenditure to each state without consideration of their impact on health or human rights.[45] As a consequence, even where SAPs have allowed developing states to realize an increase in national economic growth—a causal relationship that remains dubious at best[46]—these states have often done so at the expense of widening inequality within societies among the most poor and vulnerable.[47]

This dramatic scaling back of the government's role in providing social services, particularly public health services, has reversed many of the health gains achieved in developing countries in the last fifty years,[48]

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public services for the poor as a result of privatization has come to be known as "service apartheid." Mazur, *supra* note 19, at 61.

43. *See* Jeffrey D. Sachs, Tropical Underdevelopment (Nat'l Bureau of Econ. Research, Working Paper No. 8119, Feb. 2001), *available at* http://www.nber.org/papers/W8119 (stating that IMF measures contribute to low growth rates and instability in recipient countries and recognizing the difficulty of technological diffusion across climate zones).

44. Tony Evans, *A Human Right to Health*, 23 THIRD WORLD Q. 197, 210 (2002); *see* Gill, *supra* note 15, at 408 (noting the larger role of SAPs in pushing states to "exercise monetary restraint, cut budgets, repay debts, balance their international trade, devalue their currencies, remove subsidies and trade and investment barriers and, in so doing, restore international credit-worthiness"); Mazur, *supra* note 19, at 65 ("SAPs generally entail reductions in government spending, privatization, higher interest rates, currency devaluation, reduction of tariffs and other trade barriers, and liberalization of foreign investment regulations and labor laws.").

45. Carol Welch, *Structural Adjustment Programs and Poverty Reduction Strategy*, 4 FOREIGN POL'Y IN FOCUS 1 (2000) (noting that, unlike the World Bank's consideration of environmental and social changes, SAP lending considers only the economic conditions that will assure international credit-worthiness); *see also* CASTELLS, *supra* note 40, at 141 ("These policy recommendations (in fact, impositions) were based on pre-packaged adjustment policies, astonishingly similar to each other, whatever each country's specific conditions. . . ."); STIGLITZ, *supra* note 39, at 24 (noting that development policy for developing states is often affected by developed countries within the IMF with conscious neglect of developing states' expressed wants).

46. MANUEL CASTELLS, END OF MILLENNIUM 114-17 (2d ed. 2000) (noting that many studies have found no association between structural adjustment policies and economic development in African states). For a discussion surrounding the economic efficacy of SAPs in the wake of the East Asian financial crisis, see Takatoshi Ito, *Growth, Crisis, and the Future of Economic Recovery in East Asia*, *in* RETHINKING THE EAST ASIAN MIRACLE (Joseph E. Stiglitz & Shahid Yusuf eds., 2001).

47. Robert Hunter Wade, *Is Globalization Reducing Poverty and Inequality?*, 32 WORLD DEV. 567 (2004). *But cf.* Mark Ravallion, *Growth, Inequality and Poverty: Looking Beyond Averages*, 29 WORLD DEV. 1803 (2001) (noting that the poor in developing countries can share in rising national affluence).

48. *See* Mazur, *supra* note 19, at 66 ("Debt-related cuts in health, nutrition, and literacy programs are undoing the results of years of development efforts.").

leaving debilitated national public health infrastructures (with a shortage of qualified health workers[49] and a limited arsenal of effective antimicrobial drugs)[50] that cannot bear the burden of modern disease epidemics.[51] These developing state public health systems lack the laboratories and trained personnel for diagnosis and surveillance of disease, treatment of chronic illnesses, and prevention of drug resistance. As a result, in the two decades since SAPs were first implemented, these adjustment-mandated policies have decimated fragile health and social infrastructures in countries throughout Africa and Latin America,[52] leaving their peoples "poorer and less healthy than at the beginning of the SAP era."[53] Despite repeated World Health Organization (WHO) efforts to address disparities in health care, "[m]any developing countries did not . . . enjoy the benefits of improved public health capabilities experienced in the developed world."[54] Neither infectious nor non-infectious diseases, such as environmental disease and food-borne infection, can be controlled in an atmosphere in which states have privatized their only means of preventing disease and promoting health.[55] Consequently, these developing state governments

49. *See* Macfarlane et al., *supra* note 18, at 844 (recognizing that "an underpaid, poorly motivated, poorly organised, and increasingly dissatisfied [medical] workforce also poses the greatest threat to [health sector] reform").

50. FIDLER, *supra* note 12, at 16 ("With rare exceptions, antimicrobial drugs made available globally have had no significant impact on their intended targets.").

51. *Id.* ("While significant progress against some infectious diseases has been made . . . the global infectious disease crisis serves as evidence that infectious diseases continue to ravage the developing world. National public health infrastructures in many developing nations still remain inadequate or non-existent.").

52. MAHMOOD MONSHIPOURI, DEMOCRATIZATION, LIBERALIZATION & HUMAN RIGHTS IN THE THIRD WORLD 54 (1995); *see* Audrey R. Chapman, *Core Obligations Related to the Right to Health*, *in* CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL AND CULTURAL RIGHTS, *supra* note 1, at 212 (noting that "poor countries are . . . cutting back on investments in the health sector, often in response to IMF austerity plans"). The experience of Peru is typical of this inequitable dichotomy. About half of the Peruvian population survives on less than two dollars per day. Because of structural adjustment programs, the Peruvian government is left with little opportunity to determine health policy or endure the negative consequences of the privatization of the health care system. Jim Yong Kim et al., *Sickness Amidst Recovery: Public Debt and Private Suffering in Peru*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR, *supra* note 18, at 127, 129. Peru's Health Law of 1997, which aimed at bolstering the Peruvian health care system through privatization, has done little to remedy disease or mortality rates among poor Peruvians. "By imposing the criterion of choice on people who are in no position to exercise it," Kim et al. note that "health-care reformers have prioritized financial outcomes over health outcomes, and further imperiled the health of the poor." *Id.* at 152.

53. Brooke G. Schoepf et al., *Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR, *supra* note 18, at 91, 92. *Compare* Allan McChesney, *The Promotion of Economic and Political Rights: Two African Approaches*, 24 J. AFRICAN L. 163, 181 (1980) (discussing African national successes in providing curative and public health services prior to the structural adjustment period).

54. FIDLER, *supra* note 12, at 12.

55. McMichael & Beaglehole, *supra* note 16, at 497.

> [A]lthough responsibility for healthcare and the public-health system remains with national governments, the fundamental social, economic, and environmental determinants of population health are becoming increasingly supranational

face enormous difficulties in making the long-term budgetary commitments necessary for real improvements in public health systems and health care infrastructures.

C. Impact of Globalization on the Built Environment

Humans spend most of their lives in a built environment. In the home or workplace, in the streets and parks, in the air that is breathed and water that is drunk, a built environment creates the conditions necessary for life. Some of these conditions are conducive to health, some of them debilitating. All of them have been irreversibly altered by the forces of globalization. This section discusses how globalization has harmed healthy built environments and led to a destabilization of the living conditions and infrastructures necessary to prevent disease and promote health.

Despite the universalization of infectious disease, differential risk for health threats endures through economic privilege and structural inequities in built environments.[56] While globalization offered the promise of economic growth and its resulting benefits to health,[57] the harsh realities of globalization have led to an uneven distribution of wealth and increased poverty.[58] Through neoliberal economic programs, "specific growth-oriented policies have not only failed to improve living standards and health

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> . . . [t]his global combination of liberal economic structures and domestic policy constraint promotes socioeconomic inequalities and political instability, each of which adversely affects population health.

Id.; *see* Chapman, *supra* note 1, at 215 (stating that global trends reflecting greater gaps and inequalities in access to health care reflect a number of factors including the effects of the privatization methods of the IMF as well as a lowered governmental commitment to public health); *see also* U.N. MILLENNIUM PROJECT, TASK FORCE ON CHILD HEALTH AND MATERNAL HEALTH, WHO'S GOT THE POWER? TRANSFORMING HEALTH SYSTEMS FOR WOMEN AND CHILDREN 96-97 (2005) (highlighting deficiencies in market-based approaches to health systems), *available at* http://www.unmillenniumproject.org/documents/maternal child-complete.pdf.

56. KEVIN M FITZPATRICK & MARK LAGORY, UNHEALTHY PLACES: THE ECOLOGY OF RISK IN THE URBAN LANDSCAPE (2000).

57. Robert McCorquodale & Richard Fairbrother, *Globalization and Human Rights*, 21 HUM. RTS. Q. 735, 743 (1999) (noting that, in theory, "economic growth will increase protection of economic rights because economic growth brings increased access to health care, food, and shelter, either directly through employment and increased income or indirectly through the improvement and extension of these facilities to more people"). *See generally* WORLD HEALTH ORGANIZATION & WORLD TRADE ORGANIZATION, WTO AGREEMENTS AND PUBLIC HEALTH: A JOINT STUDY BY THE WHO AND THE WTO SECRETARIAT 23 (2002), *available at* http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf (noting the effects of trade liberalization on health, including reduced tariffs, which may result in lower prices for medical equipment and changing international patent protections, affecting the price of medications and vaccines).

58. CASTELLS, *supra* note 46, at 73-82 (charting the rise of intrastate and interstate inequality in what he refers to as the "rise of the fourth world"); McCorquodale & Fairbrother, *supra* note 57, at 743 (discussing the reasons why "the type of investment, the basis for investment decisions, and the type of economic growth" have undercut the promise of benefits through globalization). *But cf.* Richard G.A. Feachem, *Globalisation is Good for your Health, Mostly*, 323 BRIT. MED. J. 504, 504 (2001) ("China, India, Uganda, and Vietnam, for example, have all experienced surges in economic growth since liberalising their trade and inward investment policies.").

outcomes among the poor, but also have inflicted additional suffering on disenfranchised and vulnerable populations."[59]

Driving economic disparities, the export-led growth strategies spurred by structural adjustment have forced many developing states to drastically increase commodity exports in order to generate the foreign exchange capital needed to service persistent debts to international financial institutions.[60] This, in turn, has forced states to abandon rural, agriculture-based economies in favor of rapid urbanization.[61] These efforts to restructure national economic systems and subsequent urban migration have overwhelmed crumbling urban centers, leading to widespread unemployment and unsustainable living conditions.[62] Even those states that have achieved some economic growth at the national level have done so on the backs of the urban poor, most of whom have not shared in the prosperity of their substantially wealthier countrymen.[63] Because globalization operates at a collective level without regard for individual benefit, "those who suffer 'adjustment costs'—lost jobs, higher food prices, and inferior health care—acquire no special claim to a share of the collective benefits of efficient markets."[64] For these marginalized communities, changes in the built environment have led to a decrease in livability through the degradation of individual livelihood and ecological sustainability.[65]

At an individual level, opportunities do not exist to provide for one's livelihood, without the wage employment necessary to provide for housing, food, and access to medical services. The rapid introduction of market-oriented policies and concomitant urban migration has led to a bifurcation of employment opportunities in developing countries, with wealthy elites benefiting disproportionately from economic growth.[66] The poor, who rely on wage labor, have seen their earnings drop relative to the wealthy.[67] Overpopulation has increased demand for commodities, leading to a rise in the cost of land, services, and basic goods, and thus a decrease in the real

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59. Millen, *supra* note 18, at 7. *But cf.* Dollar, *supra* note 12, at 829 (finding that "percentage changes in incomes of the poor, on average, are equal to the percentage changes in average incomes"); Feachem, *supra* note 58, at 504 ("Analysis of 137 countries shows that the incomes of the poorest 20% on average rise and fall in step with national growth or recession.").

60. *See* GLOBALIZING CITIES: A NEW SPATIAL ORDER? (Peter Marcuse & Ronald van Kempen eds., 2000).

61. *Id.*

62. *Id.*

63. Mike Douglass et al., *Urban Poverty and the Environment: Social Capital and State-Community Synergy in Seoul and Bangkok*, *in* LIVABLE CITIES?: URBAN STRUGGLES FOR LIVELIHOOD AND SUSTAINABILITY at 31, 36 (Peter Evans ed., 2002) (examining the case of Bangkok); *see also supra* note 47 and accompanying text.

64. DONNELLY, *supra* note 41, at 201.

65. Peter Evans, *Introduction: Looking for Agents of Urban Livability in a Globalized Political Economy*, *in* LIVABLE CITIES?: URBAN STRUGGLES FOR LIVELIHOOD AND SUSTAINABILITY, *supra* note 63, at 1, 1.

66. *See generally id.*

67. *Id.*

wages of workers.[68] Without government health care, food, shelter, education, and other social services, the poor must bear these risks and costs alone, leading to a decline in real income. For those whose only asset is labor, disabling sickness can lead to immediate destitution. These disparities in opportunities, real wages, and services have led to dramatic increases in poverty and homelessness.[69] With rising costs of urban life, many have resorted to employment in the informal economy, including day labor, drug trafficking, and commercial sex work.[70] It is these economic conditions, employment choices, and personal behaviors that have contributed to elevated levels of preventable disease and stymied health promotion efforts among urban populations.

At a societal level, global economic changes have irreparably altered urban ecologies, the environmental qualities of the city necessary for the health of entire populations, and drained resources for health away from increasingly disenfranchised rural populations.[71] With adjustment policies having weakened the government's ability to confront overpopulation and growing urban poverty, changes to the built environment of cities have led to unimpeded increases in morbidity and mortality among the most vulnerable. As urban centers emerge in developing states—unprecedented in their rate of growth and lack of planning—the requirements of international financial institutions will leave states at the precipice of a public health disaster.

Although urbanization has the capacity to confer health benefits through improved access to health services,[72] inadequate housing, sanitation, and medical services plague impoverished urban communities throughout the developing world.[73] Individuals from rural areas hoping to find employment or seeking escape from famine, drought, or civil strife are migrating to urban centers that lack the infrastructure to support such influxes.[74] Improvements in state institutions have not kept pace with the

68. *Id.* at 5 ("A growing proportion of urban dwellers faces a discouraging disjunction between the salaries generated by city labor markets and the housing costs generated by the market for urban land.").

69. *Id.*

70. HILARY FRENCH, VANISHING BORDERS: PROTECTING THE PLANET IN THE AGE OF GLOBALIZATION 5 (2000); ILO/Marilyn Carr & Martha Alter Chen, Working Paper on the Informal Economy: Globalization and the Informal Economy: How Global Trade and Investment Impact on the Working Poor 3 (2002), *available at* http://www.wiego.org/papers/carrchenglobalization.pdf; Nana K. Poku, *Poverty, Debt, and Africa's HIV/AIDS Crisis*, 78 INT'L AFF. 531, 533-37 (2002).

71. *See* Evans, *supra* note 65, at 2 ("Ecological degradation buys livelihood at the expense of quality of life, with citizens forced to trade green space and breathable air for wages.").

72. *See* Anthony J. McMichael, *The Urban Environment and Health in a World of Increasing Globalization: Issues for Developing Countries*, 78 BULL. WORLD HEALTH ORG. 1117, 1119 (2000).

73. For a historical perspective on the role of modes of production in promoting disease, see JARED DIAMOND, GUNS, GERMS AND STEEL: THE FATES OF HUMAN SOCIETIES (1997).

74. JENNIFER BROWER & PETER CHALK, THE GLOBAL THREAT OF NEW AND REEMERGING INFECTIOUS DISEASES: RECONCILING U.S. NATIONAL SECURITY AND PUBLIC HEALTH POLICY 21-23 (2003).

harms inflicted on urban populations. These overcrowded urban centers, lacking even basic infrastructure, force millions to live in slum conditions, leading to the unsanitary conditions that contribute to the spread of disease.[75] Further, the slums that have arisen in these urban centers have created social settings predeterminant of unhealthy lifestyles, leading to drug, alcohol and tobacco abuse, domestic violence, and harmful personal choices.[76] Within these slum conditions, the emergence and spread of many diseases is abetted by socio-economic conditions conducive to pathogen transmission and unequal access to health resources.[77] When illness does strike, these disadvantaged individuals often find themselves with a lack of medical knowledge and inability to access skilled medical care, due to high physician expenses and intra-city geographic disenfranchisement.[78]

D. The Rise of the Transnational Corporation

Causing and facilitating many of the harms of these global economic changes, transnational corporations (TNCs) have taken advantage of new markets in many ways detrimental to the health of entire societies. Driven by the needs of powerful developed states and aided by international financial institutions, a rise in the unregulated industrialization of the developing world has exacerbated local and global environmental health problems while producing products damaging to the public's health. Despite these unrivaled harms, national governments, which must encourage TNC investment in their respective states, are unable to protect their peoples from these foreign actors, having sacrificed their peoples' sustainable health and survival in exchange for fleeting economic benefit.

TNCs, acting outside the law of any territorial sovereign government, damage local and global environments through unregulated production processes.[79] These production processes have damaged the ecosystems in which TNCs operate, harming the air and water upon which their communities depend.[80] Examined writ large, these processes have led to dramatic increases in the carbon dioxide levels that propel global warming, a process that threatens to destroy entire ecosystems and the societies that

75. *See* Phil Gunby, *Who Wants Rapid Response to Emerging Threats*, 275 JAMA 178, 178 (1996); Taylor, *supra* note 22, at 1336 (noting that "economic development and changes in land use, including new widespread water surfaces, provide fertile ground for infectious diseases").

76. McMichael, *supra* note 72, at 1119.

77. *See* Link & Phelan, *supra* note 17, at 81-82 (reviewing studies highlighting "the ubiquitous and often strong association between health and socioeconomic status").

78. WORLD HEALTH ORGANIZATION, COMM'N ON MACROECONOMICS AND HEALTH, *Macroeconomics and Health: Investing in Health for Economic Development* 23 (2001), *available at* http://www.emro.who.int/cbi/pdf/CMHReportHQ.pdf [hereinafter *Macroeconomics and Health*].

79. *See* Chen et al., *supra* note 12, at 288 (noting the transnational health implications of "ozone depletion, global warming, and the disposal of toxic wastes"); Taylor, *supra* note 22, at 1336 (noting that "ecological degradation, including global warming, affect the introduction and spread of many severe diseases" (citations omitted)).

80. FRENCH, *supra* note 70, at 74-75.

depend upon them.[81] While it remains difficult to quantify these changes in global public goods[82] with great precision, their overall impact on public health is now beyond question and has already begun to be felt by many societies. Furthermore, in some cases, even the product itself causes harm, exposing vulnerable populations to tainted food products and inherently harmful products, such as pesticides[83] and tobacco.[84] As an extreme example of this rapacious production of hazardous materials, TNCs have facilitated the explosive trade of both conventional armaments and weapons of mass destruction.[85] Without national product regulation, these TNCs have injected products that have dire implications for public health into the stream of commerce.

In regulating these harms, the rising economic and political clout of TNCs has undermined government efforts to make policy independent of corporate interests.[86] States have largely become subservient to the profit-seeking activities of TNCs, which operate outside of the obligations imposed by human rights standards.[87] Through the threat and practice of relocation, TNCs have stymied major national efforts to regulate their behavior, pushing states toward creating tax and regulatory safe-havens for their operations.[88] This has led to a downward, standard-lowering compe-

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81. *See generally* AL GORE, EARTH IN THE BALANCE: ECOLOGY AND THE HUMAN SPIRIT (1992).

82. For a definition and discussion of global public goods and their relevance to public health, see notes 199-202 and accompanying text.

83. In India, TNCs have created a dramatic example of corporate malfeasance to the detriment of health. Commenting on the 1984 Union Carbide toxic gas leak in Bhopal, Timothy Holtz discusses the release of toxic pesticide that killed at least 3,000 people as an example of the perils of expansive TNC power in developing states. In doing so, Holtz argues that "[i]n the grand 'trade-off' between foreign investment and economic development on the one hand, and environmental and human safety on the other, the elite reap the monetary awards while the costs to human health are visited upon the poor." Timothy H. Holtz, *Tragedy Without End: The 1984 Bhopal Gas Disaster*, in DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR, *supra* note 39, at 245, 257.

84. *See* Jeff Collin et al., *The Framework Convention on Tobacco Control: The Politics of Global Health Governance*, 23 THIRD WORLD Q. 265, 266 (2002) (recognizing "the ability of transnational corporations . . . to undermine the regulatory authority of national governments" in the context of tobacco control); Deborah Arnott, *The Killer's Lobbyists*, GUARDIAN (May 15, 2003), http://www.guardian.co.uk/analysis/story/0,3604,956270,00.html (discussing the monumental influence of the tobacco lobby in the developing world).

85. McCorquodale & Fairbrother, *supra* note 57, at 749.

86. Mahmood Monshipouri, *Promoting Universal Human Rights: Dilemmas of Integrating Developing Countries*, 4 Yale Hum. Rts. & Dev. L.J. 25, 58 (2001).

87. Mazur, *supra* note 19, at 65 ("Decision-making processes are being shifted away from governments and people to globalized economic institutions and transnational corporations which have a limited interest in the social and cultural welfare or the human rights of people in developing states.") (citing McCorquodale & Fairbrother, *supra* note 57, at 765).

88. DONNELLY, *supra* note 41, at 232 ("[F]irms are increasingly free to move "offshore" to escape the costs imposed by welfare state guarantees of economic and social goals. The resulting market pressures to constrain national social welfare policies are increasingly supplemented by pressures from international financial institutions."). These regulatory safe-havens, often referred to in policy as "free enterprise zones," have

tition among states—a "race to the bottom" in social welfare and public health regulations[89]—allowing reckless TNCs to undermine health in the pursuit of profits,[90] while stifling the state sovereignty necessary to protect human rights.[91] With developing states lowering their labor, environmental, and health standards to gain an advantage in encouraging economic investment by TNCs, impoverished communities suffer the detrimental health consequences of economic restructuring.

E. Health vs. Trade

Globalized trade regimes have imposed tremendous costs on states in lives lost, all the while granting these states little clear benefit in pharmaceutical innovation, economic development, or health promotion. Balancing trade and health issues will be the great challenge of the globalization era.

1. *Intellectual Property*

It is not possible to consider individual medical care and public health without acknowledging that it is the intellectual property regimes under the World Trade Organization (WTO) that often prevent states from easily providing medications and treatments to their peoples. The 1994 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) specifically amended the General Agreement on Trade and Tariffs (GATT) to provide patent protection for pharmaceutical products, a twenty-year minimum duration on patent protection, transitional periods with exclusive marketing rights, and enforcement of intellectual property rights through a binding WTO judicial panel.[92] While it is not immediately clear why intellectual property is "trade-related," placing intellectual property protection

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grown exponentially as states have battled with each other for corporate business. Joel Brenner et al., *Neoliberal Trade and Investment and the Health of* Maquiladora *Workers on the U.S.-Mexico Border*, *in* DYING FOR GROWTH: GLOBAL INEQUALITY AND THE HEALTH OF THE POOR, *supra* note 18, at 261.

89. Millen, *supra* note 18, at 177, 184 (noting that "in their effort to lure foreign companies to their borders, governments began to engage in a downward, standard-lowering bidding cycle, or 'race to the bottom,' whereby the needs of their citizens, especially the poor, were typically subordinated to the needs of the foreign companies.").

90. An example of this is seen in Mexico, where TNC-controlled urban shantytowns (called "*maquila* cities") are characterized by industrial pollution, overcrowding, and inadequate sanitation, all of which have led to precipitous declines in nearly all public health indices. Despite the promise of TNCs creating economic growth in Mexico, "both the number and proportion of the extremely poor have grown" during this period of economic liberalization. Brenner et al., *supra* note 88, at 287.

91. *But see* William H. Meyer, HUMAN RIGHTS AND INTERNATIONAL POLITICAL ECONOMY IN THIRD WORLD NATIONS: MULTINATIONAL CORPORATIONS, FOREIGN AID, AND REPRESSION 108 (1998) (finding that "the engines of development school is correct in its assertions that MNCs [multi-national corporations] promote both civil-political rights and socio-economic welfare at the international level").

92. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, LEGAL INSTRUMENTS—RESULTS OF THE URUGUAY ROUND, 33 I.L.M. 81 (1994) [hereinafter TRIPS].

under the WTO framework (rather than under the purview of the World Intellectual Property Organization) has handed TNCs the enforceable sanctions necessary to compel state compliance with rigid intellectual property protections and thereby elevate corporate concerns over the imperatives of public health.[93]

Many recent attempts have been made to alleviate the health inequities wrought by intellectual property frameworks. In response to the growing AIDS crisis and its destabilization of entire regions of the world, WTO states met in 2001 during the current Doha Round of negotiations to negotiate what has come to be known as the Doha Declaration on the TRIPS Agreement and Public Health (Doha Declaration).[94] In the Doha Declaration, state delegates reaffirmed that:

> We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.[95]

The states of the WTO drafted this somewhat ambiguous exception to balance "the goal of providing incentives for future inventions of new drugs and the goal of affordable access to existing drugs."[96] By offering a public health emergency exemption from patent laws under TRIPS, it was felt that states could respond to genuine public health crises through either the compulsory licensing (state manufacture without prior patent licensing) or parallel importation (state importation of drugs from other lower-priced states without the patent holder's permission) of necessary medicines.[97] Although no state has yet employed this exemption to allow for compulsory licensing or parallel importation, a few states have used the threat of

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93. *See* Zita Lazzarini, *Making Access to Pharmaceuticals a Reality: Legal Options Under TRIPS and the Case of Brazil*, 6 YALE HUM. RTS. & DEV. L.J. 103, 112 (2003) (noting that "TRIPS was drafted following extensive lobbying by international pharmaceutical manufacturers and reflects many values favorable to large multi-national corporations").

94. WORLD TRADE ORGANIZATION, Declaration on the TRIPS Agreement and Public Health of 14 November 2001, WT/MIN(01)/DEC/2, 41 I.L.M. 755 (2002), *available at* http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.pdf. [hereinafter Doha Declaration]; *see also* The Separate Doha Declaration Explained, http://www.wto.org/english/tratop_e/trips_e/healthdeclexpln_e.htm (last visited Oct. 10, 2006).

95. *Doha Declaration*, *supra* note 94, ¶ 4.

96. Rosalind Pollack Petchesky attributes the success of this position at the Doha conference to weakened U.S. opposition on the subject as a result of the United States' own public consideration of issuing a compulsory license for the generic form of the drug Cipro in the face of the U.S. anthrax scare of September 2001. ROSALIND POLLACK PETCHESKY, GLOBAL PRESCRIPTIONS: GENDERING HEALTH AND HUMAN RIGHTS 106 (2003). Despite this fleeting weakness in its negotiating position, Petchesky notes that the United States has systematically attempted to undercut consensus on the Declaration since the Doha conference. *Id.* at 107.

97. *See generally* Divya Murthy, *The Future of Compulsory Licensing: Deciphering the Doha Declaration on the TRIPs Agreement and Public Health*, 17 AM. U. INT'L L. REV. 1299, 1307-08 (2002).

generic HIV antiretroviral therapies as a means to improve their bargaining position vis-à-vis pharmaceutical corporations.[98]

The AIDS epidemic has sharply focused international attention on the conflict between intellectual property rights specific to medicine and access to "essential medicines"[99] (which the WHO has found to include antiretroviral drugs for treating HIV), creating a normative debate through which nongovernmental organizations have been able to press their governments for access to medications to combat HIV.[100] This conflict is based on competing visions of whether medicine is considered to be a public good or a private commodity. As a public good, it is clear that every person's health could be improved though widespread access; however, medicine—even essential medicine—is distinguished from traditional essential public goods like water, food, and shelter.[101] Contrasted with this public goods vision of medications, medicine has been conceptualized as a private commodity, one that needs protection through a property rights regime in order to drive innovation.[102] Under this rationale, medicines exist only because of market systems and respect for private property. Without a guarantee of profit, there is no incentive to invent (or to invest the time and resources necessary to invent). This latter interpretation of essential medicines currently holds favor in international dis-

98. Frederick M. Abbott, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*, 99 AM. J. INT'L L. 317 (2005) (discussing the WTO's definition of compulsory licensing and parallel importation); *see, e.g.*, Lazzarini, *supra* note 93, at 133.

99. The WHO has defined essential medicines as:

> [T]hose that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford.

World Health Organization, *WHO Policy Perspectives on Medicines*, No. 4: The Selection of Essential Medicines, WHO Doc. WHO/EDM/2000.4, at 1 (June 2002), *available at* http://whqlibdoc.who.int/hq/2002/WHO_EDM_2002.2.pdf. Based upon this definition, the WHO has found that one-third of the world's population lacks access to these essential medicines, including one-half of those living in the less-developed states of Asia and Africa. *Id.*

100. PETCHESKY, *supra* note 96, at 82-84 (chronicling the lobbying and legal strategies of the "global campaign for access to essential medicines" for HIV). As noted in Professor Rosalind Petchesky's assessment of HIV advocacy, "[t]here is no doubting the effective role that demonstrations and other forms of direct action have played in pressuring the US government and transnational drug companies to make significant concessions and in creating a broad public awareness of access to treatment as a human rights issue." *Id.* at 85; *see id.* at 85-104 (providing examples of direct action for HIV and human rights in South Africa and Brazil).

101. For a discussion of the role of public goods in the realization of health rights, see *infra* notes 195-201, 280-283 and accompanying text.

102. WORLD HEALTH ORGAMIZATION, COMMISSION ON INTELLECTUAL PROPERTY RIGHTS, INNOVATION AND PUBLIC HEALTH, PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY RIGHTS (2006), *at* http://www.who.int/intellectualproperty/documents/thereport/en/index.html.

courses.[103] To stymie any progression in this debate, transnational pharmaceutical corporations have found advantage in donating medications, avoiding the risk presented to the sanctity of patent law by a legal challenge.[104] In merely threatening the use of parallel importation and compulsory licensing to fulfill the health needs not met by private corporations, states have allowed TNCs to deny governmental responsibility for providing medicines.

But even assuming that a developing state were permitted to engage in compulsory licensing or parallel importation, which many public health advocates consider to be the goal,[105] this would not be enough. From a public health perspective, developing states need research in those diseases that most affect them—not just medicines for the diseases endemic to developed states.[106] Only through such research mechanisms can public health create appropriate life-saving medications, incentivizing research for the medicines necessary to treat "tropical disease"[107] and making these medications physically and economically accessible to all who need them.[108] As argued by Frank Grad:

> For the fullest attainment of health, the benefits of medical, psychological, and related knowledge must be extended to all peoples. This principle serves as a reminder that the availability of essential knowledge and medicines must not be stopped at any national border, and that such inter-

103. *See* Brook K. Baker, *Arthritic Flexibilities for Accessing Medicines: Analysis of WTO Action Regarding Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health*, 14 IND. INT'L & COMP. L. REV. 613, 619-33 (2004).

104. *E.g.*, PETCHESKY, *supra* note 96, at 90 (summarizing the actions of the Pharmaceutical Manufacturers Association in response to South African litigation).

105. Evans, *supra* note 44, at 207 (noting that "the research and development programmes of the major pharmaceutical companies concentrate on finding products for medical conditions associated with the concerns of the wealthy, like obesity, stress and baldness, rather then [sic] life-threatening diseases associated with the poor, like tuberculosis" (citing WORLD HEALTH ORGANIZATION, GLOBALIZATION, TRIPS AND ACCESS TO PHARMACEUTICALS (2001)).

106. *See* Sachs, *supra* note 43 (recognizing the difficulty of technological diffusion across climate zones). *See generally* Global Forum for Health Research, Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers (2006), *available at* http://www.globalforumhealth.org/Site/000_Home.php. (follow "What We Do" hyperlink; then follow "Publications" hyperlink; then follow "Resource Flows" hyperlink).

107. *See* Sachs, *supra* note 43, at 3 (advocating, from an economic development perspective, that "policy solutions for tropical underdevelopment will require a much greater national and international focus on technological innovation directed at the problems of tropical ecology").

108. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. and Cultural Rights [CESCR], *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, ¶ 12(b), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument [hereinafter *General Comment 14*]. Global Forum for Health Research, Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers (2006), *available at* http://www.globalforumhealth.org/Site/000_Home.php. (follow "What We Do" hyperlink; then follow "Publications" hyperlink; then follow "Resource Flows" hyperlink).

ference must not be tolerated for any political or economic reasons.[109]

This cannot be done solely through cooperation with pharmaceutical corporations, whose profit motive often conflicts with public health. Fulfilling access to these medications, i.e., making medications affordable, will require states to combat the injurious mechanics of international trade. As with the medicalization of HIV treatment, expanded access to life-saving medications for states with limited resources will need to circumvent intellectual property protections provided for by TRIPS.[110]

2. *Trade Agreements*

Even when trade agreements do not specifically address health issues, they nevertheless impact health, often detrimentally and without the input of public health policymakers.[111]

For example, the 1994 General Agreement on Trade and Services (GATS)[112] has led to harmful disparities in access to those health services that were once provided exclusively by the public sector. Compounding the harmful effects of privatization under SAPs, this "trade" agreement sought to facilitate foreign private investment in developing states' public service sectors.[113] By engendering the further privatization of state health care sectors, GATS has created a two-tiered health system in many countries, with foreign for-profit firms drawing resources and medical personnel out of the public healthcare system to care for the healthy and wealthy while abandoning the poor and sick to an underfinanced public sector.[114] This, in effect, co-opted the healthcare industry as an engine of profit, subverting health objectives for commercial gain. In analyzing these components of GATS, the United Nations High Commissioner for Human Rights found such trade liberalization to be a direct threat to health.[115]

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109. Frank P. Grad, *The Preamble of the Constitution of the World Health Organization*, 80 BULL. WORLD HEALTH ORG. 981, 982 (2002).

110. Leonard S. Rubenstein, *Human Rights and Fair Access to Medication*, 17 EMORY INT'L L. REV. 525, 532 (2003); Lazzarini, *supra* note 93, at 120-25 (2003); Yamin, *supra* note 1, at 344 (quoting ECOSOC, CESCR, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: Human Rights and Intellectual Property*, ¶ 12, U.N. Doc. E/C.12/2001/15 (Dec. 14, 2001)).

111. M. Gregg Bloche & Elizabeth R. Jungman, *Health Policy and the WTO*, 31 J.L. MED. & ETHICS 529, 529 (2003) (discussing the damaging health impact of international trade).

112. General Agreement on Trade in Services, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1B, LEGAL INSTRUMENTS—RESULTS OF THE URUGUAY ROUND, 33 I.L.M. 1167 (1994) [hereinafter GATS], *available at* http://www.wto.org/english/docs_e/legal_e/26-gats.pdf.

113. *Id.*; *see also* ECOSOC, Sub-Comm. on the Promotion and Prot. of Human Rights, *Liberalization of Trade in Services and Human Rights: Report of the High Commissioner*, U.N. Doc. E/CN.4/Sub.2/2002/9 (June 25, 2002), *available at* http://193.194.138.190/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.Sub.2.2002.9.En?Opendocument (follow "PDF" hyperlink) [hereinafter *Liberalization of Trade in Services and Human Rights*].

114. Markus Krajewski, *Public Services and Trade Liberalization: Mapping the Legal Framework*, 6 J. INT'L ECON. L. 341, 347-59 (2003).

115. *Liberalization of Trade in Services and Human Rights*, *supra* note 113; *see also* ECOSOC, Comm. on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur on His*

During the 1999 WTO meeting in Seattle, the United Nations responded directly to this threat, with the Committee on Economic, Social and Cultural Rights (CESCR)[116] admonishing delegates that "liberalization in trade, investment and finance does not necessarily create and lead to a favorable environment for the realization of economic, social, and cultural rights."[117] In conclusion, the CESCR expressed its international legal understanding that "[t]rade liberalization must be understood as a means, not an end."[118] The CESCR was not alone, with many scholars reframing trade discourses to argue that trade regimes should be structured explicitly as the means to improve health.[119] In doing so, many health scholars have simply declared the normative superiority of public health over corporate interests,[120] leading to a standoff in irreconcilable priorities that has yet to be addressed.

Mission to the World Trade Organization, U.N. Doc. E/CN.4/2004/49/Add.1 (Mar. 1, 2004) (*prepared by* Paul Hunt), *available at* http://193.194.138.190/Huridocda/Huridoca.nsf/(Symbol)/E.CN.4.2004.49.Add.1.En?Opendocument (follow "PDF" hyperlink) [hereinafter *Report of the Special Rapporteur* (Mar. 1, 2004)].

116. For a description of the role of the CESCR in interpreting the human right to health, see *infra* notes 235-236 and accompanying text.

117. ECOSOC, CESCR, *Statement of the UN Committee on Economic, Social and Cultural Rights to the Third Ministerial Conference of the World Trade Organization (Seattle, 30 November to 3 December 1999)*, ¶ 6, U.N. Doc. E/C.12/1999/9 (Nov. 26, 1999), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1999.9.En?Opendocument.

118. *Id.* Never before had an international organization argued for development as a means to achieve health. On the contrary, the United Nations has previously focused on health as a means to promote economic development. *See Macroeconomics and Health*, *supra* note 78, at 25 ("Because disease weighs so heavily on economic development, investing in health is an important component of an overall development strategy."); *e.g.*, Rubenstein, *supra* note 110, at 529 (highlighting a UNAIDS slide "showing the extraordinary decline in agricultural production in Zimbabwe as a result of HIV/AIDS"). This "health for growth" model inverted the causal link between development and health. Combating this, the CESCR attempted to refocus normative goals in health policy to view the reduction of morbidity and mortality as ends unto themselves, not intermediaries on the path to economic development.

119. *See, e.g.*, Yamin, *supra* note 1, at 330 ("The fundamental premise underlying the notion of universal human rights is that people are not expendable; those people's avoidable deaths are not just a tragic shame."). This position is in line with a general criticism of development discourses, where scholars have consistently found that a non-rights-based approach to development "amounts to a confusion of means (markets and elections) with ends (human rights and through them human dignity)." DONNELLY, *supra* note 41, at 203. These criticisms find health to be essential to "human flourishing" and the exercise of all other rights. *See* Jennifer Prah Ruger, *Health and Social Justice*, 364 LANCET 1075, 1075 (2004) ("[C]ertain aspects of health sustain all other aspects of human flourishing because, without being alive, no other human functionings are possible, including agency, the ability to lead a life one has reason to value."); Amartya Sen, *Why Health Equity?*, 11 HEALTH ECON. 659 (2002). Such a position reverses the traditional economic rationale for health interventions, reasserting health, not its neoliberal sequelae, as the focus of those committed to protecting the rights of our most vulnerable.

120. Yamin, *supra* note 1 (viewing the CESCR's interpretation of the right to health in General Comment 14 as "clearly alluding to the core obligation to provide essential medications, . . . 'emphasiz[ing] that any intellectual property regime that makes it more difficult for a State party to comply with its core obligations in relation to health, food, education, especially, or with any other right set out in the Covenant is inconsistent with the legally binding obligations of the state party'"); *see also* Rubenstein, *supra* note 110,

II. Public Health Responds to Globalization

As globalization's effects began driving morbidity and mortality rates, it became clear to public health theorists that socio-economic changes were influencing underlying determinants of health in ways that could not be accounted for by the medical model of health. Rather than impacted by medicine and medical care, it is now well accepted that the vast majority of health conditions derive from underlying determinants of health.[121] These underlying determinants of health—including, *inter alia*, poverty, employment, access to potable water and adequate sanitation, an adequate supply of safe and nutritious food, housing, healthy environmental conditions, and access to health-related information and services—are addressed not through individual medical interventions but through changes to national and international public health and social welfare systems.

The right to health had been advanced—like almost all human rights—as an individual positive right,[122] focusing on individual access to health services at the expense of collective health promotion and disease prevention programs. Despite developments in public health since the original drafting of the ICESCR, the right to health has remained mired in a clinical model of health, advancing individual medical/technological solutions to problems necessitating widespread social change. In this Part and those that follow, this Article argues that achieving the highest attainable standard of health in a globalized world necessarily requires states to fulfill health promotion and disease prevention goals through public health systems.

A. Inadequacy of the Human Right to Health

An individual right to health, implicit in the Universal Declaration on Human Rights (UDHR), is recognized as a fundamental international human right.[123] Founded upon the non-derogable right to life,[124] the

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at 532 ("[O]ne could . . . argue that human rights law should actually take precedence over intellectual property law."); Chapman, *supra* note 1.

121. Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights*, Hastings Center Rep., May-June 1997, at 6, 7.

122. While the author acknowledges that the individual right to health clearly possesses components of both positive and negative rights—and that these positive and negative components are interdependent and interrelated—this Article focuses on the entitlements delineated in Article 12 of the ICESCR and necessary for a state to fulfill the right to health. *See infra* note 126.

123. Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess., art. 3, U.N. Doc. A/810 (Dec. 10, 1948) [hereinafter UDHR]. As noted by Mann et al., "[a]lthough the UDHR is not a legally binding document, nations (states) have endowed it with great legitimacy through their actions, including its legal and political invocation at the national and international levels." Jonathan M. Mann et al., *Health and Human Rights*, *in* HEALTH AND HUMAN RIGHTS: A READER 7, 9 (Jonathan M. Mann et al. eds., 1999).

124. Virginia A. Leary, *Implications of a Right to Health*, *in* HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE 481, 487 (Kathleen E. Mahoney & Paul Mahoney eds., 1993) ("It does not strain imagination to consider the 'right to health' as implicit in the right to life."); UDHR, *supra* note 123, art.3 ("Everyone has the right to life, liberty and the security of person.").

UDHR affirms in Article 25(1) that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care and necessary social services."[125] In 1966, the United Nations legislatively embodied the economic and social parameters of this right in the ICESCR, which elaborates the right to health in Article 12.1 to include "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[126] To achieve the full realization of this right, Article 12.2 of the ICESCR requires states to take affirmative steps necessary for "(b) [t]he improvement of all aspects of environmental and industrial hygiene; (c) [t]he prevention, treatment, and control of epidemic, endemic, occupational and other diseases; [and] (d) [t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[127]

However, "since the listed measures constitute goals as opposed to actions that member nations must take,"[128] this treaty language provides little guidance as to the specific scope of states' obligations,[129] creating, at best, an "imperfect obligation" on states in implementing the right to health.[130] Outside of the sweeping platitudes enunciated in national and

125. UDHR, *supra* note 123, art. 25(1).

126. ICESCR, *supra* note 2. Although this Article focuses largely on the ICESCR, based upon its seminal and widely-accepted enunciation of the right to health, international treaty law has also recognized a right to health in, *inter alia*, Article 24 of the Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, art. 24, 144 U.N.T.S. 123, 123-52 (entered into force Sept. 2, 1990); Articles11(1)(f), 12, and 14(2)(b) of the Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Dec. 18, 1979, arts. 11, 12, and 14, 1249 U.N.T.S. 13, 18-19 (entered into force Sept. 3, 1981); and Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195, 220-21 (entered into force Jan. 4, 1969). While these and other bases of national and international law recognize a right to health, *see Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶¶ 11-20, these interpretations all stem from the cornerstone right elaborated in Article 12 of the ICESCR. Consequently, the author finds that any evolution of the ICESCR's rendering of the right to health will necessarily implicate the expansion of other sources of law.

127. ICESCR, *supra* note 2, art. 12.2. In addition, the CESCR has noted that "a State party in which any significant number of individuals is deprived . . . of essential primary health care . . . is, prima facie, failing to discharge its obligations under the [ICESCR]." ECOSOC, CESCR, *The Nature of States Parties Obligations: General Comment 3*, ¶ 10, U.N. Doc E/1991/23 (Dec. 14, 1990), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.En?OpenDocument [hereinafter *General Comment 3*].

128. Allyn Lise Taylor, *Making the World Health Organization Work*, 18 AM. J.L. & MED. 301, 327 (1992).

129. ROBERT BEAGLEHOLE & RUTH BONITA, PUBLIC HEALTH AT THE CROSSROADS: ACHIEVEMENTS AND PROSPECTS 223 (1997) (noting that the UDHR and ICESCR, "although important and legally binding in international law, do not make it easy to determine the specific obligations involved"); FIDLER, *supra* note 12, at 188 (noting that "the text of [ICESCR] Article 12(2) is too general to provide insight into concrete actions States parties need to take"); *see* Chapman, *supra* note 1, at 193 (noting "the confusion and controversy about the nature and scope of the right to health" and that "few countries . . . utilise its norms as a framework for formulating health policy").

130. Michael Kirby, *The Right to Health Fifty Years On: Still Skeptical?*, 4 HEALTH & HUM. RTS. 7, 13 (1999).

international law, what specific entitlements does the individual right to health include? With countries differing greatly in available health resources, how is the "highest attainable standard" of health defined? Although criticized for its ambiguity,[131] derided by critics as merely "aspirational,"[132] the individual right to health has been interpreted to embrace, as part of its minimum core content,[133] basic provisions of emergency health care necessary to save lives, including the treatment of prevalent diseases, the provision of essential drugs, and safeguards against serious environmental health threats.[134] Yet, despite advancements in clarifying the scope of the core content of the right to health, its rhetorical rigidity has left the core content of the right to health both inadequate and counterproductive. Human rights lose their universality and enforceability where unattainable mandatory conditions are required. For example, in the case of including the provision of "essential drugs" within the core con-

131. NORMAN DANIELS, JUST HEALTH CARE 7-8 (1985); FIDLER, *supra* note 12, at 197 ("[T]he right to health is an international human right because it appears in treaties, but the right is so broad that it lacks coherent meaning and is qualified by the principle of progressive realization."); Lawrence Gostin & Jonathan Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, *in* HEALTH AND HUMAN RIGHTS: A READER, *supra* note 123, at 54 (noting that the concept of a human right to health "has not been operationally defined"); Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights Issue*, *in* RENDERING JUSTICE TO THE VULNERABLE 161, 162 (Fons Coomans et al. eds., 2000) ("The efforts to clarify the right to health have often been either too theoretical or, alternatively, too detailed and unfocused, resulting in the widespread view that the right to health is an elusive concept and difficult to make operational.").

132. Evans, *supra* note 44, at 199-203 (noting the liberal consensus on human rights "accepts civil and political claims as human rights but relegates socioeconomic claims, including the right to health, to the status of aspirations").

133. According to rights scholars, the essential minimum core content of an economic, social, or cultural right "corresponds with an absolute minimum level of human rights protection, a level of protection which States should always uphold independent of the state of the economy or other disruptive factors in a country." Hendriks, *supra* note 1, at 394 (1998). While not originally implemented through the ICESCR, scholars, based upon the preparatory documents of the ICESCR, have developed a doctrine of "minimum core" to concretize economic, social and cultural rights in the face of the principle of progressive realization. *See* The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, U.N. Doc. E/CN.4/1987/17, Annex, (June 2-6, 1986), *reprinted in* 9 HUM. RTS. Q. 122 (1987) (memorializing the "minimum core" doctrine). As noted subsequently by the CESCR, "[i]n order for a State party to be able to attribute its failure to meet *at least its minimum core obligations* to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations." *General Comment 3*, supra note 127, ¶ 10.

134. TOEBES, *supra* note 1 (*quoting Soobramoney v. The Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) at 774 (S. Afr.) (finding a right to emergency medical care where there exists a "sudden catastrophe which calls for immediate medical attention"); REBECCA J. COOK ET AL., REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW 191 (2003) (noting that pursuant to the right to health "[t]he Constitutional Court of South Africa has found that anti-retroviral treatment . . . should . . . be available for all pregnant women [with HIV]"); *see also General Comment 14*, *supra* note 108, ¶¶ 43-44. *But cf.* Chapman, *supra* note 1, at 203-04 (interpreting General Comment 14 to provide a far more expansive list of core obligations than those enumerated in the text accompanying this footnote). For a discussion and analysis of General Comment 14's elaboration of the right to health, see *infra* Part III.B.

tent of the right to health,[135] the right to health can be seen to require states to procure all essential drugs for all who need them, an obligation few states can fulfill.[136] For the right to health to have meaning for governments, it must create concrete obligations, but those obligations must be capable of realization in the vast majority of states independent of their respective level of economic development.[137] As a result of this and other unresolved conceptual issues within the core content of the right to health, the legal content of even these fundamental conceptions of health remains insecure.[138]

Beyond providing for the minimum core content of the right to health, the level below which the right would lose all significance, the right to health requires only that states take steps toward the "progressive realization" of the right to health.[139] As a positive right, the right to health is resource-dependent. In accordance with the principle of progressive realization, enacted through Article 2 of the ICESCR, a state must take steps to operationalize the right to health only "to the maximum of its available resources, with a view to *achieving progressively the full realization of the rights*."[140] Thus, the universality of human rights loses its rigidity in the context of health. With health, as with other economic, social, and cultural rights, the "lexical primacy that is commonly thought to attend human rights does not seem to apply."[141] Under the ICESCR's conception of the

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135. *See supra* note 99 and accompanying text (applying the WHO's definition of "essential medicines").

136. *See* Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social, and Cultural Rights*, 16 HUM. RTS. Q. 693, 702 (1994) (noting that "there is an assumption, though a rebuttable one in the eyes of the [CESCR], that every state possesses sufficient resources for subsistence purposes if they define resources broadly enough and are sufficiently aggressive in resource acquisition").

137. For a discussion on the appropriateness of having core obligations in light of extremely limited national budgets, see Chapman, *supra* note 1, at 195- 97.

138. *Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 39 ("Although there is a growing national and international jurisprudence on the right to health, the legal content of the right is not yet well established."). *But cf.* Yamin, *supra* note 1, at 336 (arguing after the promulgation of General Comment 14, that "it can no longer be argued that the content of the right to health is unduly vague for implementing legislation or enforcement, or that it sets out merely political aspirations").

139. ICESCR, *supra* note 2, art. 2.

140. *Id.* (emphasis added). Many rights within the ICESCR present only an "obligation of result" under Article 2(1), obligating states to achieve a particular result but giving states a free hand under the principle of progressive realization to decide the means most appropriate to achieve that result. Thus, with states given total discretion to decide the means necessary to achieve the obligated result, "there would be little basis upon which to judge whether or not they were acting in good faith." MATTHEW C.R. CRAVEN, INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 107 (1995). In order to provide measurable indicators of a state's provision of health care pursuant to the right to health, the WHO is currently developing guidelines to assess the availability, accessibility, acceptability, and quality of health services. COOK ET AL., *supra* note 134, at 189.

141. TIMOTHY STOLTZFUS JOST, READINGS IN COMPARATIVE HEALTH LAW AND BIOETHICS 4 (2001); David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1, 46 (1999) (arguing that "the principle of progressive realization undermines the establishment of a universal health baseline of basic public health services and information

right to health, states may justifiably differ in their actions based upon their respective political will, disease prevalence, and economic resources, so long as their compliance efforts "move as expeditiously and effectively as possible towards the full realization of Article 12."[142]

This progressive standard for state obligations has set the conditions for a "flawed enforcement mechanism," through which no state can be held to account for its failure to achieve healthy conditions.[143] Because enforcement of the ICESCR is accomplished largely through self-reporting by state parties, with a monitoring body that has no authority to criticize state reports or sanction states,[144] no "international body has any power under the ICESCR to proclaim a state party is in violation of its obligations under the right to health or to order more money be spent on health or different health policies be pursued."[145] In lieu of effective international adjudication, scholars have advocated the use of national adjudication[146] and shaming of national governments by non-governmental organizations under the standards set by the right to health.[147] These enforcement

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because the principle renders health standards relative to the availability of economic resources"); *see* OBIJIOFOR AGINAM, GLOBAL HEALTH GOVERNANCE: INTERNATIONAL LAW AND PUBLIC HEALTH IN A DIVIDED WORLD 39 (2005) (noting that the "vagueness" of the principle of progressive realization "has offered an escape route to state parties to the ICESCR, thus leading to the unfortunate conclusion that the right to health is an illusion"). Because of the governmental discretion afforded in the implementation of positive rights, judicial bodies have been largely stripped of their authority to interpret and monitor state compliance with the right to health. *See* COOK ET AL., *supra* note 134, at 152 (noting that the right to reproductive choice has been successfully asserted as a negative right but not as a positive right).

142. *General Comment 14*, *supra* note 108, ¶ 31; FIDLER, *supra* note 12, at 184 ("The principle of progressive realization stands, therefore, for two propositions: (1) the ability of States to fulfill the right to health differs because their economic resources differ; and (2) the different levels of economic development . . . mean that not all countries will enjoy an equivalent standard of health."); Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 52 (1994) ("Implementation involves policy driven allocative judgments which are not based solely on principles or policies, but which are based also on political and economic considerations."); Kinney, *supra* note 1, at 1471 ("[T]he issue of how General Comment 14 will be interpreted, implemented and enforced in states parties at different stages of economic development and with markedly different cultures and values will still be a challenge.").

143. George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 VAND. J. TRANSNAT'L L. 1295 (2005) (finding fault in the right to health in its indeterminacy, justiciability, and progressive realization, with the latter flaw acting to the detriment of the former two); *see, e.g.*, Robertson, *supra* note 136, at 702 (recognizing that "an international body cannot substitute its judgement [sic] for that of a state government where resource allocations are being made").

144. *See* R. Andrew Painter, *Human Rights Monitoring: Universal and Regional Treaty Bodies*, *in* ADMINISTRATIVE AND EXPERT MONITORING OF INTERNATIONAL TREATIES 49, 53 (Paul C. Szasz ed., 1999) (noting that "[t]he absence of any inter-state or individual petition procedures reflects the margin of appreciation given to states parties in their efforts to 'progressively achieve' the [ICESCR's] substantive rights").

145. Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 CHIC. J. INT'L L. 105, 108 (2002).

146. *See, e.g.*, Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUB. HEALTH 1156 (2005).

147. *See, e.g.*, COMMONWEALTH MEDICAL ASSOCIATION, MONITORING AND PROMOTING THE RIGHT TO HEALTH: A MANUAL FOR NGOS (2000); JUDITH ASHER, THE RIGHT TO HEALTH: A

mechanisms, operating outside of international legal bodies, have met with mixed results.[148]

The seminal flaw, this Article contends, is that despite the lofty language of health for all, the right to health has been advanced in the ICESCR as an individual right, focusing on individual access to health services at the expense of collective health promotion and disease prevention programs through public health systems. This limited, atomized right to health has not been effective in forcing states to recognize individual health as a fundamental human right[149] because individuals and communities lack even the basic international legal standing to hold states accountable for their failure to uphold the right to health.[150] Compounding the harm, this constrained and unenforced right to health, relying predominantly on curative medical care,[151] has left public health systems impotent to address an expanding set of societal health claims, creating a legacy of deteriorating national health systems unable to respond to the growing needs of vulnerable populations.[152] Despite developments in public health since the original drafting of the ICESCR, the right to health—through processes of path dependence[153]—remains fixed on a curative or clinical model of

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RESOURCE MANUAL FOR NGOS (2004), *available at* http://shr.aaas.org/Right_to_Health_Manual/index.shtml (select "entire pdf").

148. *Compare* George J. Annas, *The Right to Health and the Nevirapine Case in South Africa*, 348 NEW ENG. J. MED. 750 (2003) (finding the South African Constitutional Court's decision in support of the right to health to lead to the provision of AZT to HIV-positive pregnant women), *with* Torres, *supra* note 145, at 114 (noting that the Venezuelan government disregard of the Venezuelan Supreme Court's decision in *Cruz Bermúdez et al. v Ministerio de Sanidad y Asistencia Social* where the court held that the government's failure to provide those living with HIV/AIDS with access to antiretroviral therapies violated their right to health, "contributes to the widespread perception that the right to health is symbolic rather than vital to the life of the nation").

149. Fidler, *supra* note 141, at 40 (noting that "these debates [surrounding the right to health] have not advanced the right to health much as a matter of international law").

150. Hendriks, *supra* note 1, at 391-92 (discussing the lack of an international system of supervision for the right to health). *See generally* J.K. Mapulanga-Hulston, *Examining the Justiciability of Economic, Social and Cultural Rights*, INT'L J. HUM. RTS., Winter 2002, at 29 (noting that economic, social, and cultural rights should be recognized to the same extent as are civil and political rights).

151. *See* Maria Stuttaford, *Balancing Collective and Individual Rights to Health and Health Care*, L. SOC. JUST. & GLOBAL DEV. 5, 8 (2004) (noting that "a rights based approach focuses on the interests of the individual rights-holder and excludes the interests of the community and that this may lead to disproportionate benefits to the informed and articulate and to those with the greatest resources at their disposal") (citations omitted).

152. Katarina Tomasevski, *Health*, *in* 2 UNITED NATIONS LEGAL ORDER 859, 859 (Oscar Schachter & Christopher C. Joyner eds., 1995) ("There is no agreement on the specific obligations of States in providing access to health care to all of its population, let alone whether it is obliged to undertake the provision of health care services at all."); Lynn Freedman, *Strategic Advocacy and Maternal Mortality: Moving Targets and the Millennium Development Goals*, 11 GENDER & DEV. 97, 103-04 (2003).

153. Path dependence is a concept from the social sciences, denoting a state in which "contingent events set into motion institutional patterns or event chains that have deterministic properties," hampering evolutionary advancement. James Mahoney, *Path Dependence in Historical Sociology*, 29 THEORY & SOCIETY 507, 507 (2000); *see also* Gerald Alexander, *Institutions, Path Dependence, and Democratic Consolidation*, 13 J. THEORETICAL POLITICS 249 (2001) (reviewing "path dependency" in the political science

health,[154] quixotically advancing individual medical solutions to problems requiring societal change through public health systems.[155] These dichotomized medicine-public health discourses have contributed to ambiguity in implementing the right to health,[156] stymieing efforts to operationalize the right to health through public health programs. Thus, while public health has evolved to meet changing health needs, the right to health has not evolved to meet this changing conception of health.

B. Medicine vs. Public Health

The term "public health" refers generally to the obligations of a government to fulfill the collective rights of its peoples to the "conditions in which people can be healthy."[157] Whereas medicine focuses primarily on individual curative treatments in clinical settings, public health—a form of social medicine[158]—protects and promotes[159] the health of entire societies,[160] employing multi-disciplinary, multi-agency interventions to

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literature to explain why political outcomes persist over time and remain difficult to change).

154. As noted by Audrey R. Chapman:

> Historically, health systems were developed on a curative or clinical model of health. More recently, advances in epidemiological research have sensitised policymakers to the importance of public health interventions and preventive strategies of health promotion. Social science research has also underscored the importance of social, economic, gender, and racial factors in determining health status. Nevertheless, governments have often failed to develop a comprehensive approach to health reflecting these insights.

Chapman, *supra* note 1, at 187.

155. Beauchamp, *infra* note 201, at 270 ("Market-justice [as opposed to social justice] is perhaps the major cause for our over-investment and over confidence in curative medical services. . . . But the prejudice found in market-justice against collective action perverts these scientific advances into an unrealistic hope for 'technological shortcuts' to painful social change." (citation omitted)); Chapman, *supra* note 1 at 213 ("The resurgence of some diseases, tuberculosis and malaria for example, results primarily from the deterioration of public health services, rather than from a lack of treatment alternatives.") (citing Anne E. Platt, *Infecting Ourselves: How Environmental and Social Disruptions Trigger Disease*, 129 Worldwatch Paper 10 (1996)). The reasons underlying the path dependence of the right to health in its curative conceptualization are too multifaceted for review in the present Article but will be explored in far greater detail in a forthcoming book by the author.

156. Chapman, *supra* note 1, at 187 ("Differences in the approach to health offered by the disciplines of medicine and public health contribute to the conceptual problems related to interpreting the right to health.").

157. INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 7 (1988).

158. *See* Howard Waitzkin et al., *Social Medicine Then and Now: Lessons from Latin America*, 91 AM. J. PUB. HEALTH 1592, 1594 (2001) ("[M]uch work in social medicine envisions populations, as well as social institutions, as totalities whose characteristics transcend those of individuals. Social medicine therefore defines problems and seeks solutions with social rather than individual units of analysis.")

159. For a description of the process through which the 1986 Ottawa Charter for Health Promotion added "health promotion" to public health's core mandate of "health protection," see John Raeburn & Sarah Macfarlane, *Putting the Public into Public Health: Towards a More People-Centred Approach*, *in* GLOBAL PUBLIC HEALTH: A NEW ERA 243, 245 (Robert Beaglehole ed., 2003).

160. D.E. Beauchamp & B. Steinbock, *Population Perspective*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH 25, 25 (Dan E. Beauchamp & Bonnie Steinbock eds., 1999) ("Whereas

address the collective causes of health and disease.[161] Through this expanded conception of health, public health seeks not just the highest attainable standard of health for the individual, but the widest distribution of health benefits throughout society.[162] Thus, in meeting the challenges of globalization and alleviating harm to societies, public health approaches aim "to achieve the greatest good for the greatest number,"[163] narrowing inequity in health while improving the health status of the most vulnerable.

As compared with individual medical treatments, which are largely dependent on individual public and private physicians, public health is dependent for its results on the institution of legal frameworks for societal regulation.[164] In this context, public health law provides for the

> Legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population), and the limitations on the power of the state to constrain the autonomy, privacy, liberty, or other legally protected interests of individuals for protection or promotion of community health.[165]

Through the enactment of public health law, governments can create the bureaucratic infrastructures and regulatory measures necessary to develop, as discussed below, the collective public health responses, behavioral norms, and social conditions necessary to assure the health of societies.

In developing the legislative frameworks necessary for public health policy, a succession of public health paradigms have been developed to conceptualize determinants of health, with each model serving to create unique policy approaches to disease prevention and health promotion.

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in medicine, the patient is an individual person, in public health, the 'patient' is the whole community or population.").

161. BEAGLEHOLE & BONITA, *supra* note 129, at 147, box 7.1 (listing the "essential elements of modern public health theory and practice"); FRASER BROCKINGTON, WORLD HEALTH 131 (2d ed. 1968) (defining public health as "[t]he application of scientific and medical knowledge to the protection and improvement of the health of the group"); McMichael & Beaglehole, *supra* note 16, at 495 ("Broadly defined, public health is 'the art and science of preventing disease, promoting health, and extending life through organised efforts of society.'" (quoting INDEPENDENT INQUIRY INTO INEQUALITIES IN HEALTH (Sir Donald Acheson, Chairman, 1998)).

162. *See* Uwe E. Reinhardt, *Operating Under a Global Budget: Perspectives from the United States and Abroad*, *in* INST. OF MED., CHANGING THE HEALTH CARE SYSTEM: MODELS FROM HERE AND ABROAD 68, 70 (1994).

163. Peter D. Jacobson & Soheil Soliman, *Co-opting the Health and Human Rights Movement*, 30 J. L. Med. & Ethics 705, 709 (2002).

164. *See* FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL 4 (2d ed. 1990) ("The field of public health . . . could not long exist in the manner in which we know it today except for its sound legal basis.").

165. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 4 (2000) [hereinafter GOSTIN, PUBLIC HEALTH LAW]; *see also* Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999) [hereinafter Gostin et al., *The Law and the Public's Health*]; Lawrence O. Gostin & James G. Hodge, Jr., *The Public Health Improvement Process in Alaska: Toward a Model Public Health Law*, 17 ALASKA L. REV. 77, 85 (2000) (enumerating the characteristics that distinguish public health law from medicine and the law).

Beginning at the end of the nineteenth century[166] under a "microbial model" of public health, governments focused on the spread of diseases, both communicable and noncommunicable, seeking to prevent the spread of pathogens responsible for illness.[167] Applying the "germ theory" of public health to associate a disease with a specific microbial infection, public health responses during this period targeted the pathogen—looking to the environmental conditions (e.g., water, air), food source, vector (e.g., mosquitoes), or human host responsible for disease transmission—and sought either to limit its transmission (e.g., isolation or inoculation) or prevent the conditions in which it flourished (e.g., meat inspection).[168] To accomplish these goals, epidemiologists engaged in aggressive forms of surveillance and contact tracing, sometimes engendering public opposition,[169] to monitor and study the progression of the incidence (new cases) and prevalence (existing cases) of disease.[170] In responding to these diseases, national and international public health programs addressed communicable diseases through hygiene and sanitation programs, vector eradication, and vaccination; for noncommunicable disease, these programs focused on sanitary engineering and the provision of safe water, milk, and food.[171]

This microbial model, reinforced by the discovery of disease etiologies and disease-specific medications, pervaded global public health theory until well past the Second World War.[172] With medical advancements of the Second World War resulting in groundbreaking strides against communicable disease, the microbial model led scholars to believe that a specific medicine would be all that was necessary to treat the afflicted and halt the spread of disease.[173] While communicable and noncommunicable disease prevalences remained undented in the developing world, contemporary public health scholars felt that the benefits of antimicrobial medicine

166. Prior to the end of the nineteenth century, public health, then in the early secular stages of its "Sanitary Era," focused on notions of health governed by the theory of miasma, which held that disease was the result of "poisoning by foul emanations from the soil, water, and environing air." Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: I. Eras and Paradigms*, 86 AM. J. PUB. HEALTH 668, 669 (1996).

167. *Id.* at 669-70.

168. GOSTIN, PUBLIC HEALTH LAW, *supra* note 165, at 177.

169. An example of public opposition to disease surveillance is seen in the constitutional challenges to contact tracing of HIV in the United States. *See* Scott Burris, *Public Health, "AIDS Exceptionalism" and the Law*, 27 J. MARSHALL L. REV. 251, 252 (1994); Gostin et al., *The Law and the Public's Health*, *supra* note 165, at 71 ("Germ-based interventions encounter the stiffest public opposition when controlling or identifying the microbe means controlling or identifying the person who has it, and the disease itself exposes its carriers to discrimination, ostracism, and other social risks.").

170. Gostin et al., *The Law and the Public's Health*, *supra* note 165, at 70.

171. AGINAM, *supra* note 141, at 48-53; PANNENBORG, *supra* note 28, at 180-83.

172. GEORGE ROSEN, A HISTORY OF PUBLIC HEALTH 319-486 (1958).

173. Susser & Susser, *supra* note 166, at 670 ("Once the major infectious agents seemed all to have been identified and communicable disease no longer overwhelmed all other mortal disorders, the force of the germ theory paradigm faded. . . . [F]ew anticipated the recrudescence of communicable disease or new global epidemics.").

would, in time, lead to the global eradication of all disease.[174]

With infectious disease then thought to be a challenge overcome, developed states reduced expenditures for public health systems, leading scholars in these states to seek out new disease models to account for the unhealthy conditions that remained despite medication.[175] Under a new "behavioral model" of disease, public health practitioners then examined how individual unhealthy behaviors could lead to both infectious and chronic disease.[176] Seeking to undermine harmful risk factors such as smoking and alcohol use, this chronic disease era moved away from the microbial model's focus on the structural or societal determinants of disease, shifting researchers' attentions to individual-level behaviors and choices.[177]

Most recently, the rise of the "ecological model" has led researchers to examine structural underlying determinants of health.[178] In the early 1990s, a growing number of public health researchers began to question the behavioral model's emphasis on interventions that addressed only the proximal causes of disease (individual risk factors and lifestyle choices) with little consideration of the broader distal social conditions that structure health.[179] Through this appreciation of the impact of social condi-

174. This era is defined paradigmatically by the 1967 declaration of the U.S. Surgeon General that "the time has come to close the book on infectious diseases." ANNUAL REPORT OF THE SURGEON GENERAL (1967); PUBLIC HEALTH SERVICE, U.S. DEPT. OF HEALTH, EDUCATION, AND WELFARE, SMOKING AND HEALTH: REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE (1964).

175. Dana March & Ezra Susser, *The Eco- in Eco-Epidemiology: The Evolution of Ideas*, *in* ANNALS EPIDEMIOLOGY (forthcoming 2006) ("The sharp decline in mortality due to infectious diseases in developed countries in the first half of the twentieth century ushered in an era characterized by concern with 'chronic' diseases, such as cancers and cardiovascular diseases." (citing CHRONIC DISEASES AND PUBLIC HEALTH (Abraham M. Lilienfeld & Alice J. Gifford eds., 1966); J.N. NORRIS, USES OF EPIDEMIOLOGY (1957)); Mervyn Susser, *Epidemiology in the United States After World War II: The Evolution of Technique*, 7 EPIDEMIOLOGIC REV. 147 (1985).

176. GOSTIN, PUBLIC HEALTH LAW, *supra* note 165, at 178; *see also* March & Susser, *supra* note 175 (noting that the behavioral model, examining individual risk factors, "was well suited to the dominant concepts of biological individualism during this period" (citing N. Krieger, *Epidemiology and the Web of Causation: Has Anyone Seen the Spider?*, 39 SOC SCI MED. 887 (1994)).

177. March & Susser, *supra* note 175 ("As the risk factor thought collective achieved paradigmatic status, epidemiologic inquiry into infectious diseases was relegated to the periphery. A divide between risk factor epidemiology and infectious disease epidemiology grew over time into a yawning gulf."); Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 AM. J. PUB. HEALTH 1607, 1609 (1997); A. J. McMichael, *Prisoners of the Proximate: Loosening the Constraints on Epidemiology in an Age of Change*, 149 AM. J. EPIDEMIOLOGY 887, 889-90 (1999).

178. Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: II. From Black Box to Chinese Boxes and Eco-Epidemiology*, 86 AM. J. PUB. HEALTH 674 (1996).

179. *See* McMichael, *supra* note 177, at 887 (advocating for a "social-ecologic systems perspective" to public health); Mervyn Susser, *Does Risk Factor Epidemiology Put Epidemiology at Risk? Peering into the Future*, 52 J. EPIDEMIOLOGY & COMMUNITY HEALTH 608, 609-10 (1998). These later ecologically-oriented examinations stem from earlier attempts by epidemiologists to invoke a population-centered approach to public health. *See, e.g.*, J.N. MORRIS, USES OF EPIDEMIOLOGY (1957); MERVYN SUSSER, CAUSAL THINKING IN THE HEALTH SCIENCES (1973).

tions on individual health outcomes, in particular on noncommunicable diseases, the ecological model "implicates our collective responsibility for unhealthy behavior," with public health practitioners examining underlying determinants of health, including "the causes of disease in the way society organizes itself, produces and distributes wealth, and interacts with the natural environment."[180]

The ecological model, gaining widespread acceptance in the public health community,[181] has become the focus of those seeking to improve health indicators through human rights frameworks.[182] Many among the "human rights as public health" movement espouse a broad definition of public health, which extends beyond the traditional health field[183] and encompasses the alleviation of human rights violations that are distal root causes of illness and disease, among them war, crime, hunger, poverty, illiteracy and homelessness.[184] Despite criticisms of this synoptic conception of health,[185] a focus on structural etiologies, often referred to as "structural violence,"[186] is gaining consensus among public health schol-

180. Gostin et al., *The Law and the Public's Health*, *supra* note 165, at 64; *see also* Richard Parker & Peter Aggleton, *HIV and AIDS-related Stigma and Discrimination: A Conceptual Framework and Implications for Action*, 57 SOC. SCI. & MED. 13, 23 (2003).

181. *See* March & Susser, *supra* note 175 (tracing the intellectual history of the ecological model); *e.g.*, Link & Phelan, *supra* note 17 (creating a meta-analysis of public health studies on underlying determinants of health under the ecological model).

182. *E.g.*, Solomon R. Benatar, *Global Disparities in Health and Human Rights: A Critical Commentary*, 88 AM. J. PUB. HEALTH 295, 298-99 (1998).

183. Robert Beaglehole & Ruth Bonita, *Strengthening Public Health for the New Era*, *in* GLOBAL PUBLIC HEALTH: A NEW ERA, *supra* note 159, at 253, 257.

184. Ilan H. Meyer & Sharon Schwartz, *Social Issues as Public Health: Promise and Peril*, 90 AM. J. PUB. HEALTH 1189, 1189 (2000) (noting the perils inherent in the "public healthification" of social problems). The "human rights and health" movement, tirelessly championed by the late Jonathan Mann, mentions income redistribution as a means to improving the health of peoples in developing states. George J. Annas, *Human Rights and Health—The Universal Declaration of Human Rights at 50*, 339 NEW ENG. J. MED. 1778, 1779 (1998).

185. These critics argue, for example, that "labeling so many activities as public health does little if anything to eliminate the problem of poor health." Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J. L. MED. & ETHICS 144, 144-45 (2002); *see also* Amy Fairchild & Gerald Oppenheimer, *Public Health Nihilism vs. Pragmatism: History, Politics, and the Control of Tuberculosis*, 88 AM J. PUB. HEALTH 1105 (1998) (arguing that a false choice has been created, in the case of tuberculosis, between broad social change and targeted public health interventions); Lawrence O. Gostin, *Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann*, 29 J. L. MED. & ETHICS 121, 123 (2001) (highlighting the problems with an expansive and all-inclusive view of public health, including the field's resultant lack of "precision" and "discrete expertise" as well as the risk of the field "overreaching and invading a sphere reserved for politics"). As a result of these arguments, there remain debates concerning the relative impact of broad strides in economic and infrastructural development versus targeted public health interventions as the locus of improved population health. *See* Paul Farmer & Edward Nardell, *Editorial: Nihilism and Pragmatism in Tuberculosis Control*, 88 AM. J. PUB. HEALTH 1014 (1998).

186. Paul Farmer has coined the term "structural violence" as a rhetorical tool to highlight the violence to health that arises from structural and power-based inequalities, including those rooted in gender, ethnicity, religion, and social class. *See generally* PAUL FARMER, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR (2003).

ars, who argue that "public health cannot be separated from its larger socioeconomic context."[187]

In focusing analyses within this far-reaching public health framework, health interventions can best be mapped by examining the continuum on which these programs operate:

Individual Health → Population Health → Public Health

While many include population health–individual health measures performed on a number of individuals–within the purview of public health,[188] others find that this conflation "fails to establish any meaningful lines of demarcation between individual health and public health."[189] But it is for this reason that including population health within public health is so attractive. Public health includes more than purely public goods such as clean air and water. For example, if a nation provides family planning services, is it only the cumulative health of a large group of individuals at stake, or is it the public's health? Does smoking cessation involve the health of many individual smokers or is this, too, a public health issue? Securing population health is not merely the health of many individual persons, but a collective "public" good that is greater than the sum of its constituent parts.[190]

While the ecological model has gained widespread acceptance among public health scholars, this approach has not yet been taken up by human rights scholars seeking to address health rights. With the individual right to health incapable of responding to societal problems through the tools of public health regulation,[191] public health scholars have turned to practical interventions.[192] Although states have long recognized a responsibility to protect their populations from "obvious risks and hazards to their

187. Meyer & Schwartz, *supra* note 184, at 1189.

188. These concepts are defined in widely divergent terms, with some scholars reversing the latter two elements of this continuum, for example, Daniel M. Fox, *Populations and the Law: The Changing Scope of Health Policy*, 31 J.L. MED. & ETHICS 607, 607 (2003) (arguing that population health "includes but is not limited to what is generally called public health"). Others use the two concepts interchangeably. David P. Fidler, *Racism or* Realpolitik*? U.S. Foreign Policy and the HIV/AIDS Catastrophe in Sub-Saharan Africa*, 7 J. GENDER RACE & JUST. 97, 117 (2003) ("Theoretically, 'public health' is about the protection . . . of population health, as opposed to focusing on the health of the individual.").

189. Rothstein, *supra* note 185, at 145.

190. *See* McMichael & Beaglehole, *supra* note 16, at 495 (noting recently shared epidemiological views that "a population's health reflects more than the simple aggregation of the risk-factor profile and health status of its individual members"). As a cautionary note, however, Gostin et al. posit that "[a]ny activity that aims to encompass environmental protection, medical care, personal behavior, and the 'development of social machinery' for health makes ambitious, if not hubristic, claims of jurisdiction." Gostin et al., *The Law and the Public's Health*, *supra* note 165, at 69.

191. *Supra* Part II.A.

192. *See, e.g.*, FARMER, *supra* note 186 (arguing for the practical need to "scale up" public sectors for the provision of essential medicines and interventions for public health).

health,"[193] scholars, as discussed in the following section, have developed varied practical interventions to influence "underlying determinants" of health.[194]

C. Public Health as a Public Good: Understanding the Underlying Determinants of Health

Under this expansive, "ecological" view of public health, programs and practitioners respond to the fundamental social structures affecting public and population health, addressing, *inter alia*, disease outbreaks, patterns of population growth, distributive justice, and deleterious lifestyle trends. By examining the underlying political, social, and behavioral determinants of health inequalities, public health research can be applied by local, national, and global governance structures to create the public health systems necessary to stem the health inequities brought about by globalization.[195]

Bruce Link and Jo Phelan created the first meta-analysis of the epidemiologic basis for understanding underlying determinants of health.[196] In doing so, they criticized medical discourses for their "focus on the connection of social conditions to single diseases via single mechanisms at single points in time," noting that such a framework "neglects the multifaceted and dynamic processes through which social factors may affect health and, consequently, may result in an incomplete understanding and an underestimation of the influence of social factors on health."[197] They contrasted this conceptualization of underlying determinants of health with the predominant view of individual rights, characterizing the latter by noting that "[t]he focus on proximate risk factors, potentially controllable at the individual level, resonates with the value and belief systems of Western culture that emphasize both the ability of the individual to control his or her personal fate and the importance of doing so."[198]

Evolving discourses on underlying determinants of health has led to broader public health analyses of social construction. In doing so, these approaches "pushed [public health scholars] away from . . . early preoccupation with diverse forms of risk behavior, understood in largely individualistic terms, toward a new understanding of vulnerability as socially, politically, and economically structured, maintained, and organized."[199] Through these discourses, there grew an appreciation of public health as a

193. Leary, *supra* note 124, at 486; *see also* David P. Fidler, *A Globalized Theory of Public Health Law*, 30 J. L. MED. & ETHICS 150, 156 (2002) ("The frequency with which states have used international law for the purpose of protecting and promoting human health speaks not only to states' legal powers to assure healthy conditions, but also to their respective duties to do so.").

194. Gostin, *supra* note 185, at 122-23 (discussing various views of the determinants of public health).

195. McMichael & Beaglehole, *supra* note 16, at 495.

196. *See* Link & Phelan, *supra* note 17.

197. *Id.* at 81.

198. *Id.* at 80 (citing Marshall H. Becker, *A Medical Sociologist Looks at Health Promotion*, 34 J. HEALTH & SOC. BEHAVIOR 1 (1993)).

199. Parker, *supra* note 20, at 41 (emphasis in original).

public good. Among public goods making up public health, scholars and practitioners have emphasized a variety of shared social, environmental, and structural factors—including clean water and air, food, shelter, sanitation, education, employment, wealth, health infrastructures, social stability, and security from violence and discrimination—finding these underlying determinants of health potentially more important than medicines and health services in promoting public health.[200] Pursuant to this broader construction of health, public health systems can be seen to alleviate harmful societal determinants of health and assure the provision of public goods necessary for beneficial health outcomes.[201]

However, while public health scholarship has come to appreciate the role of structural forces in determining health status, the right to health has remained mired in largely ineffective individualistic discourses. As noted by Audrey Chapman:

> Historically, health systems were developed on a curative or clinical model of health. More recently, advances in epidemiological research have sensitised policymakers to the importance of public health interventions and preventive strategies of health promotion. Social science research has also underscored the importance of social, economic, gender, and racial factors in determining health status. Nevertheless, governments have often failed to develop a comprehensive approach to health reflecting these insights.[202]

Consequently, human rights scholars, employing an individual right to health—a right drafted at an unrepresentative time, when advances in medicine and curative technology led physicians to believe that a state of "complete" health was possible[203]—have been unable to respond to globalization's health harms.[204] It is imperative that international law take account of this changing understanding of health, codifying the state obligations necessary to respond to the unhealthy manifestations of globalization.

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200. For a discussion of public goods, public health as a public good, and the role of human rights in realizing public goods, see *infra* Part III.C.1.

201. Dan Beauchamp, *Community: The Neglected Tradition of Public Health*, HASTINGS CENTER REP., Dec. 1985, at 28, 29 ("[P]ublic health and safety are not simply the aggregate of each private individual's interest in health and safety . . . . Public health and safety are community or group interests.").

202. Chapman, *supra* note 1, at 187 (footnotes omitted).

203. PANNENBORG, *supra* note 28, at 82 (noting that advances in medicine "initiated the *absolute* disease-orientation thereby creating the conterminality of health and medicine" (citations omitted)); Mervin Susser, *Ethical Components in the Definition of Health*, 4 INT'L J. HEALTH SERVICES 539 (1974).

204. As noted by Australian High Court Justice Michael Kirby in the context of evaluating the UDHR,

> The [UDHR] did not foresee the many new problems for human rights that have come along in the past fifty years, such as the rights of people living with HIV/AIDS, the huge problems of health and poverty associated with the world's great population increase, and the staggering debt burdens of most countries of the Third World.

Kirby, *supra* note 130, at 13 (citing E. Dumbutshena, *Human Rights in the 21st Century*, *in* COMMONWEALTH LAW CONFERENCE: CONFERENCE PAPERS 604 (1990)).

III. A Collective Right to Public Health

Many scholars have looked to human rights in response to the harms of globalization. Despite years of human rights scholarship and advocacy, however, there remain debates surrounding even the recognition and applicability of existing social and economic human rights in addressing the consequences of globalization.[205] The author finds that these lingering questions stem from an individualistic conception of human rights that is incapable of speaking to the societal ramifications of globalization. It is at the collective level—the level at which globalization operates—that human rights must respond. By transmuting human rights discourse from individual to collective human rights, human rights can combat globalization's insalubrious effects, giving states the discursive tools required to fulfill the public's right to health through public health systems.

With globalization impacting entire societies, collective rights and their corollary implementation mechanisms become necessary to assure the collective action required to provide for the tools and shared benefits of public health. Legal discourses surrounding health and human rights often fail to view public health itself as a human right. While it has long been held that promoting the general welfare is inherent in state authority, it has not heretofore been presented in the lexicon of human rights as an obligation of the state. Collective solidarity rights acknowledge this obligation, "assigning rights and obligations to the principal agents able to advance global public goods in the late twentieth century,"[206] thus addressing the provision of public goods at the societal level. In the case of advancing health rights, this involves assigning rights at the societal level to public health systems.

Although the tension between individual human rights and governmental public health measures dominates health and human rights discourse,[207] particularly in the wake of bioterrorism fears and the SARS pandemic,[208] emphasis on this conflict undermines health rights. Whereas many Western scholars focus on individual negative rights, i.e.,

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205. *See* RICHARD FALK, HUMAN RIGHTS HORIZONS: THE PURSUIT OF JUSTICE IN A GLOBALIZING WORLD 48 (2000) (noting that through neoliberal policy, "[h]uman rights are narrowed to the point where only civil and political rights are affirmed"); *see also* BRITISH MEDICAL ASSOCIATION, THE MEDICAL PROFESSION AND HUMAN RIGHTS: HANDBOOK FOR A CHANGING AGENDA 314 (2001) (recognizing "that there is still considerable debate about whether the language of human rights is applicable to issues of poverty, justice and equity in health").

206. Stephen Marks, *The Human Right to Development: Between Rhetoric and Reality*, 17 HARV. HUM. RTS. J. 137, 138 (2004).

207. James F. Childress & Ruth Gaare Bernheim, *Beyond the* LIBERAL AND COMMUNITARIAN IMPASSE: A FRAMEWORK AND VISION FOR PUBLIC HEALTH, 55 FLA. L. REV. 1191, 1193 (2003) (noting that "much of the debate about public health concerns when government may justifiably coerce individuals"); *e.g.*, LAWRENCE GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 43-55 (1997); JONATHAN M. MANN, *Medicine and Public Health, Ethics and Human Rights*, *in* HEALTH AND HUMAN RIGHTS: A READER, *supra* note 123, at 439, 444-46; SUSAN KING, *Vaccination Policies: Individual Rights v. Community Health*, 319 BRIT. MED. J. 1448, 1449 (1999).

208. *See, e.g.*, George J. Annas, *Bioterrorism, Public Health, and Civil Liberties*, 346 NEW ENG. J. MED. 1337 (2002) (bioterrorism); Sofia Gruskin, *Is There a Government in*

those that restrain government action from infringing upon individual liberties,[209] a positivistic human rights framework acknowledges that governments must act affirmatively to fulfill the economic, social and cultural components of human rights.[210] Fulfilling these positive components of health rights will require fulfillment of both individual and collective rights, including rights belonging to minorities, peoples, and societies.[211]

The realization of collective rights in a globalized world demands international cooperation.[212] In collectivizing rights discourse at the societal level, a right to public health would provide a powerful additional voice to the demand for national and global redistribution of health resources. Applying human rights impact statements to development programs, a human right to public health would build support for elevating economic, social and cultural rights above the needs of economic development, using public health systems as a means to achieve global justice.

A. Third Generation Human Rights - The Rise of Collective Human Rights

Human rights were initially conceived following the Second World War solely as individual rights.[213] Whereas rights had previously been accorded to minority groups, to protect them in the aftermath of the First

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the Cockpit: A Passenger's Perspective or Global Public Health: The Role of Human Rights, 77 TEMP. L. REV. 313 (2004) (SARS).

209. JÜRGEN HABERMAS, BETWEEN FACTS AND NORMS: CONTRIBUTIONS TO A DISCOURSE THEORY OF LAW AND DEMOCRACY 85 (William Rehg trans., 1996) (discussing the view that private law arises from "negative rights that protect spheres of action by grounding actionable claims that others refrain from unpermitted interventions in the freedom, life, and property of the individual"); JOHN RAWLS, POLITICAL LIBERALISM 173 (1993) (arguing for the "priority of the right over the good"); Jacobson & Soliman, *supra* note 163, at 707 (noting that, in the United States, "the government's powers are defined not by what it has an obligation to do, positive rights, but rather by what it does not have the power to do, negative rights").

210. LOUIS HENKIN ET AL., HUMAN RIGHTS 320-30 (1999); HENRY J. STEINER & PHILIP ALSTON, INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS 136-41, 146-47 (2d ed. 2000); *cf.* Stephen P. Marks, *Jonathan Mann's Legacy to the 21st Century: The Human Rights Imperative for Public Health*, 29 J. L., MED. & ETHICS 131, 136 (2001) (arguing against a negative-positive distinction).

211. For a description of those qualities that transmute a collectivity into a right-bearing unit, see Koo VanderWal, *Collective Human Rights: A Western View*, *in* HUMAN RIGHTS IN A PLURALIST WORLD: INDIVDUALS AND COLLECTIVITIES 83, 93-94 (Jan Berting et al. eds., 1990) (laying out the qualifications of collectivities necessary "for ascription of rights and obligations of its own").

While this Article advances a collective right to public health, it has avoided the task of defining the individual social units that make up such a collective in each state. Such particularized, state-specific research on national communities is beyond the scope of the present Article. For the purpose of this analysis, it is sufficient to note that this collective right resides within social units smaller than the state itself, as the discourse of human rights rests upon strengthening the position of human beings vis-à-vis the state, not strengthening the state itself.

212. *See* Mazur, *supra* note 19, at 63 (noting obligations of the international community to fulfill a right to development).

213. *See* MICHELINE R. ISHAY, THE HISTORY OF HUMAN RIGHTS: FROM ANCIENT TIMES TO THE GLOBALIZATION ERA 221 (2004).

World War, it was felt by leaders of the victorious Allied Powers that this elevation of collective minority rights had led to many of the ethnic tensions that culminated in the Second World War.[214] Through the War, it had become clear that elevating group identity over individual inviolability had given rhetorical force to many of the Nazi crimes against humanity.[215] Following the War, the rights-bearer would be framed as the sovereign individual.[216]

However, as decolonization rapidly progressed throughout the world and the United Nations expanded several-fold, nascent member states—those that did not take part in the original drafting of the UDHR and subsequent Covenants—forced a reexamination of this individualistic conception of human rights. Collective human rights were first advanced in the late 1960s and early 1970s by the Non-Aligned Movement, a loose grouping of developing states in Africa, Asia, and the Middle East that had banded together to advance their interests against those of the two major superpowers.[217] Viewing traditional human rights frameworks as an extension of neo-colonial domination, these developing states advanced solidarity rights as a means of freeing states from the societal binds of international relations.[218]

Often referred to now as "third generation" rights,[219] a remnant of Western discourse from the Cold War, collective rights operate in ways similar to individual rights, often seeking the same goals. However, rather than seeking the empowerment of the individual, collective rights operate at a societal level to assure public benefits that can only be enjoyed in common with similarly-situated individuals and cannot be fulfilled through individual rights mechanisms.[220] While lacking the humanizing quality of

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214. In particular, it was felt that Nazi Germany had misappropriated minority rights as a justification for the invasion of Czechoslovakia, an invasion ostensibly premised on protecting the German minority in that state. *Id.*

215. *Id.* at 240-42.

216. DONNELLY, *supra* note 41, at 23 ("Even where one might expect groups to appear as right-holders, they do not.").

217. ISHAY, *supra* note 213, at 221-22.

218. *See* Rhoda Howard, *Evaluating Human Rights in Africa: Some Problems of Implicit Comparisons*, 6 HUMAN RTS. Q. 160, 163-64 (1984).

219. While other scholars have referred to "solidarity rights" as "third generation rights"—including them within a tripartite framework of first (civil and political), second (economic and cultural), and third (solidarity) generation rights—the author finds that referring to human rights in generational terms implies an hierarchical devolution in rights that would be inappropriate to describe the interdependence of human rights in the present analysis.

220. For an historical analysis of the dichotomy between individual and collective rights, see Peter R. Baehr & Koo VanderWal, *Human Rights as Individual and as Collective Rights*, *in* HUMAN RIGHTS IN A PLURALIST WORLD: INDIVIDUALS AND COLLECTIVITIES, *supra* note 211, at 33; Michael R. Geroe & Thomas K. Gump, Note, *Hungary and a New Paradigm for the Protection of Ethnic Minorities in Central and Eastern Europe*, 32 COLUM. J. TRANSNAT'L L. 673, 678-79 (1995) (noting that "despite the fact that the League of Nations treaties provided precedent for the collective protection of human rights, the drafters of the agreements underlying the post World War II human rights regime failed to implement any such collective rights guarantees").

individual rights,[221] collective rights have nevertheless proven effective in shifting the balance of power in international relations and creating widely recognized, if not always realized, entitlements in international law.

As developing states broke free from their colonial pasts and joined the world community, they attempted to imprint their collective vision of rights onto international law.[222] After the supremacy of individual rights in early United Nations treaties, collective rights received their first explicit recognition in the African human rights system, in which African states memorialized communal rights in the Universal Declaration of the Rights of Peoples.[223] Since that time, scholars have put forth arguments for collective rights to, *inter alia*, development, environmental protection, humanitarian assistance, peace, and common heritage.[224]

Despite their long and established history, the very existence of such collective rights remains under debate. Decried by Western scholars, collective rights arguments are often reduced to communitarian (often Occidental) appeals to cultural relativism.[225] Given this subsidiary status in human rights discourse, should solidarity rights, belonging to entire peoples, be considered equivalent to other human rights? If so, should they be considered as merely "aspirational" or as creating legally binding obligations? An example of the weaknesses in collective rights discourse is seen in the right to development. The United Nations has given its imprimatur to a collective right to development—reaffirming it through a 1986 General Assembly Declaration,[226] recognizing it as a universal and inalienable right in the Vienna Declaration,[227] and appointing a Special Rapporteur, Arjun Sengupta, to oversee its progress and implementation.[228] Although a mete-

221. *See* Alicia Ely Yamin, *Defining Questions: Situating Issues of Power in the Formulation of a Right to Health Under International Law*, 18 HUM. RTS. Q. 398, 398 (1996) ("Looking at society through a prism of rights forces one to see individual faces among the ubiquitous pools of misery that flood much of the developing world.").

222. *See, e.g.*, World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, art. 1, ¶ 10, U.N. Doc A/CONF.157/23 (July 12, 1993) [hereinafter World Conference on Human Rights] (recognizing a collective right to development as a human right).

223. Universal Declaration of the Rights of Peoples, Algiers, July 4, 1976, *reprinted in* ISSA G. SHIVJI, THE CONCEPT OF HUMAN RIGHTS IN AFRICA 111-15 (1989).

224. Marks, *supra* note 206, at 138; *see also* Stephen P. Marks, *Emerging Human Rights: A New Generation for the 1980's?*, 33 RUTGERS L. REV. 435 (1981).

225. DONNELLY, *supra* note 41, at 114 (decrying communitarian criticisms of individual human rights as "utopian or shortsighted"); ANN KENT, BETWEEN FREEDOM AND SUBSISTENCE: CHINA AND HUMAN RIGHTS 30-31 (1993).

226. Declaration on the Right to Development, Preamble, G.A. Res. 41/128,Annex, U.N. GAOR, 41 Sess., 97th plen. mtg., U.N. Doc. A/RES/41/128 (Dec. 4, 1986) (defining development as a "comprehensive economic, social, cultural and political process, which aims at the constant improvement of *the well-being of the entire population and of all individuals*" (emphasis added)). In proclaiming the creation of a then unknown human right, the Declaration stated: "The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized." *Id.* art. 1, ¶ 1.

227. World Conference on Human Rights, *supra* note 222, art. 1, ¶ 10.

228. STEPHEN MARKS, OBSTACLES TO THE RIGHT TO DEVELOPMENT 1 (2003); REFLECTIONS ON THE RIGHT TO DEVELOPMENT (Arjun Sengupta et al. eds., 2005); Marks, *supra* note

oric rise in scholarship has accompanied the advent of the right to development, the right has nevertheless faced many obstacles to its realization. Because the right to development is often described as a "vector" of rights,[229] encompassing all economic and social rights (in addition to civil and political rights) under a single banner,[230] it is made unenforceable by states' inability ever to realize all of its components.[231] In attempting to protect everything, the right has protected nothing. Because of its overbreadth, Western states—the United States most vocally—have successfully opposed a right to development in any form more binding than aspirational platitudes and have abjured all national or international obligations deriving therefrom.[232]

As exemplified by the right to development, despite widespread conceptual recognition of collective rights, states have been left without the programmatic considerations necessary to implement many of these rights.[233] These rights are derided as mere aspiration, unenforceable and existing only to serve as lofty goals, not legal obligations.[234] In spite of their denigrated status, these collective rights have repeatedly shown them-

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206, at 139; Arjun Sengupta, *On the Theory and Practice of the Right to Development*, 24 HUM. RTS. Q. 837 (2002).

229. In his interpretation of the right to development, Arjun Sengupta has noted that:

> It is convenient to describe [the right to development] in terms of an improvement of a "vector" of human rights, which is composed of various elements that represent the different economic, social, and cultural rights as well as the civil and political rights. The improvement of this vector, or in the realization of the right to development, would be defined as the improvement of some—or at least one—of those rights without the violation of any other rights.

ARJUN SENGUPTA, DEVELOPMENT COOPERATION AND THE RIGHT TO DEVELOPMENT 3 (2003).

230. Arjun Sengupta, *Realizing the Right to Development*, 31 DEV. & CHANGE 553, 555 (2000).

231. Franz Nuscheler, *The "Right to Development": Advance or Greek Gift in the Development of Human Rights?*, *in* THE INTERNATIONAL DEBATE ON HUMAN RIGHTS AND THE RIGHT TO DEVELOPMENT 54, 59 (Franz Nuscheler ed., 1998) (arguing that separate emphasis should be placed on each individual economic and social right).

232. For a description of U.S. objections to the right to development, see Philip Alston, *Making Space for New Human Rights: The Case of the Right to Development*, 1 HARV. HUM. RTS. Y.B. 3, 22 (1988); Marks, *supra* note 206. Among other reasons, skeptics of the right to development fear frameworks similar to those that surrounded the New International Economic Order, which aimed (and failed) to fundamentally restructure trade, transnational corporations, aid and international institutions to the detriment of international financial institutions. Ruth E. Gordon & Jon H. Sylvester, *Deconstructing Development*, 22 WIS. INT'L L.J. 1, 60 (2004) (noting that "many of the principles found in the New International Economic Order were soon reformulated and reintroduced as the Right to Development"). This North-South divide in adherence to the right to development has only grown as governmental and nongovernmental groups have rushed to make use of it. *See* William F. Felice, *The Viability of the United Nations Approach to Economic and Social Human Rights in a Globalized Economy*, 75 INT'L AFF. 563, 563-64 (1999).

233. DONNELLY, *supra* note 41, at 208-11 (enumerating procedural roadblocks to collective rights claims and "caution[ing] *prima facie* skepticism toward (although not automatic rejection of) most (but not necessarily all) group human rights claims"); Brigitte I. Hamm, *A Human Rights Approach to Development*, 23 HUM. RTS. Q. 1005, 1009 (2001) ("In spite of the broad acceptance of the right to development after Vienna, critics continue to question its value for strengthening human rights in general.").

234. DONNELLY, *supra* note 41, at 208-11.

selves necessary in responding to societal changes brought on by globalization. To find such essential obligations *sub rosa*, international legal bodies have strained logic to place societal obligations on states without tainting their reasoning through the loaded language of collective human rights. The CESCR does just that in General Comment 14, as discussed in the following section, attempting to find public health obligations under the right to health without ever declaring public health itself to be a human right. And yet these collective obligations under the right to health, rights advanced but never named, are public health.

B. Invoking Public Health in General Comment 14

In 2000, the CESCR, the legal body charged in the ICESCR with drafting official interpretations of and monitoring state compliance with the ICESCR,[235] took up issues surrounding the right to health in drafting General Comment 14.[236] Finding the right to health to be subject to evolution over time,[237] the CESCR sought to interpret the individual right to health in light of shifting definitions of the concept of health, drawing together the interdependent positive and negative rights frameworks that impact a state's ability to respect, protect, and fulfill the right to health.[238] Through

235. In 1985, the United Nations Economic and Social Council (ECOSOC), the body charged with this task in the ICESCR, created the CESCR as a subsidiary organ to undertake its review of "reports on the measures which [states parties] have adopted and the progress made in achieving the observance of the rights recognized [in the ICESCR]." ICESCR, *supra* note 2, art. 16. For an analysis of the evolving role of the CESCR in interpreting the ICESCR, see Scott Leckie, *The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform*, *in* THE FUTURE OF UN HUMAN RIGHTS TREATY MONITORING 129 (Philip Alston & James Crawford eds., 2000).

236. *General Comment 14*, *supra* note 108. The CESCR, like many universal treaty bodies, has developed a series of general comments to "reflect the experience gained by the Committee in its consideration of a significant number of reports, and deal with specific articles of the Covenant or particular issues raised under it." U.N. OFFICE OF THE HIGH COMM'R FOR HUMAN RIGHTS, UNITED NATIONS MANUAL ON HUMAN RIGHTS REPORTING UNDER SIX MAJOR INTERNATIONAL HUMAN RIGHTS INSTRUMENTS 265, UN Doc. HR/PUB/91/1, U.N. Sales No. GV.E.97.0.16 (1997), *available at* http://www.unhchr.ch/pdf/manual_hrr.pdf.

237. PETCHESKY, *supra* note 96, at 119 ("In its May 2000 Comment, the CESCR also presents a view of the right to health, like human rights generally, as historically situated and evolving over time.").

238. The CESCR accounts for these positive and negative components of the right to health by laying out a tripartite framework through which states must respect, protect, and fulfill the right to health. Under a state obligation to "respect" the right to health, a state must not interfere with the negative rights necessary to realizing health. Looking beyond the state and its agents, the obligation to "protect" the right to health requires a state to ensure that others, including non-state actors, do not violate this right. Lastly, the obligation to "fulfill" the right to health mandates that a state must take positive measures to ensure the full enjoyment of the right to health. *General Comment 14*, *supra* note 108, ¶¶ 33-37; *see also* CRAVEN, *supra* note 140, at 110 (noting that this framework serves "to counteract some of the traditional assumptions that tended categorically to distinguish economic, social, and cultural rights from civil and political rights"). Although the CESCR enumerated this tripartite framework as the basis of state obligations under the right to health, the CESCR had previously applied it to other economic, social, and cultural rights beginning in a 1987 "Report on the Right to Food as a Human Right." *See General Comment* 3, E/C.12/1989/SR.20. Scholars have attempted to add to

globalization, it became clear that a focus only on individual medical interventions pursuant to the right to health would have little effect on morbidity and mortality. How would the right to health incorporate these evolving public health frameworks for disease prevention and health promotion? General Comment 14 goes a long way towards acknowledging a collective right to public health through its modernization of state obligations under Article 12 of the ICESCR.[239]

With the CESCR viewing the curative conception of health in Article 12 as anachronistic in light of modern understandings of health disparities,[240] the CESCR has recently begun to look to health disparities at the societal level, starting with an examination of principles of equity in the provision of curative care.[241] This collective framework for examining health is in keeping with the CESCR's expanding review of violations of economic, social, and cultural rights through a national lens, scrutinizing national public health indicators rather than individual ailments and treatments.[242] Through its review of country reports, the CESCR has proven itself adept at monitoring national population health programs, using the right to health to criticize states for their failure to adhere to public health mandates.[243]

In General Comment 14, the CESCR implicitly acknowledges a correlation between individual and public health, finding access to public health services and information as a necessary component of the right to health, which encompasses safe water, adequate sanitation, education, food, hous-

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this framework a fourth obligation pursuant to the realization of economic, social, and cultural rights: a duty to promote. *See* G.J.H. van Hoof, *The Legal Nature of Economic, Social and Cultural Rights: A Rebuttal of Some Traditional Views*, *in* THE RIGHT TO FOOD 97 (P. Alston & K. Tomasevski eds., 1985).

239. *General Comment 14*, *supra* note 108, ¶ 10 ("Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope."). Additionally, in 2002, the Commission on Human Rights appointed a Special Rapporteur, Paul Hunt, with a mandate to focus on the right to health for a period of three years. In 2003 the Special Rapporteur issued a preliminary report in which he outlined his general approach to the mandate, extending the logic of General Comment 14 and focusing on a number of underlying determinants of health related to the realization of the right to health. *Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1.

240. Chapman, *supra* note 1, at 189 ("[T]here is now far greater awareness than at the time the [ICESCR] was drafted that health status reflects a wide range of non-medical factors.").

241. *General Comment 14*, *supra* note 108, ¶ 43 (finding the "core obligations" of the right to health to include an "equitable distribution of all *health facilities, goods and services*" (emphasis added)).

242. Philip Alston, *The Committee on Economic, Social and Cultural Rights*, *in* THE UNITED NATIONS AND HUMAN RIGHTS: A CRITICAL APPRAISAL 473, 495 (Philip Alston ed., 1992) (noting the CESCR's conclusion that "a State Party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the [ICESCR]").

243. COOK ET AL., *supra* note 134, at 189-90 (noting the CESCR's criticism of Gambia for inadequate maternal and child public health services (citing ECOSOC, CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: The Gambia*, ¶ 16, UN Doc. E/C.12/1994/9 (May 31, 1994))).

ing, and the promotion of conditions necessary for a healthy environment.[244] Even where Comment 14 does not explicitly label its strategies as public health, it nevertheless solidifies the public health underpinnings of the right to health, holding that there exist governmental responsibilities for addressing the "underlying determinants of health."[245] According to the text of Comment 14, the right to health codified in Article 12 of the ICESCR extends

> [N]ot only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[246]

In prescribing the steps to be taken by states under Article 12.2 (b) through (d), the CESCR has delineated (1) under the right to a healthy natural and workplace environment a state obligation to "discourage[ ] the abuse of alcohol, and the use of tobacco, drugs and other harmful substances;" (2) under the right to treatment and control of diseases a state obligation to "make available relevant technologies;" and (3) under the right to health care facilities, goods and services a state obligation to provide "equal and timely access to basic preventive, curative, rehabilitative health services and health education; . . . appropriate treatment of prevalent diseases, . . . [and] the provision of essential drugs."[247] Thus, through General Comment 14, the CESCR has elaborated specific entitlements to several underlying determinants of health within the right to health.

Furthermore, in expounding on the obligations necessary to fulfill these constituent rights, General Comment 14 speaks not only to the individual as a bearer of rights, but also specifically to a state responsibility to assist "communities," "groups," and "populations."[248] In addressing the subject of public health directly, even if not explicitly naming it a right, General Comment 14 observes, almost as an afterthought in its penultimate footnote, that:

> States parties are bound by both the collective and individual dimensions of Article 12. Collective rights are critical in the field of health; modern public

244. Chapman, *supra* note 1, at 204 (noting that "the adoption and implementation of a national health strategy [under General Comment 14] is to be within a public health or population based framework utilising epidemiological data"); Gostin & Gable, *supra* note 1, at 112 (noting that General Comment 14 "directly mention[s] population-based health obligations that fit well within the traditional public health paradigm").

245. *Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 23 ("The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health." (citing *General Comment 14*, *supra* note 108, at ¶ 8)). *But cf.* Chapman, *supra* note 1, at 197 (arguing that General Comment 14 does not attempt to provide a definition of health).

246. *General Comment 14*, *supra* note 108, ¶ 11.

247. *Id.* ¶¶ 15-17. For a diagrammatic analysis of those rights included in and excluded from the right to health under General Comment 14, see LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW AND ETHICS: A READER 98 fig. 8 (2002).

248. *General Comment 14*, *supra* note 108, ¶ 37.

> health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.[249]

This semi-colon linkage between collective rights and public health evidences a link between, on the other hand, the individual right to health and disease prevention and, on the other hand, health promotion—the twin hallmarks of public health practice.[250] These formulations of international law indicate that the CESCR has found the right to health to include far more specific public health mandates on states than just individual primary health care.[251] For states to create an environment conducive to good health, thereby realizing the "highest attainable standard of health" for their peoples, they must employ an expansive public health system, fulfilling the economic, social, and cultural rights, as well as the civil and political rights, upon which health is based.[252]

Despite this, the expansive language of General Comment 14 is insufficient to establish a collective right to public health programs under Article 12 of the ICESCR. General Comment 14 places public health systems squarely under the aegis of the right to health. Like much contemporary human rights scholarship, it supports an individual right while acknowledging that human rights are necessarily embedded in their social context[253] and, therefore, "individual human rights are characteristically exercised, and can only be enjoyed, through collective action."[254] Despite criticism that General Comment 14 "go[es] far beyond what the treaty itself provides and what the states parties believe to be the obligation they have accepted,"[255] General Comment 14 cannot go far enough in providing

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249. *Id.* at n.30.

250. *See supra* Part II.B. (discussing the role of disease prevention and health promotion in public health practice).

251. Mann et al., *supra* note 123, at 8; *see also* TOEBES, *supra* note 1, at 17-18 (finding that it is "more appropriate to abbreviate a 'right to the highest attainable standard of physical and mental health' to a 'right to health' than to a 'right to health care'" and finding the former to be more expansive and encompassing the latter).

252. *See* Marks, *supra* note 210, at 136 (noting General Comment 14's recognition that civil and political rights also determine health status).

253. DONNELLY, *supra* note 41, at 114 ("Enjoyment of individual human rights will be greatly fostered by a healthy social environment and supportive social institutions." (alteration in original)).

254. *Id.* at 25.

255. Katherine Gorove, Office of the Legal Advisor, U.S. Dep't of State, Remarks at the Ninety-Eighth Annual Meeting of the American Society of International Law: Shifting Norms in International Health Law (Apr. 1, 2004), *summarized in* 98 AM. SOC'Y INT'L L. PROC. 18, 20 (2004); *see also* Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?*, 98 AM. J. INT'L L. 462, 494 n.229 (2004) (noting that the CESCR's "recent views on social issues, such as its opposition to restrictive abortion laws [in General Comment 14], find no support in the text of the Covenant or in its negotiating history"). The United States, in contrast to General Comment 14's expanded interpretation of Article 12 of the ICESCR, "opposes an entitlement approach to thinking about health issues." Gorove, *supra*, at 22. As noted by Gorove in describing the U.S. position, the right to health's "focus is on the right to an adequate standard of living, which in turn places duties upon the state to have an economic, legal, and regulatory system that allows every individual to exercise that right." *Id.* at 21-22.

for a collective right to public health. While General Comment 14 has accomplished a great deal "in clarifying the normative content of the right to health,"[256] its interpretations of the ICESCR lack the self-executing authority and detailed, explanatory reasoning necessary to create national policy.[257] As an interpretive body, the CESCR merely lays out programmatic recommendations for those states seeking to uphold an individual right to health. Because of its lack of normative conceptualization of the evolving nature of the right to health, states have taken regressive liberties in their "progressive realization" of public health systems, with the CESCR's legislative overreaching permitting reactive state practice in blatant nonconformity with General Comment 14's public health recommendations, hampering the advancement of individual and collective health rights.[258]

C. Public Health As a Human Right

Health rights must evolve to meet societal threats to health. International legal scholars have long recognized "the validity and the necessity of a dynamic approach to human rights."[259] Where appropriate, it is possible to re-envision human rights in light of shifting paradigms,[260] reformulating rights to "reflect[ ] changing needs and perspectives and respond[ ] to the emergence of new threats to human dignity and well-being."[261] The

256. Yamin, *supra* note 1, at 330.

257. *See* AGINAM, *supra* note 141, at 37 ("Any inquiry aimed at unmasking the reason(s) why these efforts [to concretize the contents of the right to health] are still largely marginalized and peripheral in international policy making would inevitably indict the current international system, which has failed to adequately empower the United Nations Committee on Economic, Social, and Cultural Rights."); *cf. Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 7 (noting that "the right to health can enhance health policies and also strengthen the position of health ministries at the national level").

258. Chapman, *supra* note 1, at 193.

259. Philip Alston, *Conjuring Up New Human Rights: A Proposal for Quality Control*, 78 AM. J. INT'L L. 607, 607 (1984). Alston adds, however, that "reason for serious concern with respect to current [human rights] trends arises not so much from the proliferation of new rights but rather from the haphazard, almost anarchic manner in which this expansion is being achieved." *Id. See also* Dianne Otto, *Rethinking the "Universality" of Human Rights Law*, 29 COLUM. HUM. RTS. L. REV. 1, 10 (1997) (noting that it is "obvious" that "all human rights are in a constant process of evolution which relies on debate and contending claims").

260. *See* Habermas, *supra* note 209, at 88 ("[P]rivate law has undergone a reinterpretation through the paradigm shift from bourgeois formal law to the materialized law of the welfare state. But this . . . must not be confused with a revision of the basic concepts and principles themselves, which have remained the same and have merely been *interpreted* differently . . . ." (citation omitted)). In respecting negative rights, this evolution of human rights norms has been seen most dramatically in the expansion of human rights to protect against discrimination on the basis of gender, race, and sexual orientation. *See, e.g.*, Convention on the Elimination of All Forms of Discrimination Against Women, *supra* note 126; International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 126.

261. Alston, *supra* note 259, at 609; *see also* Kirby, *supra* note 130, at 12 ("[T]he voyage of discovery that the Universal Declaration initiated is far from complete. With each new decade, new insights are gained and shared.").

social transformations inherent in globalization engage an evolving framework for health rights.[262] General Comment 14 is an initial, though incomplete, part of this evolving notion of the right to health.[263] Despite this evolution, the right to health cannot, as an individual right, be effective in responding to the societal harms of globalization,[264] fostering "a need to promote and protect socioeconomic rights by designing and creating new institutions where rights as 'trumps,' trump economic interests."[265]

Moving beyond an analysis of General Comment 14 and the ICESCR in operationalizing collective interpretations of health, it is incumbent on scholars of health and human rights to "create new conceptual frameworks that will enable us to incorporate causes and effects that are not characteristics of individuals and to expand the discussion of social problems."[266] Through globalization, the underlying determinants of health "transcend spatial boundaries to signify respective degrees of overlaps and commonalities in experiences,"[267] affecting entire societies. Generalizing from the HIV/AIDS pandemic to modern health crises, Jonathan Mann argued that:

> [I]t ought to be clear that since society is an essential part of the problem, a societal-level analysis and action will be required. In other words, the new public health considers that both disease and society are so interconnected that both must be considered dynamic. An attempt to deal with one, the disease, without the other, the society, would be inherently inadequate.[268]

Globalization's societal impacts on health implicate collective responses to health dilemmas.[269] Such a collective framework involves an expansive right to public health, obligating states to address the systematic and social conditions that underlie disease. This Part addresses the theoretical basis for such a right, followed by a detailed programmatic outline of its national implementation and international obligations.

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262. *See* J. Herman Burgers & Rob Kroes, *Social Transformation and Human Rights*, *in* Human Rights in a Pluralist World: Individuals and Collectivities, *supra* note 211, at 167, 167 (assuming that "major processes of social transformation exert significant influences on approaches toward human rights and on compliance with them").

263. For a discussion of the flaws stymieing General Comment 14's ability to create a right to public health, see *supra* notes 255-258 and accompanying text.

264. *See supra* Part II.A.

265. Evans, *supra* note 44, at 211 (citing HENRY SHUE, BASIC RIGHTS: SUBSISTENCE, AFFLUENCE, AND U.S. FOREIGN POLICY (1996)).

266. Meyer & Schwartz, *supra* note 184, at 1191.

267. L. Amede Obiora, *Feminism, Globalization, and Culture: After Beijing*, 4 IND. J. GLOBAL LEGAL STUD. 355, 402 (1997).

268. Jonathan M. Mann, *Human Rights and AIDS: The Future of the Pandemic*, *in* HEALTH AND HUMAN RIGHTS: A READER, *supra* note 123, at 216, 222. In the case of distinguishing a right to health from a right to public health approach to HIV, it is clear that while donations of HIV medications under the right to health may be an immediate solution to the problem of premature death from HIV, this may not be as sustainable a solution as the right to public health in working to ameliorate the lack of access to life-saving medications and prevention or containment of the spread of HIV.

269. *See* VanderWal, *supra* note 211, at 96 ("[A] number of burning social and political problems of our times are primarily collectivity-related, which causes attention to be focused particularly on the collective dimension of human existence.").

1. Theoretical Conceptualization

Globalization theory offers a useful basis for considering both the fundamental causes of disease and the collective rights implicated by our interconnected world. It also serves as a starting point from which to proclaim these necessary rights and anchor a public health systems approach to disease prevention and health promotion. Through globalization, "tension persists between the philosophy of neoliberalism, emphasising the self-interest of market-based economics, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal."[270] This market-based economy, in directing state policy and international relations, has proven incompetent to speak to individual human rights and detrimental to states seeking to fulfill these rights through social justice programs.[271] In response to globalized processes, globalization scholars have sought to develop a "third way" between the individualistic neoliberal economic policies and the more collectivist values of social democracy.[272] To do so, scholars "are searching for how best to manage the forces of globalization, to shape it so that benefits accrue to the greatest number of people . . . ."[273] Where existing human rights frameworks have proven inadequate to address global harms, scholars have offered "new rights" competent to speak to these harms.[274] In the areas of disease prevention and health promotion, collective human rights offer a framework for addressing societal inequities that result from globalization, altering the atomistic egoism that plagues the fulfillment of an individual right to health and pressing national governments to be responsive to the common good rather than bowing to the rampant individualism bred by the engines of globalization.[275]

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270. McMichael & Beaglehole, *supra* note 16, at 496 (footnote omitted).

271. In addressing this conflict, Jack Donnelly notes that:

> Like (pure) democracy, (free) markets are justified by arguments for collective good and aggregate benefit, not individual human rights . . . . Assuaging short-term suffering and ensuring long-term recompense—which are matters of justice, rights, and obligations, not efficiency—are the work of the (welfare) state, not the market. They raise issues of individual rights that markets simply cannot address [ ]—because they are not designed to do so.

DONNELLY, *supra* note 41, at 201-02.

272. ANTHONY GIDDENS, THE THIRD WAY: THE RENEWAL OF SOCIAL DEMOCRACY (1998); CASTELLS, *supra* note 40, at 139.

273. KELLEY LEE, GLOBALIZATION AND HEALTH 15 (2003) ("The protection and promotion of health has been recognized since the mid 1990s as a core element of such efforts to promote socially and environmentally responsible forms of globalization . . . .").

274. DONNELLY, *supra* note 41, at 230 ("We also regularly encounter arguments that 'new issues,' such as the environment, require new rights. Many of these issues are precisely those that cross state boundaries or challenge state control.").

275. This process of using globalized human rights processes to counteract globalized economic processes involves what Boaventura de Sousa Santos refers to as "localized globalism," which "consists of the specific impact of transnational practices and imperatives on local conditions that are thereby destructured and restructured in order to respond to transnational imperatives." BOAVENTURA DE SOUSA SANTOS, TOWARD A NEW COMMON SENSE: LAW, SCIENCE AND POLITICS IN THE PARADIGMATIC TRANSITION 263 (1995).

Applying only a curative health model to societies preoccupied with the individual right to health has denigrated collective responsibility for health, relegating obligations for healthy conditions to the individual alone.[276] Yet, to the degree that the right to health, like all individual rights, is premised on the autonomy of the individual,[277] globalization's autonomy-diminishing effects impair the individual's ability fully to recognize this right, and necessitate a collective approach to health rights. Thus, as seen in the cases of tobacco use, obesity, and other risk factors for disease, globalization has impinged the right of the informed individual to make healthy choices for him or herself.[278] Whereas traditional human rights scholarship views "man" as "a separate isolated individual who, as such and apart from any social context, is bearer of rights,"[279] combating the health disparities of a globalized world will require renewed focus on the collective social factors that facilitate the onset and spread of disease. Creating societal interventions to combat these societal determinants of health will require broad public health systems that move well beyond the individual curative model of medicine.

The tools of public health programs—including medical knowledge, disease surveillance, and treatment options—are public goods that, by their very nature, have meaning only in the context of societies.[280] Like many environmental protections,[281] a public health system, based upon its non-divisible and non-excludable externalities, cannot easily be divided among

276. *See* Link & Phelan, *supra* note 17, at 80; *see also* Childress & Bernheim, *supra* note 207, at 1195 ("The health of the public is a public good because it is not just the sum of individual health indices and cannot be attained through individual actions alone.").

277. *See* ALASTAIR V. CAMPBELL, MEDICINE, HEALTH AND JUSTICE: THE PROBLEM OF PRIORITIES 282 (1978) (arguing that states must prioritize health interventions "most likely to increase autonomy amongst those least able to exercise it without outside help"); Smith, *supra* note 143, at 1300 (finding, in an analysis of Articles 22 and 29 of the UDHR, that "autonomy—and its exercise—is central to the recognition and implementation of the very goal of maintaining human rights").

278. *See supra* note 33 and accompanying text.

279. VanderWal, *supra* note 211, at 83.

280. *See* Dyna Arhin-Tenkorang & Pedro Conceição, *Beyond Communicable Disease Control: Health in the Age of Globalization*, *in* PROVIDING GLOBAL PUBLIC GOODS: MANAGING GLOBALIZATION 484, 489 (Inge Kaul et al. eds., 2003); Beauchamp, *supra* note 201, at 273 (recognizing that "the public health ethic is a *counter-ethic* to market-justice and the ethics of individualism as these are applied to the health problems of the public" (emphasis in original)); Rosalind Pollack Petchesky, *From Population Control to Reproductive Rights: Feminist Fault Lines*, 3 REPRODUCTIVE HEALTH MATTERS 152, 160 (1995) ("Such enabling conditions [for achieving social rights] entail correlative obligations on the part of governments and international organizations to treat basic human needs, not as market commodities but as human rights."). In the context of infectious disease, the elimination of the disease (in addition to the vaccination tools of public health) can be considered a public good, where disease eradication serves to prevent transmission even to the unvaccinated. Arhin-Tenkorang & Conceição, *supra* note 280, at 491.

281. For an analysis of the environment as a global public good, see Anthony J. McMichael et al., *Global Environment*, *in* GLOBAL PUBLIC GOODS FOR HEALTH: HEALTH, ECONOMIC, AND PUBLIC HEALTH PERSPECTIVES 94, 95-101 (Richard Smith et al. eds., 2003) (discussing the health implications of analyzing global climate change and stratospheric ozone depletion within a global public goods framework).

individuals but can only be enjoyed in common with similarly-situated peoples.[282] As a shared public good, public health leads to positive externalities, in this case, health for all. While it is intuitive for infectious disease surveillance to be included among public goods, globalization processes have served to convert noncommunicable disease prevention and health promotion from private goods into global public goods.[283] In this context, even public health knowledge can be seen as a public good, something realized only through communal efforts and beneficial to all.[284] Thus, with a broad conception of public health viewed as a collective public good, no individual can rightly make a claim against the state under the individual right to health for a specific component of a public health system. A collective human right to public health is necessary to give meaning to this public good and provide for its realization under international law.

2. *Programmatic Components*

While collective health rights have a great deal of conceptual clarity to offer above and beyond the individual right to health, one must pause before proffering that a right has evolved to include collective components, fundamentally challenging the very basis of the individualistic human rights system.[285] To find such a collective right, it is not sufficient simply to argue for its theoretical worth. Contrasting it with the case of the collective right to development,[286] it is imperative that such a collective right to public health possess the programmatic practicalities necessary to develop enforceable state obligations from this right.[287] In meeting this conceptual burden, the present section attempts to lay out the tangible programmatic frameworks necessary to operationalize this theoretical construct.

At a programmatic level, a collective right to public health would buttress the long-term and sustainable public health systems necessary to address societal determinants of health.[288] This would involve more than simply the provision of health care. While the state cannot easily be held accountable for meeting individual health needs in the provision of health

282. *See* VanderWal, *supra* note 211, at 88 ("It will have to be made understood that these [collective] rights are of a non-reducible collective nature, that is, that they cannot be analyzed adequately and without loss of meaning in terms of individual rights.").

283. *See* Chen et al., *supra* note 12, at 285 (arguing "that although health may have both public and private properties, globalization may be shifting the balance of health to a global public good").

284. *See* Stiglitz, *supra* note 39, at 224 ("Knowledge itself is an important global public good: the fruits of research can be of benefit to anyone, anywhere, at essentially no additional cost.").

285. *See, e.g.*, DONNELLY, *supra* note 41, at 25 ("Collectivities of all sorts have many and varied rights. But these are not—cannot be—human rights, unless we substantially recast the concept.").

286. *See supra* notes 225-232 and accompanying text.

287. *See* DONNELLY, *supra* note 41, at 117 ("Critics of the destructive unintended consequences of Western practices must confront the problems of implementing their alternative visions.").

288. This is the approach undertaken in General Comment 14, in which "the core obligations reflect elements in the disparate approaches to health represented by the disciplines of medicine and public health." Chapman, *supra* note 1, at 204.

care services—where such responsibility is increasingly being assumed by partnerships of public, private, and not-for-profit actors[289]—the state has far greater control over the underlying conditions of health, a collective right to which could be upheld at substantive and procedural levels under a human right to public health.

a) Substantive Elements

Substantively, it is necessary first to define the content of the right in question. As with other economic, social and cultural rights, this is often done by way of delineating and distinguishing between core and peripheral obligations. In defining the core content of this right—those facets of the right amenable to immediate implementation—state obligations would arise in connection with infectious and non-infectious disease surveillance and control.[290] At the center of these efforts, it is clear that comprehensive public health law modernization and bureaucratic reorganization, having little budgetary impact but vastly improving the efficiency of the public health system,[291] would fall under the core content of a right to public health.[292] In addition, there are many other cost-neutral structural and bureaucratic facets of disease prevention that could be considered essential for protecting public health because of either a particular disease or particular program's societal effect on morbidity and mortality. By creating a set of minimum public health conditions vital to a life with dignity, all states should be able to fulfill this minimum core content of a right to public health in restructuring their national public health system.

Looking beyond the minimum core content of this right, a right to public health would possess funding-dependent obligations for health promotion (for non-communicable or chronic disease). Such a right to public health would require states to create the population health programs necessary for health promotion,[293] as a "government possesses an obligation,

289. Stuttaford, *supra* note 151, at 3-4.

290. Again, although negative rights are not addressed in this Article, *supra* note 122, it can be assumed that many of the negative obligations on states under a right to public health—i.e., obligations that require state forbearance rather than positive action—are found in the core content of the right because they would require no expenditure.

291. Even among those states that lack the bureaucratic and budgetary capacity to reform their public health legislation and reorganize their public health system independently, the WHO is currently creating draft principles to guide the comprehensive reform of national public health legislation. Center for Law and the Public's Health, The WHO Framework of Essential Elements for Comprehensive National Legislation on the Health of the Public with Special Attention to the MDGs (draft of Apr. 4, 2006) (on file with author).

292. Similarly, as an example of highly economical implementation strategies inapplicable to the principle of progressive realization under the individual right to health, Paul Hunt notes that states have an immediate obligation, without regard to resources, to prepare "a national public health strategy and plan of action." *Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 27.

293. WHO defines health promotion to include "the process of enabling people to increase control over, and to improve, their health." WHO, *Constitution* (July 22, 1946), *reprinted in* WHO, BASIC DOCUMENTS 1 (40th ed. 1994) [hereinafter WHO Constitution]; First International Conference on Health Promotion, Ottawa Charter for Health Promo-

within the constraints of its resources, to provide an environment conducive to the public's health and well-being."[294] Bounded inherently by the logic of progressive realization, this would entail the scaling-up of public health systems and other infrastructures necessary for the provision of public goods. In speaking to underlying determinants of health, a collective right to public health would create equality in realizing its minimum core standard and peripheral obligations. Whereas an individual right to health is ill-equipped to provide for an equitable distribution of medical interventions, a collective right to public health would provide for minimum societal-level health standards for all persons.

Programmatic claims based on obligations such as these cannot progress without detailed analyses of state allocative judgments, wherein "[a] standard of resource allocation must recognize human rights to be a priority, but must balance that recognition against other state obligations and private property rights."[295] In allocating the "maximum of its available resources"[296] progressively toward various health promotion efforts, states could prioritize resources toward those programs most likely to provide the greatest good to the greatest number of persons, a utilitarian hallmark of public health administration.[297] Thus, in considering a state's allocation of resources in accordance with the principle of progressive realization, a right to public health would permit states—particularly developing states seeking to uphold health rights—to consider the most cost-effective delivery of life-saving services.[298] It was long assumed that since clinical or

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tion, Ottawa, Can., Nov. 21, 1986, U.N. Doc. WHO/HPR/HEP/95.1 (Nov. 21, 1986), *available at* www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf; *see also* Gostin & Lazzarini, *supra* note 207, at 29 (defining the right to health as the duty of the state, "within the limits of its available resources, to *ensure the conditions necessary for the health* of individuals and populations" (emphasis added)). This minimum core content has been elaborated in part through the 1994 Cairo United Nations Conference on Population and Development and the 1995 Beijing United Nations World Conference on Women, which require states to take responsibility for and, where necessary, ameliorate the underlying determinants of sexual and reproductive health. *See* International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, *Programme of Action*, U.N. Doc A/CONF.171/13 (Oct 18, 1994); Fourth World Conference on Women, Beijing, China, Sept. 4-15, 1995, *Beijing Declaration and Platform for Action*, U.N. Doc A/CONF.177/20 (Oct. 17, 1995).

294. GOSTIN & LAZZARINI, *supra* note 207, at xiv.

295. Robertson, *supra* note 136, at 695.

296. ICESCR, *supra* note 2, art. 2.

297. D.M. Eddy, *From Theory to Practice: Health System Reform: Will Controlling Costs Require Rationing Services?*, 272 JAMA 324 (1994); *see also* Jeremy Bentham, An Introduction to the Principles of Morals and Legislation 32 (1907).

298. *See, e.g.*, Chapman, *supra* note 1, at 211 ("To be consistent with a human rights approach . . . [health expenditures] should be invested to bring about the greatest health benefit for the population. This requires giving priority to public health measures, primary care, and preventive services, and refraining from investments in expensive tertiary care facilities."); *see also* Osita C. Eze, *Right to Health as a Human Right in Africa*, *in* THE RIGHT TO HEALTH AS A HUMAN RIGHT 76, 87 (René-Jean Dupuy ed., 1979) (noting that "[i]t is little use" to look at the numbers and statistics of health facilities and service provided; rather, "[i]t is necessary to ascertain how many benefit from these facilities"). Arjun Sengupta, in *Realizing the Right to Development*, 31 DEV. & CHANGE 553, 561 (2000), notes that:

curative health played an instrumental role in improving health in industrialized countries, it was also the best model for developing countries with nascent healthcare systems.[299] Yet, in states of limited resources, it is public health infrastructures and programs that provide the most efficient means for the realization of health rights, supporting a basis for widespread governmental health efforts that satisfy both the minimum core content of a right to public health and the principle of progressive realization.[300] Curative services that cater to individual needs are highly resource and personnel dependent, making it difficult for most developing countries to sustain a consistent level of care.[301] Compared with individual medical services, which states provide preferentially rather than universally, public health systems can raise health standards for more people using fewer resources.[302] Where financial resources are scarce and physicians more so, a right to public health will have a far more sustainable effect on the health of individuals than any attempts to realize an individual human right to health care.[303] This efficiency, combined with "state-

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> If all rights are of equal value or have the same importance—as claimed in the human rights instruments—it is the nature of the resource constraints that may determine the priorities. Those rights that require the least expenditures of resources which are in short supply will tend to be realized first.

Id. This application of a right to public health is in accordance with General Comment 14's recommendation that states prioritize health interventions in the efficient use of their resources. *See General Comment 14*, *supra* note 108, ¶ 40.

299. CHRISTINE MCMURRAY & ROY SMITH, DISEASES OF GLOBALIZATION: SOCIOECONOMIC TRANSITIONS AND HEALTH 32 (2001).

300. Chapman, *supra* note 1, at 189 ("In many regions of the world the most valuable steps toward improvement of health are not the provision of medical services but improved public health protection.").

301. MCMURRAY & SMITH, *supra* note 299, at 32-33 (describing "clinic-based curative medicine" as dependent on "sophisticated equipment and medicines and a hierarchy of trained staff" that many developing countries cannot afford).

302. *See* J.-L. Bobadilla et al., *Design, Content and Financing of an Essential National Package of Health Services*, *in* GLOBAL COMPARATIVE ASSESSMENTS IN THE HEALTH SECTOR 171 (C.J.L. Murray & A.D. Lopez eds., 1994) (developing public health programs appropriate to low- and middle-income states).

Such wide-ranging national decisions on the allocation of health resources come with the political taint that stems from any discussion of health care rationing. Richard H. Morrow & John H. Bryant, *Health Policy Approaches to Measuring and Valuing Human Life: Conceptual and Ethical Issues*, 85 AM. J. PUB. HEALTH 1356, 1356 (1995). This Article has thus far avoided use of the term "rationing," all the while discussing the health expenditures necessary to achieve the progressive realization of health. Despite this rhetorical neglect, the topic of rationing should not be avoided, as it is one of the principal bases on which the United States opposes any entitlements under the right to health. *See supra* note 255. To the degree that any attempt to achieve equity in health requires a rationing of limited public health care resources, rationing should be considered inherent in any government's obligation for fulfilling a right to public health. For a comparative discussion of national approaches to health care rationing, see EMILY JACKSON, MEDICAL LAW: TEXT, CASES, AND MATERIALS 35-82 (2006).

303. *See* Annas, *supra* note 184, at 1780 ("Public health deals with populations and prevention of disease—the necessary frame of reference in the global context."). An example of this is found in the recent discovery of a vaccine against cervical cancer that works by preventing the spread of the human papilova virus (HPV) or genital warts. The presence of genital warts is a leading risk factor in the development of cervical cancer. It has been argued that if this vaccine could be distributed in the developing world, it

mediated" equity in distribution, would be consistent with social justice mandates for realizing economic and social rights.[304]

Evidence-based standards for prioritizing health needs and optimally allocationg funds would give states leeway in implementing public health programs specific to their populations. In the context of this interconnectedness between individual and public health, society-based disease prevention and health promotion efforts are necessary to assure that health services are available, accessible, and acceptable to all.[305] Rather than focusing on individual curative and rehabilitative means of health promotion, a right to public health would give states the authority to employ their limited means to prevent disease and promote health at the collective level through public health systems.[306] This in turn would provide an equality that is not found in the individual right to health,[307] a tool to improve environmental conditions in the pursuit of health,[308] and an ability to achieve the highest attainable standard of health for citizens consistent with the principle of progressive realization.[309] These public health frameworks for political decision-making would provide a mechanism by which to assess dangers to the public's health and to respond dispassionately to health threats in a manner and at an expense commensurate to the

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could obviate the need for annual pap smears. H. Cronjé, *Screening for Cervical Cancer in the Developing World*, 19 BEST PRAC. & RES.: CLINICAL OBSTETRICS & GYNAECOLOGY 517, 525 (2005). Because many women in the developing world have no access to annual gynecological exams given the relative dearth of health clinics and resources, providing a vaccine under these circumstances is far more sustainable than creating and maintaining the infrastructure necessary to provide regular pap smears to women.

304. DONNELLY, *supra* note 41, at 68.

305. Kinney, *supra* note 1, at 1458 (noting that a right to health services "requires nation states to take affirmative steps to assure that residents of the country have access to population-based health protection measures"). For example, preventing the spread of the AIDS pandemic requires an understanding of individual behaviors, which are influenced by the social forces of discrimination, sexual preference and family structure, among a litany of other societal concerns. *See generally* Ronald Bayer, *Public Health Policy and the AIDS Epidemic: An End to HIV Exceptionalism?*, 324 NEW ENG. J. MED. 1500 (1991) (examining the public health response to HIV and AIDS and suggesting broader applications of this response for other infectious diseases). Moreover, treating HIV and AIDS patients requires a public health system sufficient to deliver the medications ensured under the right to health. *See* Freedman, *supra* note 152, at 105-06 ("[T]he need for a health system strong enough to deliver treatment will still present an enormous obstacle . . . .").

306. *See* NIELSEN, *supra* note 1, at 26 n.59 (1999) (noting that "WHO has expressed that health is most effectively addressed through an emphasis on prevention which preserves the human capital in a cost-effective manner").

307. *See supra* notes 162-163 and accompanying text.

308. *See* Chapman, *supra* note 1, at 189 ("Poor countries with limited resources would better raise health standards by investing scarce resources in clean water and environmental clean-up than by offering curative health care to a small fraction of the population.").

309. *See* NIELSEN, *supra* note 1, at 22 ("In order to meet the requirement of steps to the maximum of available resources states must use the most cost-effective means of promoting health.") (citing ECOSOC, CESCR, Report on the Eighth and Ninth Sessions, May 10-28, 1993, Nov. 22-Dec. 10, 1993, ¶ 298, UN Doc. E/1994/23 and E/C.12/1993/19 (Dec. 10, 1993)).

risk and magnitude of the harm.[310] To the degree that uncertainty exists, it could be adjudged by accountable representatives fully informed by bureaucratic risk assessment and guided by the precautionary principle[311] and cost-benefit analysis.

Through such changes in public health systems, a right to public health would give states the ability to seek out and rectify the underlying causes of societal deprivation. Through state-specific interventions that address underlying determinants of health, states could act preferentially to create equity in health.[312] This would be in accordance with the preamble to the WHO Constitution, which declares that governments have a responsibility to provide adequate health and social measures.[313] These social measures, as noted by Aart Hendriks,

> [E]ntail[ ] a duty for States to undertake measures aimed at the creation of conditions favourable to the achievement and maintenance of the highest attainable level of health, notably by gradually improving the socio-economic conditions which may hamper the realisation of this right, and is not confined to ensuring adequate health promotion measures or guaranteeing a comprehensive health care insurance and delivery system.[314]

By emphasizing the social measures necessary for health, a right to public health, like the collective right to development, would underscore the interrelation of all human rights but successfully fulfill those rights by focusing

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310. *See* PANNENBORG, *supra* note 28, at 187 (noting that in developed states, public health expenditure breakdowns "reflect[ ] the improper disproportionality in terms of need and effectiveness between individual-oriented disease concepts and community-oriented health notions").

311. Pursuant to the precautionary principle, "[i]f there is a potential for harm from an activity and if there is uncertainty about the magnitude of impacts or causality, then anticipatory action should be taken to avoid harm." PROTECTING PUBLIC HEALTH AND THE ENVIRONMENT: IMPLEMENTING THE PRECAUTIONARY PRINCIPLE 1 (Carolyn Raffensperger & Joel A. Tickner, eds. 1999); *see also* CASS R. SUNSTEIN, RISK AND REASON: SAFETY, LAW, AND THE ENVIRONMENT 102-05 (2002).

312. *But cf.* P. Braveman & S. Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & COMMUNITY HEALTH 254 (2003). Braveman and Gruskin describe that "equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy." *Id.* In this sense, public health is viewed as inherently redistributive, "creat[ing] increasingly inclusive or egalitarian access to resources." Maureen Mackintosh & Paula Tibandebage, *Inequality and Redistribution in Healthcare: Analytical Issues for Developmental Social Policy*, *in* SOCIAL POLICY IN A DEVELOPMENT CONTEXT 143, 144 (Thandika Mkandawire ed. 2004).

313. *Id.*

314. Hendriks, *supra* note 1, at 391. The Council of Europe adopted many of these aspects of health in the European Social Charter, with European States Parties undertaking:

> either directly or in co-operation with public or private organisations . . . 1. to remove as far as possible the causes of ill-health; 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

on their realization through public health systems.[315]

b) Procedural Elements

Procedurally, a right to public health would provide benchmarks to national and international bodies in uncovering insalubrious societal conditions and guide states in their allocation of health resources in responding to these conditions.[316] In providing justiciability not found in national and international enforcement of the right to health,[317] a right to public health would provide concrete, measurable, and readily-available national indicators by which states could accurately report the state of health in their respective territories and international treaty bodies could better gauge and adjudge these states' annual reports on the realization of health rights, assuring that these governments would be held accountable for realizing healthy conditions.[318] Because a panoply of factors determine health status,[319] an individual is hard-pressed to demonstrate a causal link between his or her health status and state action or omission, negating any benefit from an individual complaint procedure under the right to health.[320] Thus, as compared with the right to health, which can be adjudged only through obligations of conduct (ostensibly measured through resource allocations),[321] a right to public health would permit international bodies to hold states accountable for achieving certain out-

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European Social Charter art. 11, May 3, 1996, Europ. T.S. No. 163.

315. *See* Chapman, *supra* note 1, at 189 ("Because health status reflects a wide range of socio-economic factors, the right to health is interrelated with other rights, for example, the rights to food, housing, education, and safe working conditions."). As noted by Allan McChesney in an early interpretation of the individual right to health:

> Ensuring "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (I.C.E.S.C.R. Article 12) also requires resources flowing from a successful economy, as well as the costly promotion of education and literacy (I.C.E.S.C.R. Article 13), and the continuous improvement of living conditions and food availability (Article 11).

McChesney, *supra* note 53, at 173.

316. *Compare* Reidar K. Lie, *Health, Human Rights and Mobilization of Resources for Health*, BMC INT'L HEALTH & HUM. RTS., Oct. 8, 2004, *with* Stuttaford, *supra* note 151, at 8 (suggesting that "viewing rights in a collective framework may assist in framing resource allocation decisions").

317. *See supra* notes 128-156 and accompanying text. *But cf.* AGINAM, *supra* note 141, at 36 (criticizing Western scholars for "unduly emphasiz[ing] justiciability predicated on an individual making a claim against the state, before a court or tribunal, seeking redress for the violation of her rights").

318. This Article has intentionally avoided the contested issue of selecting a venue most appropriate to adjudication of a right to public health. Because the U.N. Commission on Human Rights is currently developing a proposal for a single complaint mechanism for economic, social, and cultural as well as civil and political rights, see Dennis & Stewart, *supra* note 255, at 462-63, the author will defer to that unified adjudication mechanism proposal unless or until it proves unworkable.

319. *See supra* Part II.C.

320. *See* NIELSEN, *supra* note 1, at 64-65 ("[V]iolations of Article 12 ICESCR will in many cases inflict on the health status of the whole population and, thus, not call for an individual complaints procedure . . . .").

321. *See* Robertson, *supra* note 136, at 703 (noting "serious deficiencies" in using resource utilization to measure state compliance with economic, social and cultural rights).

comes,[322] with results easily quantified through minimum national public health indicators—for example, life expectancy and infant mortality—and amenable to providing judicial bodies with standards necessary to identify a rights violation.[323] By expanding the population under consideration, public health practitioners could appreciate the significance of anomalies in health status and correlate these anomalies with underlying determinants of health.[324] Translating this significance into enforceable obligations, a right to public health would create a claim to systemic public health interventions. In addressing such claims, states would be pressed to create sustainable national public health bureaucracies—which in many states either are nonexistent or have been eviscerated in adherence to structural adjustment programs[325]—to coordinate national disease prevention responses.[326]

In bringing forward a claim pursuant to this collective right, it is necessary to define the persons bound together in the right-bearing collective and those capable of exercising a right to public health on behalf of that collective. By identifying those bound in their communal suffering and marginalization, it is possible to bring together discrete groups and avoid a proliferation of individuals seeking redress under the mantle of collective harm.[327] In identifying groups connected by shared vulnerability—as opposed to easily identified ascriptive or immutable characteristics—adjudicative bodies will undoubtedly face hurdles in identifying those competent to represent a societal problem in bringing a cause of action against the state;[328] however, this should pose no greater challenge than those

322. That is, whereas the individual right to health may create iniquitous obligations of conduct, a right to public health could place quantifiable obligations of result on states. For a discussion of the distinction between obligations of conduct and obligations of result, see CRAVEN, *supra* note 140, at 108 ("The distinction between obligations of conduct and result is complicated by the fact that some of the specified 'steps' may also be seen to be independent norms imposing separate obligations of result.").

323. *See* Tom J. Farer, *Toward a Humanitarian Diplomacy: A Primer for Policy*, *in* TOWARD A HUMANITARIAN DIPLOMACY: A PRIMER FOR POLICY 25 (Tom J. Farer ed. 1980) ("Development experts generally agree that life expectancy, infant mortality and literacy are the most appropriate indicators for measuring the physical well-being of any country's population and for the measurement of progress towards higher levels of economic and social well-being for the general population.").

324. L. Gordis, *From Association to Causation: Deriving Inferences from Epidemiologic Studies*, *in* EPIDEMIOLOGY 184, 185 (2d ed. 2000).

325. *See supra* Part I.B.

326. *See* Gostin et al., *supra* note 165, at 64 ("The essential job of public health agencies is to identify what makes us healthy and what makes us sick, and then to take the steps necessary to make sure we encounter a maximum of the former and a minimum of the latter.").

327. *See* DONNELLY, *supra* note 41, at 209 ("Unless we can restrict the range of collective right-holders, we are likely to be swamped in a wild proliferation of human rights that would devalue the practical force of claims of human rights.").

328. *Id.* at 210 (noting that "agency is likely to be highly problematic, especially when the group is large or heterogeneous"); *see also* Richard N. Kiwanuka, *The Meaning of "People" in the African Charter on Human and Peoples' Rights*, 82 AM. J. INT'L L. 80, 82 (1988) (arguing that the meaning of the term "people" "is not consistent in the [African Charter on Human and Peoples' Rights] as it is always determined by the context of the particular rights referred to") .

overcome through judicial procedures developed to certify a class of individuals in U.S. class action practice.[329] In fact, because these collectives are often geographically bounded, individual class members can easily be identified based upon shared exposure to adverse underlying determinants of health, regardless of whether they are currently manifesting adverse health effects.

By grouping rights-bearers together, elected officials and nongovernmental organizations could then press claims on behalf of societies based on a similar history of ongoing and systematic disadvantage. Civil society groups hold a unique role in representing group interests, both in working with public health systems and in compelling state recognition of human rights connected to these systems.[330] As public health is best assessed at the local level, civil societies, "associations that are formed in civil life without reference to political objects,"[331] offer the most theoretically and practically appropriate means for empowering communities to promote a right to public health.[332] Although globalization processes have attempted to impose programs from above, organic civil society movements, galvanized locally and internationally by globalization, hold the promise of giving voice to communities in improving health from below.[333] Public health rightly places the onus back on community associations to take action to address their communal health problems.[334] Coordinating with local and national governments and nongovernmental organizations, civil societies

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329. For a description of the procedures employed by U.S. federal courts in certifying a class of individuals in a tort action, see generally ERWIN CHEMERINSKY, FEDERAL JURISDICTION § 10.3.1 (3d ed. 1999). As distinguished from a class action, however, a collective right is not merely the collective exercise of individual claims but rather the collective exercise of a collective claim.

330. *See* Kirby, *supra* note 130, at 15.

> Out of [the] ideals [of the UDHR] have grown a vast array of nongovernmental organizations and civil society bodies committed, in very practical ways, to upholding universal rights at home and abroad. These bodies, in turn, stimulate national governments, regional bodies, and international agencies to respond to cases of abuse, measured against the Universal Declaration, now brought to light by the global media.

Id.

331. ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 115 (Phillips Bradley ed., 1990).

332. *See* Kirby, *supra* note 130, at 20 (noting that local nongovernmental organizations "can help to turn serious deprivations of the fundamental right to health into the subjects of political action").

333. *See* Jan Berting, *Societal Change, Human Rights and the Welfare State in Europe*, *in* HUMAN RIGHTS IN A PLURALIST WORLD: INDIVIDUALS AND COLLECTIVITIES, *supra* note 211, at 189, 205.

> [I]n the process of societal transformation important interest groups came to the fore which tried to realize *their* model of society and image of man in social life, not by replacing the 'first generation of human rights,' but by extending its application to new areas, by reformulating rights and by adding new (generations of) rights.

Id.

334. *See* Evans, *supra* note 65, at 3 (noting that the "complexity [of globalization] defies the ability of any human agent to produce more desirable alternative outcomes"); Macfarlane et al., *supra* note 18, at 841 (noting that "good public-health practice encourages people and communities to take part in decisions about their own health").

can work with public health systems to protect vulnerable communities from the ravages of globalization.[335] In fact there is evidence that "community-health processes initiated by residents and actively supported by health bureaucracies can achieve what decades of so-called top-down efforts have failed to do."[336]

D. Harmonizing Individual and Collective Health Rights

While Western scholars have often presupposed an opposition between individual and collective human rights,[337] this distinction is inappropriate to the modern era of globalization, particularly in the field of health, where the goals of individual and collective rights frequently overlap.[338] That is, the individual and public components of health rights are not mutually exclusive but rather are interdependent.[339] Thus, in situating and operationalizing health rights, a collective right to public health can be seen to complement, not deny, the individual right to health.

Despite widespread international acceptance of derogation from individual rights where necessary to secure public health,[340] Western liberta-

335. *See* Evans, *supra* note 65, at 21 ("Creating instances of 'state-society synergy,' in which engaged public agencies and mobilized communities enhance one another's capacity to deliver collective goods, is not easy, but it does happen. Some of the best examples involve *the delivery of collective goods to poor urban communities.*" (emphasis added)); Ruger, *supra* note 119, at 1076 ("Enabling individuals to exercise their agency—both individually and collectively—enables them to prioritise and decide which health domains they value most (eg, to trade-off quality and quantity of life) and to choose what health services they would like to consume (eg, making choices about treatment options)."). The most dramatic example of civil societies organized around health rights has been seen in the effectiveness of the various campaigns for access to HIV treatments. *See* PETCHESKY, *supra* note 96, at 76-124.

336. Macfarlane et al., *supra* note 18, at 845; *id.* at 842 ("Experience during the past few decades has shown that people can organise themselves to solve their own public-health issues and other concerns in partnership with government and non-governmental organisations (NGOs).").

337. *See* VanderWal, *supra* note 211, at 85-86 (noting objections to collective human rights in "Western circles"); Obiora, *supra* note 267, at 396 ("A peculiar feature of Western legal discourses and practices is the primacy of the individual over society.").

338. *But cf.* Gostin et al., *supra* note 165, at 68 (noting the existence of a "prevention paradox," wherein "those measures that have the greatest potential for improving pubic health (like seatbelt use) offer little absolute benefit to any individual, while measures that heroically save individual lives (like heart transplants) make no significant contribution to the population's health" (citing Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 INT'L J. EPIDEMIOLOGY 32, 38 (1985))).

339. *See* VanderWal, *supra* note 211, at 90 (noting that "the rights of collectivities can be analyzed adequately and without loss of meaning in terms of individual rights").

340. Chris Brown, *Universal Human Rights: A Critique*, *in* HUMAN RIGHTS IN GLOBAL POLITICS 103, 110 (Tim Dunne & Nicholas J. Wheeler eds., 1999) (noting that human rights are not "absolutes to be defended in all circumstances"); Jacobson & Soliman, *supra* note 163, at 713 ("Writings on health and human rights consistently recognize that individual rights can be limited to protect public health."); Kirby, *supra* note 130, at 16 ("In the past, when human rights impinged on public health, they were usually discussed as a legal concept in terms of the right of public health authorities, acting for the state, to depart from human rights of individuals in the name of the public health of the whole community."). The International Covenant on Civil and Political Rights explicitly permits derogation from individual negative rights where "provided by law" and where

rian theorists give reflexive preeminence to individual rights, subordinating the communitarian and positive rights of public health where even a slight abridgement of individual liberties exists.[341] Even some health and human rights scholars, often viewing public health through the lens of state responses to the AIDS epidemic, have argued that "public health programs should be considered discriminatory and burdensome on human rights until proven otherwise."[342] This zero-sum view of individual and collective health rights has led to a largely false dichotomy in state obligations for health, obligating states to apply individual curative interventions for health harms best served through public health systems. Because of this "emphasis . . . on individualism and market forces rather than on the collective responsibility for social welfare," rights scholars have been unable to develop a global public health ethic.[343] Through globalization, these Western models of individualism and curative health have been transplanted to developing states.[344] As a consequence, global public health and the individuals who make up the public have suffered.

An example of this is seen in the emergence of antibiotic and antimicrobial resistance. Stemming from the overuse and misuse of an individual medical treatment for a disease (e.g., underdosing), the microorganisms responsible for a disease can develop resistance to specific treatments, remaining immune to that treatment in both the patient and in secondary contacts (i.e., subsequent patients).[345] Although drug resistance has

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"necessary to protect public safety, order, *health* or morals or the fundamental rights and freedoms of others." International Covenant on Civil and Political Rights art. 11(3), *opened for signature* Dec. 16, 1966, S. Exec. Doc. E, 95-2, at 27 (1978), 999 U.N.T.S. 171, 176 (entered into force Mar. 23, 1976) (emphasis added).

341. DONNELLY, *supra* note 41, at 114 ("[A] society in which self must always be categorically subordinated to other simply cannot be considered 'civilized' in the twenty-first century."); JOHN RAWLS, A THEORY OF JUSTICE 101 (1971) (arguing that the principle of equal liberty must be fully satisfied before any consideration is made of the principle of equality of opportunity). *But cf.* Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations on Personal and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1109 (2003) (acknowledging the necessary abridgement of individual rights in cases of "significant risk").

342. Mann et al., *supra* note 123, at 13; *see also* Gostin & Hodge, *supra* note 165, at 87 ("Public health law struggles to determine the point at which government authority to promote the population's health must yield to individual rights claims.").

343. Annas, *supra* note 184, at 1780.

344. Evans, *supra* note 44, at 212 (noting that NGO involvement with humanitarian aid has exported Western conceptions of medicine and justice); Falk, *Interpreting the Interaction of Global Markets and Human Rights*, *supra* note 13, at 74 (noting that neoliberal thinking has moved to incorporate a narrow view of human rights that includes only select civil and political rights); McMichael & Beaglehole, *supra* note 16, at 4 ("In developing countries, health has become largely commodified as an asset to be managed by personal behavioral choices and personal access to the formal health care system.").

345. For a discussion of the biochemical underpinning of disease mutations that cause antibiotic and antimicrobial resistance, see J.T. Magee et al., *Antibiotic Prescribing and Antibiotic Resistance in Community Practice: Retrospective Study, 1996-8*, 319 BRIT. MED. J. 1239, 1240 (1999); SUB-GROUP ON ANTIMICROBIAL RESISTANCE, STANDING MED. ADVISORY COMM., DEPT. OF HEALTH, THE PATH OF LEAST RESISTANCE (1998).

become a pressing fixture of global public health,[346] with determinants often outside the national context,[347] there has been little momentum for international regulation to control the resistance epidemic[348] and no proposal to ground such an effort in human rights. In this context, an individual right to health not only is incompetent to speak to such issues but is detrimental to public health. Specifically, whereas a right to health seems to require the medication (erring on the side of overmedication) of individual patients, the process of treating individuals, when practiced writ large, can lead directly to the resistance that poses such a threat of irreparable harm to public health.

Containment of drug resistance, as a public health strategy for achieving a collective public good,[349] mandates that physicians not try to achieve the highest attainable standard of health for each patient when there is a reasonable likelihood that doing so will lead to a drug-resistant strain of the disease.[350] Although the individual right to health was developed by states at a time of unprecedented promise for individual medical treatments,[351] the circumstances underlying this faith in a pharmaceutical pan-

346. Laurie Garrett, *The Return of Infectious Disease*, 75 FOREIGN AFF. 66 (1996); Richard D. Smith & Joanna Coast, *Antimicrobial Resistance: A Global Response*, 80 BULL. WORLD HEALTH ORG. 126, 126 (2002) (noting that antimicrobial resistance harms public health by reducing the effectiveness of existing treatments, leading to morbidity, mortality, and unnecessary health care expenditure); *see, e.g.*, David Brown, *Firms Are Asked to Stop One-Drug Malaria Therapy*, WASH. POST, at A08, Jan. 20, 2006 (noting a WHO warning that artemisinin use for malaria could lead to drug resistance, with WHO requesting that private pharmaceutical corporations refrain from its use as a standalone therapy); Paul Farmer, *Pathologies of Power: Rethinking Health and Human Rights*, 89 AM. J. PUB. HEALTH 1486, 1487 (1999) (discussing the human rights implicated by the emergence of tuberculosis strains that have acquired resistance to multiple drug regimens). Antimicrobial resistance, irreversible once developed, results in exacerbated harm in developing states, "where many of the second and third line therapies for drug-resistant infections are unavailable, and many of the narrow spectrum antimicrobials available in the developed world are not affordable." Richard D. Smith & Joanna Coast, *Antimicrobial Drug Resistance*, *in* GLOBAL PUBLIC GOODS FOR HEALTH: HEALTH, ECONOMIC, AND PUBLIC HEALTH PERSPECTIVES, *supra* note 281, at 73, 73.

347. Smith & Coast, *supra* note 346, at 73-74 ("In an increasingly interconnected world, AMR [antimicrobial resistance] is a problem against which no single country can orchestrate a response sufficient to protect the health of its population.").

348. David P. Fidler, *Legal Issues Associated with Antimicrobial Drug Resistance*, 4 EMERGING INFECTIOUS DISEASES 169, 172 (1998), *available at* http://www.cdc.gov/ncidod/eid/vol4no2/fidler.htm (arguing that "the global scope of antimicrobial resistance indicates that an integrated strategy operating at both the national and international legal levels is needed").

349. *See* Smith & Coast, *supra* note 346, at 127 (finding the containment of antimicrobial resistance to be a public good).

350. Such regulation of physician behavior, particularly where such regulation is perceived to infringe upon a physician's duty toward each individual patient, may present practical obstacles to national policy reform from both physician's organizations and pharmaceutical corporations. *See* Fidler, *supra* note 348, at 173 (noting, in the context of the United States, that "any attempt to legislate more rational use of drugs might evoke negative reactions from physicians and their medical associations, who might oppose the government's efforts to interfere with their professional judgment").

351. *Supra* note 203 and accompanying text; *see also* PANNENBORG, *supra* note 28, at 85 ("Due to the increasing effectiveness of microbiological control and its stupendous breakthroughs in the Second World War period (e.g., antibiotics), this importance [of

acea have long past.[352] Rather than focusing on the narrow goals of the individual patient, health regulation must consider the effect of fleeting individual need against permanent effects on the public's health. Further, because the creation of such resistant strains threatens the entire planet, national regulation of pharmaceutical use will have little impact on this global public good in the absence of a mutual commitment from all nations.[353] A right to public health would provide the human rights foundation for developing such international regulation that strikes a balance between individual and collective rights, protecting public health through the rational use of antibiotic and antimicrobial drugs.[354] Such a framework for working toward the global public good of containing antimicrobial resistance—if developed by the WHO pursuant to the recommendations of the following section—would provide the legal harmonization, financial structures, global epidemiologic surveillance, public health information and reporting, enforcement infrastructure, and collaborative research and quarantine mechanisms necessary to contain antibiotic and antimicrobial resistance.[355]

As with creating drug resistance frameworks, although individual and collective health rights may at times conflict, these conflicts should have no greater impact on human rights than current conflicts between negative and positive rights.[356] As seen in the periodic effectiveness of international environmental regulation,[357] by recognizing the interdependence of individual and collective human rights, it becomes apparent that there need not always be a tradeoff between advancing individual human rights and promoting public health. In a globalized world, the collective enjoyment of public health is a precondition for an individual human right to health, with public health systems addressing the collective determinants of health outside of the control of the individual. Through a right to public

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public health] decreased steadily as microbiological threats to health had by then either been eliminated all together or could be controlled at increasingly low costs.").

352. Smith & Coast, *supra* note 346, at 73 (noting the emergence of a "post-antibiotic" era) (citations omitted).

353. *Id.* at 126 ("No country acting on its own can adequately protect the health of its population against AMR [antimicrobial resistance]. International collective action is essential, yet responsibility for health remains predominantly national.").

354. For an analysis of various proposals for national and international regulation of antimicrobial resistance, see Fidler, *supra* note 348 (discussing programs for public health); Smith & Coast, *supra* note 346, at 127-31 (discussing means of global collective action).

355. At present, WHO is investigating the role that it can play in organizing and facilitating a global response to antimicrobial resistance. *See* World Health Organization, *WHO Global Strategy for Containment of Antimicrobial Resistance* WHO/CDS/CSR/DRS/2001.2 (2001), *available at* http://www.who.int/drugresistance/WHO_Global_Strategy_English.pdf.

356. *See supra* notes 207-211 and accompanying text.

357. Lorraine Elliot, *The United Nations' Record on Environmental Governance: An Assessment*, *in* A WORLD ENVIRONMENT ORGANIZATION: SOLUTION OR THREAT FOR EFFECTIVE INTERNATIONAL ENVIRONMENTAL GOVERNANCE? 27-28 (Frank Biermann & Stephen Bauer eds., 2005).

health, the discourse of collective rights can be used to supplement individual rights in affirming the inherent equality and solidarity of all people.

E. International Obligations

A right to public health would give states renewed sovereignty over health in international development discourses. Working through formal human rights discourses, rather than the noncommittal and ineffective languages of morality, charity, or social justice,[358] provides a normative framework for debating the lending policies of the IMF and World Bank and trade policies of the WTO, protecting health infrastructures during structural adjustment and trade negotiations and shaping national public health systems to address those most vulnerable to the ramifications of globalization.[359] This rights-based approach to development[360] would allow the participation of public health scholars and advocates in development discourses, reforming the conditions upon which development decisions are made and carried out.[361] Employing such "an integrated socioeconomic approach to development,"[362] a right to public health would allow health considerations beyond simply the provision of health services. In doing so, a framework for addressing a right to public health would provide health standards for development programs and projects, improve the enforcement of health rights, and provide supervisory bodies with the national-level epidemiological data necessary to show a rights violation.[363] Through national and international considerations of the degree of societal health risk and/or benefit, the cost of the public health obligation, and the efficacy of the public health program, public health indicators could be factored into traditional human rights impact assessments of development

358. *See* DONNELLY, *supra* note 41, at 67 ("The meager amounts of humanitarian and development aid currently offered amount not even to a down payment on an emaciated global welfare state.").

359. *See* Mazur, *supra* note 19, at 61 (noting that "rights-based development is gaining adherents and becoming more fully articulated and integrated into national and international development polices [sic] and practices").

360. The author qualifies this by noting that a rights-based approach to development is distinguished from the right to development that is discussed in the following section. *Compare* notes 226-233 and accompanying text. *See also* Hamm, *supra* note 233, at 1010 ("The right to development cannot function as a substitute for a human rights approach to development, because of its vagueness, lack of legal obligation laid down in an international treaty, and lack of consensus."); Mary Robinson, *Foreword* to MARTA SANTOS PAIS, A HUMAN RIGHTS CONCEPTUAL FRAMEWORK FOR UNICEF at iv (1999), *available at* http://ideas.repec.org/p/ucf/inness/inness99-1.html (click on "download the selected file"; then follow "open PDF" hyperlink) (defining "a rights-based approach to development" as "describing situations not in terms of human needs, or areas for development, but in terms of the obligation to respond to the rights of individuals" which "empowers people to demand justice as a right, and not as a charity").

361. *See* Hamm, *supra* note 233, at 1011.

362. H. MAHLER, INTRODUCTION OF THE DIRECTOR-GENERAL ON THE ACTIVITIES OF THE WORLD HEALTH ORGANIZATION: THE NEW INTERNATIONAL ECONOMIC ORDER 1 (1976).

363. In considering the public health impact of development projects, public health indicators could be employed in weighing the development needs of a particular country, the identification of particular development projects, project design, and implementation.

projects.[364] In so doing, a collective right to public health can speak to deficiencies in both the formal public health system and underlying determinants of health brought about by economic globalization.

Where states cannot overcome the obstacles of economic restructuring and meet minimum public health standards alone, a right to public health, securing a global public good, would create international obligations for realizing health. Merely holding individual governments accountable for their failure to realize human rights ignores the degree to which those individual governments have lost control over the spread of disease within their own borders and the responses they take to improve underlying social determinants of health.[365] The determinants of health have become increasingly supranational. The rise of such a global risk society[366] necessitates an international response that takes into account the interconnectedness of the world system. A human rights paradigm that views each state in isolation fails to appreciate the global power relations inherent in resource distribution. International law must govern those aspects of regulation that fall outside the jurisdiction of individual states.

The realization of collective rights in a globalized world requires international cooperation.[367] In fulfilling these international obligations, a collective right to public health would provide states with additional tools to act cooperatively in disease prevention and health promotion, with national epidemiological public health programs working together to stem disease throughout the world.[368] The UDHR provides that "everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."[369] While rarely recognized by scholars of the UDHR, this international order is particularly relevant for facilitating the UDHR's promise of health rights: "*a standard of living adequate for the health* and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social

364. *See* ECOSOC, CESCR, *International Technical Assistance Measures: General Comment 2*, ¶ 8(b), U.N. Doc. E/1990/23 (Feb. 2, 1990) (recommending that consideration be given by U.N. agencies to the proposal that human rights impact statements be required to be prepared in connection with all major development activities) (citing E/CN.4/1334, ¶ 314); *see also* MAC DARROW, BETWEEN LIGHT AND SHADOW: THE WORLD BANK, THE INTERNATIONAL MONETARY FUND, AND INTERNATIONAL HUMAN RIGHTS LAW 271 (2003) (applying human rights impact assessments to international development projects).

365. *See supra* Part I.

366. *See generally* ULRICH BECK, THE RISK SOCIETY: TOWARD A NEW MODERNITY (1992) (laying out the concept of a global risk society).

367. *See* Mazur, *supra* note 19, at 63.

368. *See* Mark W. Zacher, *Global Epidemiological Surveillance: International Cooperation to Monitor Infectious Diseases*, *in* Global Public Goods: International Cooperation in the 21st Century 266, 268-69 (Inge Kaul et al. eds., 1999).

369. UDHR, *supra* note 123, art. 28. While this provision details the "social and international order" necessary for realization of the rights in the UDHR, it neglects to describe the economic order that has become so heavily correlated with health indicators. *See* Falk, *supra* note 13, at 71.

services."[370] Creating the "social and international order" necessary to uphold a right to public health will require international structures for facilitating cooperation among public health systems.[371] Health rights necessitate international cooperation.[372] Under an expansive right to health and public health, each state bears an obligation to assist other states in addressing global health disparities.[373] General Comment 14 lends credence to this interpretation of health rights, with the CESCR "emphasis[ing] that it is particularly incumbent on State parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfil their core and other obligations."[374]

Globalization has channeled the spread of disease, connected societies in shared vulnerability, and highlighted the risks posed by inadequate domestic legislation.[375] Yet if globalization has presented challenges to health promotion and disease prevention, globalized institutions offer the promise of bridging national boundaries to alleviate these inequities. Because, as noted above, health is a public good, international markets cannot create the institutions necessary to create public health infrastruc-

370. UDHR, *supra* note 123, art. 25 (emphasis added). As a result of the lack of discourse or application of the "substantive commitments" to human rights expressed in Articles 25 and 28, Richard Falk refers to these Articles as the "the sleeping provisions" of the UDHR. Falk, *supra* note 13, at 71.

371. *See* Cees Flinterman, *Three Generations of Human Rights*, *in* HUMAN RIGHTS IN A PLURALIST WORLD: INDIVIDUALS AND COLLECTIVITIES, *supra* note 211, at 75, 79 ("A social and international order, as mentioned in Article 28 [of the UDHR], embodies the idea that a full promotion and protection of human rights in a particular state is dependent upon worldwide solidarity or to use that old-fashioned term ?brotherhood' (*fraternité*).").

372. *See* NIELSEN, *supra* note 1, at 37 (concluding that "the realization . . . of the right to health presupposes an institutional framework through which action can be taken in order to combat health problems in individual countries").

373. *See Report of the Special Rapporteur* (Feb. 13, 2003), *supra* note 1, ¶ 28. ("States are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy adversely impacts upon the right to health, and that their representatives in international organizations take due account of the right to health, as well as the obligation of international assistance and cooperation, in all policy-making matters.") (citing *General Comment 14*, *supra* note 108, ¶¶ 38-39). With prescient recognition of the implications of state activity on global health, Judge Christopher Weeramantry's dissenting opinion in *Legality of the Use by a State of Nuclear Weapons in Armed Conflict* became the first legal acknowledgement of state responsibility for global health. Legality of the Use by a State of Nuclear Weapons in Armed Conflict, Advisory Opinion, 1996 I.C.J. 226, 429 (July 8) (Weeramantry, J., dissenting). Citing Article 12 of ICESCR, *supra* note 126, Judge Weeramantry found "that the recognition by States of the right to health is in the general terms that they recognize the right of 'everyone' and not merely of their own subjects. Consequently, each State is under an obligation to respect the right to health of all members of the international community." *Id.*

374. *General Comment 14*, *supra* note 108, ¶ 45 (citing ICESCR, *supra* note 2, art. 2.1).

375. Hassan El Menyawi, *Toward Global Democracy: Thoughts in Response to the Rising Tide of Nation-to-Nation Interdependencies*, 11 IND. J. GLOBAL LEGAL STUD. 83, 88-90 (2004); Taylor, *supra* note 1, at 501; *see also* FIDLER, *supra* note 12, at 13 (noting that "the distinction between national and international public health has been obliterated through the emergence and re-emergence of infectious diseases").

tures.[376] Where the externalities of these public goods are non-divisible and non-excludable at the international level, such as global disease eradication, these public goods become global public goods, necessitating collective state action at the global level.[377]

Such cooperation can be fulfilled through state participation in public health lawmaking within the WHO. Global collective action through international law is essential to develop the governance structures for "dealing with externalities that can take on global dimensions"[378] and thus are outside the control of individual states.[379] Although the WHO has not taken advantage of its authority under the individual right to health,[380] by moving health rights toward a recognition of global public goods, a right to public health would provide the necessary impetus for the WHO to employ its treatymaking authority to coordinate state actions to achieve global public goods for health.[381] As states have become largely impotent to prevent disease through domestic legislation[382] and regional organizations, international health law has become necessary to impose obligations on states and provide the global public health systems necessary to confront the globalization of disease.[383] By examining threats to public health for what

376. STIGLITZ, *supra* note 39, at 222 (noting that "[m]arkets cannot be relied upon to produce goods that are essentially public in nature"); Beauchamp, *supra* note 201, at 272 (arguing that markets have been "fatally deficient in protecting the health of the public"); *see also* Terry M. Moe, *The New Economics of Organization*, 28 AM. J. POL. SCI. 739, 759 (1984) (noting that bureaucracies exist because of the failure of markets to provide for public goods).

377. *See* Scott Barrett, Johns Hopkins Univ., Sch. of Advanced Int'l Studies, Remarks at the Ninety-Eighth Annual Meeting of the American Society of International Law: Shifting Norms in International Health Law (Apr. 1, 2004), *summarized in* 98 AM. SOC'Y INT'L L. PROC. 13 (2004). For a description of polio elimination as a national public good in developed countries, see Arhin-Tenkorang & Conceição, *supra* note 280, at 491.

378. STIGLITZ, *supra* note 39, at 223.

379. Chen et al., *supra* note 12, at 286-87; Anne-Marie Slaughter, *The Real New World Order*, 76 FOREIGN AFF. 183, 184; *see* Evans, *supra* note 44, at 210 (noting that securing health rights in all countries requires "strategic planning at the global level, global management and the creation of global regimes and agreements").

380. NIELSEN, *supra* note 1, at 63 ("Where the UN in Article 12 ICESCR has endorsed an approach as a human right to health the WHO has generally addressed health as a set of factual functional problems to be solved by direct action."); Chapman, *supra* note 1, at 193-94 ("Despite the rhetorical commitment to a right to health in various documents, WHO does not understand this language as imposing specific requirements."); Kirby, *supra* note 130, at 14 ("In the field of health rights, WHO has historically demonstrated an ambivalence about defining health in terms of human rights.").

381. Taylor, *supra* note 22, at 1328 (noting that WHO "is the primary multilateral organization charged with addressing the international threat posed by emerging infectious diseases and improving global health conditions").

382. Dean T. Jamison et al., *International Collective Action in Health: Objectives, Functions, and Rationale*, 351 LANCET 514, 515 (1998) ("Although responsibility for health remains primarily national, the determinants of health and the means to fulfil that responsibility are increasingly global.").

383. David P. Fidler, *The Globalization of Public Health: The First 100 Years of International Health Diplomacy*, 79 BULL. W. HEALTH ORG. 842, 844 (2001) ("Globalization undermines a state's ability to control what happens in its own territory. Consequently, it is necessary to construct procedures, rules, and institutions through international law."); Taylor, *supra* note 1, at 501 (citing R. DODGSON ET AL., GLOBAL HEALTH GOVERNANCE: A CONCEPTUAL REVIEW (2002)). *But cf.* Barrett, *supra* note 377, at 15 (doubting the

they are—violations of human rights—public health practitioners can build upon the WHO's nascent international lawmaking mechanisms to challenge global threats to public health.

Conclusion

As faculty and students of the Cornell Law School enter its esteemed Moot Court Room, they are confronted by Roscoe Pound's admonition: "The law must remain stable, but it cannot stand still."[384] Such it is with health rights. Although health is a fundamental human right, without which no other rights would be possible, those committed to global justice cannot move forward solely on the inertia of an established individual right to health. The social transformations inherent in globalization engage an evolving framework for health rights. With globalization transmuting health risks from the individual to collective level, responding to changes in underlying determinants of health demands the evolution of health rights to encompass a collective right to public health.

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effectiveness of international law for public health in the absence of mechanisms for assessing and enforcing financial contributions).

384. ROSCOE POUND, INTERPRETATIONS OF LEGAL HISTORY 1 (1923).