THE HIGHEST ATTAINABLE STANDARD: ADVANCING A COLLECTIVE HUMAN RIGHT TO PUBLIC HEALTH*

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I. INTRODUCTION

Every individual positive right includes its underlying determinants, which often can be expressed as collective rights. The right to health is no exception. Although largely ignored in

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formalistic analyses of the right to health, modern processes of globalization make clear that a collective right to public health is necessary to give meaning to health rights. Globalization has transformed health and disease, diminishing individual control over health status while magnifying the impacts of societal determinants of health. The paradigm of individual health, focused on a right to individual medical care, is no longer applicable to a globalizing world, compelling a renewed focus on the societal factors that facilitate the spread of disease. Through an emphasis on the 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.

Globalization[1] has fundamental implications upon individual and public health. State implementation of neoliberal economic policies has resulted in the escalation of endemic diseases and the rapid proliferation of infectious and chronic diseases. Controlling the spread of disease will require a set of rights commensurate to combating the insalubrious effects of these neoliberal policies. Thus, in analyzing health in the context of globalization, health policies cannot be viewed solely through the lens of medicine, but must encompass topics ranging from economic development and gender equality to agricultural sustainability and cultural practice. To participate in development policy and analyze the broad range of political, social, economic, and medical issues that underlie societal determinants of health, health scholars need the normative backing of a human right to public health.

Legal discourses surrounding health and human rights often

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1. The term "globalization" is used throughout this Article to refer broadly to the increasing interconnectedness between states that began, in its most recent form, in the early 1980s. Although this Article begins 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 exists within the stream of scholarship addressing the contentious dialectic between "globalization-from-above" (capital formation) and "globalization-from-below" (human rights). *See* Richard Falk, *The Making of Global Citizenship*, *in* Global Visions: Beyond the New World Order 39 (Jeremy Brecher et al. eds., 1993).

fail to view public health itself as a human right. Although the tension between individual human rights and governmental public health measures dominates health and human rights discourse,[2] particularly in the wake of bioterrorism fears and the SARS pandemic, emphasis on this conflict undermines health rights. Whereas many Western scholars focus on individual negative rights, i.e., those that restrain government action from infringing upon individual liberties,[3] a positivistic human rights framework acknowledges that governments must act affirmatively to fulfill the economic, social, and cultural components of human rights.[4] Fulfilling these positive components of health rights will require both individual and collective rights, including rights belonging to minorities, peoples, and societies.[5] These collective health rights,

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2. 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.*, Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights*, *in* Health and Human Rights 444, 444–46 (Jonathan M. Mann et al. eds., 1999); S. King, *Vaccination Policies: Individual Rights v. Community Health*, 319 Brit. Med. J. 1448, 1449 (1999); Lawrence Gostin & Zita Lazzarini, Human Rights and Public Health in the AIDS Pandemic 43–55 (1997).

3. Jürgen Habermas, Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy 85 (William Rehg trans., 1996) (1992) (characterizing the Western notion of individual rights as "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"); *see* John Rawls, Political Liberalism 173 (1993) ("[T]he right and the good are complementary: no conception of justice can draw entirely upon one or the other, but must combine both in a definite way."); Peter D. Jacobson & Soheil Soliman, *Co-opting the Health and Human Rights Movement*, 30 J. L. Med. & Ethics 705, 707 (2002) (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").

4. *See* Louis Henkin et al., Human Rights 320–30 (1999) (discussing how governments promote the political-civil and economic-social rights of citizens); Henry J. Steiner & Philip Alston, International Human Rights in Context 136–41, 146–53 (2d ed. 2000) (discussing basic instruments of the human rights movement that address economic and social rights); *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).

5. 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 83, 93–94 (Jan Berting et al. eds., 1990) (laying out the qualifications of collectivities necessary "for ascription of

rights advanced but never codified in international law, are public health.

This Article advances a society-based collective right to public health that complements the individual human right to health. Viewing public health as a necessary precondition for fulfilling health rights in the modern age of globalization, a global public health framework may be realized through which states can join together under international human rights law to oppose global threats to the public's, and each individual's, health. Beginning with an acknowledgement of globalization's challenges to disease prevention and health promotion, this Article attempts to frame the difficulties in addressing public health. After defining the scope of the individual human right to health, the authors argue that globalization has created new underlying determinants of health unaccounted for by this limited right. The authors find that inherent in an evolving human right to health is a collective right to public health, a right both recognized in jurisprudential discourse surrounding the right to health and justified as a collective right independent of, yet complementary to, the individual right to health. This Article concludes that a new framework is essential for health rights, one which explicitly acknowledges the public health interventions necessary to fulfill individual health needs. By laying out rights-based solutions to global health dilemmas, the authors advocate the use of international law in confronting disease, thereby allowing states to come together to solve collective harms under the mantle of a human right to public health.

II. GLOBALIZATION OF DISEASE

Modern processes of globalization impact public health through myriad proximal and distal mechanisms. Although modernization has led to many improvements in health,[6] it has,

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rights and obligations of its own").

While this Article advances a collective right to public health, this Article 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.

6. A.J. McMichael & R. Beaglehole, *The Changing Global Context of Public*

through multiple, overlapping processes,[7] also served to exacerbate disparities in health between rich and poor.[8] While this section addresses globalization's alterations to the social conditions underlying health, it can only hope to outline these issues in broad, thematic terms. By identifying these social conditions in the broadest terms, this part, like the Article as a whole, simply lays out directions for future research as scholars and policymakers consider the ramifications of globalization on public health.[9]

While globalization is not new,[10] the present wave of

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) (noting that economic development and international health systems have improved health status in developing countries).

7. *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 though 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").

8. 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)).

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 authors accept 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." U.N. Econ. & Soc. Council [ECOSOC], Comm. on Human Rights, *Report of the Special Rapporteur: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 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/e06a5300f90fa0238025668700518ca4/9854302995c2c86fc1256cec005a18d7/$FILE/G0310979.pdf (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).

9. *See* Tony McMichael & Robert Beaglehole, *The Global Context of Public Health*, *in* Global Public Health 1, 1 (Robert Beaglehole ed., 2003) (noting the lack of systematic research concerned with the effects of globalization on health).

10. Ilona Kickbusch & Kent Buse, *Global Influences and Global Responses; International Health at the Turn of the Twenty-First Century*, *in* International

globalization is unique in its rate, speed, and volume of interaction.[11] Global trade and travel allow infectious diseases to spread rapidly throughout the world, disregarding national and regional boundaries.[12] Under this new, globalized risk of disease, divisions between region and government no longer guarantee protection.[13] The rapid transmission of disease among populations cannot be stymied at the local, or even national, level. Where once quarantines and other public health measures were effective in safeguarding a state from infectious disease, infectious diseases have reemerged in force through globalization, emasculating even the most advanced national health controls. As seen most recently in the AIDS, SARS, BSE (mad cow disease), avian influenza, and drug-resistant tuberculosis pandemics, infectious diseases are no longer relegated to the developing world. 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."[14]

Despite this universalization of infectious disease, differential risk for health threats endures through economic privilege. The spread of many diseases is abetted by socioeconomic conditions conducive to pathogen transmission and unequal access to

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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); Julio Frenk et al., *The Globalization of Health Care*, *in* International Co-operation in Health 31, 44 (Martin McKee et al. eds., 2001).

11. David P. Fidler, International Law and Infectious Diseases 14 (1999); David Dollar, *Is Globalization Good for your Health?*, 79 Bull. W. 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.").

12. Fidler, *supra* note 11, 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.").

13. 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)).

14. Jonathan M. Mann, *Preface* to Laurie Garrett, The Coming Plague, xi–xii (1994).

health resources.[15] While globalization offered the promise of economic growth and its resulting benefits to health,[16] the harsh realities of globalization have led to uneven distributions of wealth and increases in poverty.[17] Through neoliberal economic programs, "specific 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."[18] These effects of globalization are felt at both the individual and societal levels.

At the individual level, the radical individualism spawned by global economic markets has turned attention away from the structural preconditions of health, forcing individuals to bear the burdens of disease alone.[19] Inadequate housing, sanitation, and

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15. Link & Phelan, *supra* note 7, at 81–82 (reviewing studies highlighting "the ubiquitous and often strong association between health and socioeconomic status").

16. 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 [WHO] & World Trade Organization [WTO], WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat 23 (2002), http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf (enumerating the health benefits of freer trade and economic growth, including reduced tariffs on medical equipment and improved international patent protections on medications).

17. McCorquodale & Fairbrother, *supra* note 16, 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.").

18. Joyce V. Millen et al., *Introduction* to Dying for Growth: Global Inequality and the Health of the Poor 3, 6–7 (Jim Yong Kim et al. eds., 2000) [hereinafter Dying for Growth]. *But cf.* Dollar, *supra* note 11, 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 17 ("Analysis of 137 countries shows that the incomes of the poorest 20% on average rise and fall in step with national growth or recession.").

19. Dan E. Beauchamp, *Public Health as Social Justice*, *in* Health and Social Justice 267, 269–70 (Richard Hofrichter ed., 2003); *see also* Maria Stuttaford, *Balancing Collective and Individual Rights to Health and Health Care*, L. Soc. Just. & Global Dev. 5 (June 4, 2004),

medical services plague impoverished urban communities throughout the developing world.[20] 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.[21] At the same time, chronic diseases such as cardiovascular disease and diabetes, once seen predominately in developed countries, are on the rise in developing countries.[22] This "double disease burden"[23] of both infectious and chronic diseases has risen to pandemic levels. When disease does strike, these disadvantaged individuals often find themselves with a lack of medical knowledge and unable to access skilled medical care due to high physician expenses and geographic disenfranchisement.[24] This interplay between powerlessness, poverty, and disease has served only to validate the widely held assumption that "disease epidemics result from social processes,"[25] reinforcing notions that individuals are responsible for their own health status.

At the societal level, global financial institutions disadvantage public health structures. Whether created by the International Monetary Fund (IMF), the World Bank, or trade

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http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/stuttaford/stuttaford.rtf ("[T]he increasing emphasis on the responsibility of citizens [for health] is a trend that has been identified as part of neoliberal policies.").

20. For an 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).

21. Jennifer Brower & Peter Chalk, The Global Threat of New and Reemerging Infectious Diseases 21–22 (2003).

22. Derek Yach et al., *The Global Burden of Chronic Disease*, 291 J. Am. Med. Ass'n 2616, 2617–18 (2004) (noting that as economic development begins, tobacco use, obesity, and other risk factors 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 not yet seen in any developing state); *see also* Chen et al., *supra* note 11, at 288–289 (noting that globalization of advertising has contributed to exponential increases in the developing world in the array of chronic diseases correlated with smoking).

23. Macfarlane et al., *supra* note 8, at 841.

24. Commission on Macroeconomics and Health, *Macroeconomics and Health* 23 (2001), http://www.cid.harvard.edu/cidcmh/CMHReport.pdf.

25. Brooke G. Schoepf et al., *Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa*, *in* Dying for Growth, *supra* note 18, at 91, 92; *see also* Beauchamp, *supra* note 19, at 274 (warning public health scholars to "be suspicious of behavioral paradigms for viewing public health problems since they tend to 'blame the victim' and unfairly protect majorities and powerful interests from the burdens of prevention").

agreements,[26] 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.[27] For example, structural adjustment programs (SAPs)—IMF loans conditioned upon market-liberalizing adjustments to state institutions—have left many developing states without the health resources and infrastructures necessary to respond to the majority of the world's disease burden.[28] Through these SAPs, states are pressured 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...."[29] This dramatic scaling back of the government's role in providing health services has reversed many of

26. 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, *supra* note 18, at 11, 20; Joseph E. Stiglitz, Globalization and Its Discontents 17 (2002). Through what has become known as the "Washington Consensus," these organizations began the processes of engendering fiscal austerity, privatization, and market liberalization, creating the harbinger of the ills of globalization, structural adjustment programs.

27. Manuel Castells, The Informational City 347 (1989); 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).

28. *See* Jeffrey D. Sachs, National Bureau of Economic Research, Tropical Underdevelopment (Nat'l Bureau Econ. Research Working Paper No. W8119) (Feb. 2001), http://www.nber.org/papers/w8119.pdf (stating that IMF measures contribute to low growth rates and instability in recipient countries and recognizing the difficulty of technological diffusion across climate zones).

29. Stephen Gill, *Globalisation, Market Civilisation, and Disciplinary Neoliberalism*, 24 Millennium 399, 408 (1995).

the health gains achieved in developing countries, leaving debilitated national public health infrastructures (with a shortage of qualified physicians[30] and a limited arsenal of effective antimicrobial drugs[31]) that cannot bear the burden of modern disease epidemics.[32] 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,[33] leaving their peoples "poorer and less healthy than at the beginning of the SAP era."[34]

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 improving health.[35] Consequently, these developing country

30. *See* Macfarlane et al., *supra* note 8, at 844 (recognizing that "an underpaid, poorly motivated, poorly organised, and increasingly dissatisfied [medical] workforce also poses the greatest threat to [health sector] reform").

31. Fidler, *supra* note 11, at 16 ("With rare exceptions, antimicrobial drugs made available globally have had no significant impact on their intended targets.").

32. *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.").

33. Mahmood Monshipouri, Democratization, Liberalization & Human Rights in the Third World 54 (1995); *see* Audrey Chapman, *Core Obligations Related to the Right to Health*, *in* Core Obligations: Building a Framework for Economic, Social, and Cultural Rights 185, 212 (Audrey Chapman & Sage Russell eds., 2002) (noting that "poor countries are also 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, *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 notes that "health-care reformers have prioritized financial outcomes over health outcomes, and further imperiled the health of the poor." *Id.* at 152.

34. Schoepf et al., *supra* note 25, at 91–92.

35. McMichael & Beaglehole, *supra* note 9, at 9 ("[A]lthough responsibility for healthcare and the public health system remains with national governments, the fundamental social, economic, and environmental determinants of population

governments face enormous difficulties in making the long-term budgetary commitments necessary for real improvements in public health and health care infrastructures. Despite repeated World Health Organization 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."[36]

Compounding the damage of these global economic changes, the rising economic and political clout of transnational corporations (TNCs) has further undermined government efforts to make policy independent of corporate interests. Since governments are now vying with each other to attract TNCs, the balance of power has tilted in favor of the TNCs and away from host governments. This has led to a downward, standard-lowering competition among states—a "race to the bottom" in public health regulations[37]—allowing reckless TNCs to undermine health in the pursuit of profits.[38] TNCs not only damage local and global environments,[39] but also expose vulnerable

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health are increasingly supranational. This combination of liberal economic structures and domestic policy constraint promotes socioeconomic inequalities and political instability, each of which adversely affects population health."); *see* Chapman, *supra* note 33, at 215 (stating that a lowered government commitment to public health is a reflection of the privatization methods instituted by the IMF).

36. Fidler, *supra* note 11, at 12.

37. Joyce V. Millen & Timothy H. Holtz, *Dying for Growth, Part I: Transnational Corporations and the Health of the Poor*, *in* Dying for Growth, *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"); *see also* Kenichi Ohmae, The Borderless World: Power and Strategy in the Interlinked Economy 196 (1990) (noting that when corporations have a viable exit option, governments are forced into a race to the bottom with regards to regulation and taxation).

38. 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. Joel Brenner et al., *Neoliberal Trade and Investment and the Health of Maquiladora Workers on the U.S.-Mexico Border*, *in* Dying for Growth, *supra* note 18, at 261, 287.

39. *See* Chen et al., *supra* note 11, at 288–89 (noting the transnational health implications of "ozone depletion, global warming, and the disposal of toxic wastes").

populations to harmful products such as pesticides[40] and tobacco products.[41] As an extreme example of this, TNCs have facilitated the explosive trade of both conventional armaments and weapons of mass destruction.[42] Thus, with developing states lowering their labor, environmental, and health standards to gain advantage in encouraging economic investment by TNCs, it is the poor who often suffer the detrimental health consequences of economic restructuring.

Through these multiple, overlapping processes, disadvantaged populations have felt the acute burdens of globalization. As exemplified in the illustrations above, neoliberal economic institutions negatively affect the fundamental determinants of disease risk, health vulnerability, and government response. By recognizing that globalization harms health at the societal level—disproportionately affecting vulnerable populations independent of individual choice—public health programs attempt to redress socially-created inequities in the underlying determinants of health. The following sections address the public health and human rights frameworks that scholars have employed to alleviate the insalubrious burdens of globalization.

III. HEALTH—A LIMITED RIGHT

An individual right to health, implicit in the Universal Declaration on Human Rights (UDHR), is recognized as a

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40. 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, *supra* note 18, at 245, 257.

41. *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 (TNCs) to undermine the regulatory authority of national governments" in the context of tobacco control); Deborah Arnott, *The Killer's Lobbyists*, The Guardian (May 15, 2003), http://www.guardian.co.uk/analysis/story/0,3604,956270,00.html (noting the monumental influence of the tobacco lobby in the developing world).

42. McCorquodale & Fairbrother, *supra* note 16, at 749.

fundamental international human right.[43] Founded upon the non-derogable right to life,[44] the 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...."[45] In 1966, the United Nations legislatively embodied the economic and social parameters of this right in the International Covenant on Economic, Social and Cultural Rights (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."[46]

To achieve the full realization of this right, Article 12.2 of the ICESCR requires states to take affirmative steps necessary for "(b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment, and control of epidemic,

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43. *Universal Declaration of Human Rights*, G.A. Res. 217A, U.N. GAOR, 3d Sess., art. 3, U.N. Doc. A/810 (1948) [hereinafter UDHR]. As noted by Mann, "[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, *supra* note 2, at 16.

44. UDHR, *supra* note 43, art.3 ("Everyone has the right to life, liberty and the security of person."); Virginia A. Leary, *Implications of a Right to Health*, *in* Human Rights in the Twenty-First Century 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.").

45. UDHR, *supra* note 43, art. 25(1).

46. 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].

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 5 (e) (iv) of the International Convention for the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, art. 5, S. Exec. Doc. C, 95-2, at 4 (1978), 660 U.N.T.S. 195, 220–21 (entered into force Jan. 4, 1969); Articles 11 (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, art. 11, 12, and 14, 1249 U.N.T.S. 13, 18–19 (entered into force Sept. 3, 1981); and 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). While these and other bases of national and international law recognize a right to health, *see* ECOSOC, *supra* note 8, ¶¶ 11–20, these interpretations all stem from the cornerstone right elaborated in Article 12 of the ICESCR. Consequently, the authors find that any evolution of the ICESCR's rendering of the right to health will necessarily implicate the expansion of other sources of law.

endemic, occupational and other diseases; [and] (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[47] However, "since the listed measures constitute goals as opposed to actions that member nations must take,"[48] this treaty language provides little guidance as to the specific scope of states' obligations under the right to health.[49] Outside of the sweeping platitudes enunciated in national and 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,[50] the individual right to health has been interpreted to embrace, as part of its minimum core content,[51] basic provisions of emergency health care necessary to

47. ICESCR, *supra* note 46, art. 12.2. In addition, Matthew Craven 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]." Matthew C.R. Craven, International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development 141 (1995) (citing General Comment 3, *infra* note 54).

48. Allyn L. Taylor, *Making the World Health Organization Work*, 18 Am. J.L. & Med. 301, 327 (1992).

49. Fidler, *supra* note 11, 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"); Robert Beaglehole & Ruth Bonita, Public Health at the Crossroads 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"); *see* Chapman, *supra* note 33, at 193 (noting that because of confusion and controversy surrounding the right to health "few countries . . . utilise its norms as a framework for formulating health policy").

50. 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, *supra* note 2, at 54 (noting that the concept of a human right to health "has not been operationally defined"); Fidler, *supra* note 11, 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."); 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."); Norman Daniels, Just Health Care 7–8 (1985) (noting that a right to health embodies a confusion about the kind of thing which can be the object of a rights claim).

51. According to rights scholars, the essential minimum core content of an economic, social, or cultural right "corresponds with an absolute minimum level

save lives, including the treatment of prevalent diseases, the provision of essential drugs, and safeguards against serious environmental health threats.[52] Yet despite recent advancements in clarifying the scope and core content of the right to health, the legal content of even these fundamental conceptions of health remain undefined.[53]

Beyond providing for the minimum core content of the right to health, the level below which the right would lose all significance, Article 12 requires only that states take steps toward the "progressive realization" of the right to health. In accordance with the principle of progressive realization, legislatively 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*."[54]

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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." Aart Hendriks, *The Right to Health in National and International Jurisprudence*, 5 Eur. J. Health L. 389, 394 (1998). For a discussion of the appropriateness of having core obligations in light of extremely limited national budgets, see Chapman, *supra* note 33, at 195–97.

52. Brigit C.A. Toebes, The Right to Health as a Human Right in International Law 284 (1999); *Soobramoney v. The Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 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 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 generally* Comm. on Econ. Soc. and Cultural Rights, U.N. Econ. and Soc. Council, Report on the Twenty Second Session, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14*, ¶¶ 43–44, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment 14]; *cf.* Chapman, *supra* note 33, 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 an analysis and discussion of General Comment 14's elaboration of the right to health, see *infra* Part IV.B.1.

53. ECOSOC, *supra* note 8, ¶ 39 ("Although there is a growing national and international jurisprudence on the right to health, the legal content of the right is not well established."). *But cf.* 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) (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").

54. ICESCR, *supra* note 46, art. 2 (emphasis added). Even under the principle of progressive realization, "[i]n order for a State party to be able to

As a positive right, the right to health is resource dependent. 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."[55] Under the ICESCR's conception of the 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."[56]

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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." Comm. on Econ. Soc. and Cultural Rights, U.N. Econ. and Soc. Council, Report on the Fifth Session, Supp. 3, Annex III, *General Comment No. 3: The Nature of States Parties Obligations*, ¶ 10, U.N. Doc E/1991/23 (Dec. 14, 1990) (emphasis added), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.En?OpenDocument [hereinafter General Comment 3]. 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 52, at 189.

55. 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 because the principle renders health standards relative to the availability of economic resources"). 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 52, at 152 (noting that, as a consequence of the principal of progressive realization, the right to reproductive choice has been successfully asserted as a negative right but not as a positive right).

56. General Comment 14, *supra* note 52, ¶ 31; Eleanor D. Kinney, Lecture, *The International Human Right to Health*, 34 Ind. L. Rev. 1457, 1471 (2001) ("[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."); 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."); Fidler, *supra* note 11, 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.").

The right to health has been advanced in the ICESCR as an individual right, focusing on individual access to health care at the expense of collective health promotion and disease prevention programs. This limited, atomized right to health has not been effective in forcing states to recognize individual health as a fundamental human right,[57] with individuals lacking even the basic international legal standing to hold states accountable for their failure to uphold the right to health.[58] This failure of the right to health has left in its wake deteriorating national health systems that lack the ability to address an expanding set of societal health claims,[59] damaging vulnerable populations through its reliance on curative medical care rather than basic public health services.[60] Despite developments in public health since the original drafting of the ICESCR, the right to health remains mired in a curative or clinical model of health,[61] quixotically advancing individual medical solutions to problems requiring societal change through public health programs.[62] These dichotomized medicine-public health discourses

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57. Fidler, *supra* note 55, 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").

58. Hendriks, *supra* note 51, 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 (arguing that economic, social, and cultural rights should be recognized to the same extent as civil and political rights).

59. Lynn Freedman, *Strategic Advocacy and Maternal Mortality*, 11 Gender & Dev. 97, 103–04 (2003).

60. *See* Stuttaford, *supra* note 19, at 8 (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)).

61. 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 sensitized 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 33, at 187.

62. *Id*. at 213 ("The resurgence of some diseases, tuberculosis and malaria

have contributed to the ambiguity in implementing the right to health,[63] stymieing efforts to operationalize the right to health through public health programs. Thus, while public health has developed to meet changing health needs, the right to health has not evolved to meet this changing conception of health. Through the parts 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 interventions.

IV. GLOBALIZATION IMPLICATES A HUMAN RIGHT TO PUBLIC HEALTH

Globalization has taken responsibility for health out of the control of the individual, predetermining harm at the societal level.[64] Applying only a curative health model to societies under the individual right to health has denigrated collective responsibility for health, relegating obligations for healthy conditions to the individual alone.[65] Yet, to the degree that the right to health, like all individual

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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)); Beauchamp, *supra* note 19, 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.").

63. Chapman, *supra* note 33, 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.").

64. *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], in turn, 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.").

65. *See* Link & Phelan, *supra* note 7, at 80 ("The 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." (citing Marshall H. Becker, *A Medical Sociologist Looks at Health Promotion*, 34 J. Health & Soc. Behavior 1 (1993))); *see also* Childress & Bernheim, *supra* note 2, at 1195 ("The health of the public is a public good because it is not just the sum of

rights, is premised on the autonomy of the individual,[66] globalization's autonomy-diminishing effects impair an individual right to health and necessitate a collective approach to health rights.

Health rights, like other individual economic, social, and cultural rights, "plac[e] obligations on government to act for the communal good."[67] Rather than being viewed solely as a Millsian intrusion on individual liberties,[68] modern public health programs can be framed expansively as part of a social justice movement for shaping the underlying societal determinants of health, codifying nascent public health norms and researching ways to improve the health of the public and the individual in the modern era of globalization.[69] Through this broader construction of health rights, public health measures may enhance individual and collective rights by alleviating harmful societal determinants of health and assuring the provision of public goods necessary for beneficial health outcomes.[70]

Many models have been advanced to ameliorate the effects of globalization on health. While these approaches aim to improve

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individual health indices and cannot be attained through individual actions alone.").

66. *See*, *e.g.*, A.V. Campbell, Medicine, Health and Justice 48 (1978) (explaining that, under Kant's theory of autonomy, "priority should be given to those medical interventions most likely to increase autonomy amongst those least able to exercise it without outside help" (emphasis omitted)).

67. Lawrence O. Gostin, Public Health Law and Ethics 97 (2002).

68. John Stuart Mill, On Liberty 68 (Gertrude Himmelfarb ed., Penguin Books 1985) (1859) ("[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."); Jacobson & Soliman, *supra* note 3, at 707 ("The American interpretation of rights allows public health opponents to co-opt human rights arguments, using it to strictly mean negative civil rights and portray public health advocates as willing to limit citizens' individual rights in favor of collective rights.").

69. *See* Jacobson & Soliman, *supra* note 3, at 710 ("Public health is as much a social movement involved in framing the public understanding of issues as it is a political effort to legislate collective well-being.").

70. Dan Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 Hastings Center Reps. 28, 29 (1985) ("[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."); *see also* Habermas, *supra* note 3, at 86 ("In certain instances an individual right yields not only a right on the part of person *A* to something protected from the interference of third parties, but also a right, be it absolute or relative, to a share in organized services."); Gostin & Lazzarini, *supra* note 2, at xiv.

health, health is not the primary impetus for these interventions. For example, scholars have taken advantage of the current international relations environment to argue that global diseases amount to a threat to "human security," a rhetorical fiction meant to conjure up national security fears in response to public health threats.[71] Thus, instead of recognizing the loss of millions of lives as the result of AIDS, the United Nations Security Council highlighted the effects of AIDS on international peace and security. Compounding this deflection of health concerns, the United Nations has focused on health as a means to promote economic development.[72] However, this "health for growth" model inverts the causal link between development and health. Consequently, any attempts to improve development simply through technological health advancements,[73] ignoring the fundamental causes of disease, will continue to leave states unable to improve either economic development or health. By refocusing normative goals in health policy, it becomes possible to view the reduction of morbidity and mortality as ends unto themselves, not intermediaries on the path to economic development or national security.[74] Health is essential to "human flourishing" and the exercise of all other rights.[75] It is the threat to health, not its neoliberal sequelae, that should be the focus of those committed to

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71. *See*, *e.g.*, Larisa Mori et al., *Health, Human Security and the Peace-Building Process*, *in* Conflict and Human Security: A Search for New Approaches of Peace-Building 176, 179 (Hideaki Shinoda & Ho-Won Jeong eds., 2004) *available at* http://home.hiroshima-u.ac.jp/heiwa/Pub/E19/Chap8.pdf ("Poor health can be as devastating within a society as war, taking away from people their ability to exercise choice, take advantage of social opportunities and plan for their future."). As Director-General of the World Health Organization, Gro Harlem Brundtland described this concept as a form of "health security." Gro Harlem Brundtland, Health and Population, BBC Reith Lectures 2000 (May 3, 2000), *quoted in* Kelley Lee, Globalization and Health 19 (2003); *see also* H. Nakajima, *Global Disease Threats and Foreign Policy*, 4 Brown J. World Aff. 319, 319 (1997).

72. *See* Commission on Macroeconomics and Health, *supra* note 24, at 25 ("Because disease weighs so heavily on economic development, investing in health is an important component of an overall development strategy.").

73. Sachs, *supra* note 28.

74. *See* Yamin, *supra* note 53, 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.").

75. *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."); *see also* Amartya Sen, *Why Health Equity?*, 11 Health Econ. 659 (2002).

protecting the rights of our most vulnerable.

To protect health, we must reexamine the ways in which we view health solely as an individual right. Human rights scholars have underutilized international legal standards in advancing health care conditions.[76] Creating a framework for discussing public health as a human right—mainstreaming human rights in public health discourse—allows international legal bodies to derive concrete, measurable indicators for governments in enacting public health programs and assures that these governments can be held accountable by entire populations for their failure to fulfill these duties.

A. Public Health—A Limitless Vision

The term 'public health' refers generally to the obligations of a government to fulfill the collective rights of its peoples to health. Rather than focusing on the health of individuals, public health focuses on the health of societies.[77] At its most basic, "[p]ublic health is what we, as a society, do collectively to assure the conditions for people to be healthy."[78] Whereas medicine focuses primarily on individual curative treatments in clinical settings, public health actions protect and promote[79] the health of entire populations by using multi-disciplinary interventions to address the underlying determinants of health and disease.[80] By examining the underlying

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76. Cook et al., *supra* note 52, at 148 ("The application of human rights in the health care context remains particularly challenging because there is little, although growing, experience of their application at the national and international levels.").

77. D.E. Beauchamp & B. Steinbock, *Population Perspective*, *in* New Ethics for the Public's Health 25, 25 (D.E. Beauchamp & B. Steinbock eds., 1999) ("Whereas in medicine, the patient is an individual person, in public health, the 'patient' is the whole community or population.").

78. Comm. for the Study of the Future of Public Health, Institute of Med., The Future of Public Health (1988); *see also* McMichael & Beaglehole, *supra* note 9, at 2 ("Broadly defined, public health is the art and science of preventing disease, promoting population health, and extending life through organized local and global efforts."); 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").

79. 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*, *in* Global Public Health, *supra* note 9, at 243, 245.

80. Beaglehole & Bonita, *supra* note 49, at 147 box 7.1 (listing the

political, social, and behavioral determinants of health inequalities, public health research can be applied by local, national, and global governance structures to create social policies to stem the health inequities brought about by globalization.[81]

It was widely assumed that since clinical or curative health played an instrumental role in improving health in industrialized countries, it would also be the best model for developing countries with nascent healthcare systems.[82] Yet, in states of limited resources, it is public health programs that provide the most efficient means for the realization of the right to health, supporting a basis for widespread governmental health efforts that satisfy both the minimum core content of the right to health and the principle of progressive realization.[83] Compared with individual medical services, which states provide preferentially rather than universally, public health programs can raise health standards for more people using fewer resources.[84] 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.[85] Where financial resources are scarce and physicians more so, public health will have a far greater effect on the health of individuals than any attempts to achieve the progressive realization of an individual human right to health care.[86] In the context of this

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"essential elements of modern public health theory and practice").

81. McMichael & Beaglehole, *supra* note 9, at 2.

82. Christine McMurray & Roy Smith, Diseases of Globalization: Socioeconomic Transitions and Health 32 (2001).

83. Chapman, *supra* note 33, 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.").

84. *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).

85. McMurray & Smith, *supra* note 82, 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).

86. *See* George J. Annas, *Human Rights and Health—The Universal Declaration of Human Rights at 50*, 339 New Eng. J. Med. 1778, 1780 (1998) ("Public health deals with populations and prevention of disease – the necessary frame of reference in the global context."). 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?*,

interconnectedness between individual and public health, society-based disease prevention and health promotion efforts are necessary for a government to assure that health services are available, accessible, and acceptable to all.[87]

Although states have long recognized a responsibility to protect their populations from "obvious risks and hazards to their health,"[88] scholars have developed varied interpretations of what must be done collectively to assure "underlying determinants" necessary for health.[89] Many among the "human rights as public health" movement espouse a broad definition of public health, which extends beyond the traditional health field[90] 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.[91] Despite criticisms of this limitless expansion of the purview of public health,[92] this broad conception of

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324 New Eng. J. Med. 1500 (1991) (examining the public health response to HIV and AIDS and suggesting broader applications of this response to 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 59, at 105–06.

87. Kinney, *supra* note 56, 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").

88. Leary, *supra* note 44, 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.").

89. Lawrence O. Gostin, *Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann*, 29 J. L., Med. & Ethics 121, 122–123 (2001) (discussing various views of the determinants of public health).

90. Robert Beaglehole & Ruth Bonita, *Strengthening Public Health for the New Era, in* Global Public Health, *supra* note 9, at 253, 257.

91. 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. Annas, *supra* note 86, at 1779.

92. 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* Gostin, *supra* note 89, at 123 (highlighting the practical difficulties of moving public health into controversial, politicized fields in which it lacks expertise).

public health, focusing on structural etiologies, is gaining consensus among public health scholars, with "the realization that public health cannot be separated from its larger socioeconomic context. [93]

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,[94] others find that this conflation "fails to establish any meaningful lines of demarcation between individual health and public health."[95] 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.[96]

Under this expansive view of public health, programs and practitioners respond to the fundamental social structures affecting public and population health, which involves, *inter alia*, disease outbreaks, patterns of population growth, distributive justice, and deleterious lifestyle trends. In meeting these challenges and alleviating harm, public health approaches can be "designed to

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93. Meyer & Schwartz, *supra* note 91, at 1189 (citations omitted).

94. 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.").

95. Rothstein, *supra* note 92, at 145.

96. *See* McMichael & Beaglehole, *supra* note 9, at 3 (noting recent epidemiological consensus that "a population's health reflects more than the simple summation of the risk-factor profile and health status of its individual members").

achieve the greatest good for the greatest number,"[97] thus narrowing inequity in health status.

B. Protecting the Public's Health Through Human Rights Frameworks

Human rights frameworks offer unparalleled opportunities to advance public health and combat the injurious effects of globalization. Because health promotion and disease prevention address the underlying determinants of health, states must employ collective public health strategies that acknowledge the fundamental causes of health problems if health rights are to be secured. The interpretations of the individual right to health in the Committee on Economic, Social and Cultural Rights' General Comment 14 lay out a framework for examining public health systems within the context of article 12 of the ICESCR. But such a textual analysis is neither necessary nor sufficient to establish the evolution of a right to public health. While General Comment 14 has "gone far in clarifying the normative content of the right to health,"[98] its interpretations of the ICESCR lack the self-executing authority necessary to create national policy.[99] Recognizing the mere hortatory nature of General Comment 14, this part moves beyond the text of the General Comment to discuss the normative evolution of a right to public health. Moving beyond the confines of current discourse on article 12, this part discusses a more robust anchor for public health as a distinct, collective human right. Finally, this part harmonizes the discourses between the individual and collective rights to health, finding that a collective vision of health rights is compatible with fulfillment of the individual right to health. Only after establishing these bases in law and theory can a right to public health advance from academic interpretation to legislative reality, giving societies the normative authority to hold states accountable for addressing globalization's alterations to the underlying determinants of health.

1. Revisiting General Comment 14

In 2000, the United Nations Committee on Economic, Social

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97. Jacobson & Soliman, *supra* note 3, at 709.

98. Yamin, *supra* note 53, at 330.

99. *Cf.* ECOSOC, *supra* note 8, ¶ 7 (noting that "the right to health can enhance health policies and also strengthen the position of health ministries at the national level").

and Cultural Rights (CESCR), the legal body charged in the ICESCR with drafting official interpretations of and monitoring state compliance with the ICESCR,[100] took up the evolving issues surrounding the right to health in drafting General Comment 14. With the CESCR viewing the curative conception of health in Article 12 as anachronistic in light of a modern understanding of health disparities,[101] General Comment 14 implicitly acknowledges a correlation between individual and public health, finding access to public health services and information to be necessary components of the right to health.[102] Even where General Comment 14 does not explicitly label these strategies as public health, it nevertheless solidifies the public health underpinnings of the right to health, holding that governments are responsible for addressing the "underlying determinants of health."[103]

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100. 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).

101. Rosalind Pollack Petchesky, Global Prescriptions: Gendering Health and Human Rights 119 (2003) ("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."); *see* Chapman, *supra* note 33, at 189 ("[T]here is now far greater awareness than at the time the Covenant [ICESCR] was drafted that health status reflects a wide range of non-medical factors.").

102. Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities*, 63 Md. L. Rev. 20, 112 (2004) (noting that General Comment 14 "directly mention[s] population-based health obligations that fit well within the traditional public health paradigm"); Chapman, *supra* note 33, 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").

This correlation between individual and public health is in accordance with the CESCR's expanding review of public health programs under the right to health. 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. Cook et al., *supra* note 52, at 189–90 (noting the CESCR's criticism of Gambia for inadequate maternal and child public health services) (citing U.N. Comm. on Econ., Soc. and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Political Rights: The Gambia*, ¶ 16, UN Doc. E/C.12/1994/9 (May 31, 1994)).

103. ECOSOC, *supra* note 8, ¶ 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 52, ¶ 8)). *But cf.* Chapman, *supra* note 33, at 197 (arguing that General Comment 14 does not attempt to provide a definition of health).

According to the text of General Comment 14, the right to health codified in Article 12 of the ICESCR extends

> not 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.[104]

Further, in prescribing the steps to be taken by states under Article 12.2(b) through (d), the CESCR has delineated several state obligations. For example, there exists a state obligation to (1) "discourage[] the abuse of alcohol, and the use of tobacco, drugs and other harmful substances" under the right to a healthy natural and workplace environment;[105] (2) "make available relevant technologies" under the right to treatment and control of diseases;[106] and (3) provide "equal and timely access to base preventive, curative, rehabilitative health services and health education... appropriate treatment of prevalent diseases... [and] the provision of essential drugs" under the right to health care facilities, goods, and services.[107] Thus, through General Comment 14, the CESCR has elaborated specific entitlements to several underlying determinants of health within the right to health.

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."[108] Moreover, 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 health policy relies heavily on prevention and promotion which are approaches directed primarily to groups."[109] This semicolon

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104. General Comment 14, *supra* note 52, ¶ 11.

105. *Id*. ¶ 15.

106. *Id*. ¶ 16.

107. *Id*. ¶ 17. For a diagrammatic analysis of those rights included in and excluded from the right to health under General Comment 14, see Gostin, *supra* note 67, at 98 fig. 8.

108. General Comment 14, *supra* note 52, ¶ 37.

109. *Id.* at n.30.

linkage between collective rights and public health clearly evidences a link between the individual right to health and disease prevention and health promotion, the twin hallmarks of public health practice.

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.[110] For states to create an environment conducive to good health, thereby realizing the right to health for their peoples pursuant to Article 12 of the ICESCR, they must establish an expansive public health system, fulfilling the economic, social, and cultural rights and the civil and political rights upon which health is based.[111]

However, such expansive language is insufficient to establish a collective right to public health programs. Despite criticism that it "go[es] far beyond what the treaty itself provides and what the states parties believe to be the obligation they have accepted,"[112] in fact, General Comment 14 cannot go far enough in providing for a

110. Mann et al., *supra* note 43, at 8; *see also* Toebes, *supra* note 52, at 17–18 (comparing a "right to health" with a "right to health care," finding the former to be more expansive and encompassing the latter).

111. *See* Marks, *supra* note 4, at 136 (noting General Comment 14's recognition that civil and political rights also determine health status).

112. 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 (April 1, 2004) *summarized in* 98 Am. Soc'y Int'l L. Proc. 13, 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; criticizing the CESCR's interpretation for lacking the "rigor one would see in a law journal article making the case that a particular interpretation is a legal obligation of states parties to that treaty." *Id*. at 20. Without trivializing the role of the United States government in shaping the right to health, the authors find that this strict constructionist approach to the right to health improperly constrains the definition of health itself, minimizes the role of treaty interpretation bodies, reduces the right to health to nothing more than a civil and political right, and vitiates any state responsibility for the health of its peoples.

collective right to public health. As an interpretive body, the CESCR merely lays out programmatic recommendations for those states seeking to uphold an individual right to health. Because of this, states have taken regressive liberties in their "progressive realization" of public health programs, with the CESCR's legislative overreaching permitting reactive state practice in blatant nonconformity with General Comment 14's public health recommendations, thereby hampering the advancement of collective health rights.[113] For these reasons, nothing short of a formalized collective human right can fulfill societal needs for public health.

2. A Collective Right to Public Health

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."[114] Through globalization, the underlying determinants of health "transcend spatial boundaries to signify respective degrees of overlaps and commonalities in experiences,"[115] 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.[116]

Globalization's societal impacts on health implicate collective

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113. *See* Reidar K. Lie, *Health, Human Rights and Mobilization of Resources for Health*, 4 BMC Int'l Health & Human Rights (Oct. 8, 2004), http://www.biomedcentral.com/content/pdf/1472-698X-4-4.pdf (noting that judicial bodies have been reluctant to examine allocation of public health resources because there remains no normative consensus as to how such state judgments should be made).

114. Meyer & Schwartz, *supra* note 91, at 1191.

115. Amede Obiora, *Feminism, Globalization, and Culture: After Beijing*, 4 Ind. J. Global Legal Stud. 355, 402 (1997).

116. Jonathan M. Mann, *Human Rights and AIDS*, *in* Health and Human Rights, *supra* note 2, at 216, 222.

responses to health dilemmas.[117] Such a collective framework involves an expansive right to public health, obligating states to address the systematic and social conditions that underlie disease.

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."[118] Where appropriate, it is possible to reenvision human rights *a priori* in light of shifting paradigms,[119] reformulating rights to "reflect[] changing needs and perspectives and respond[] to the emergence of new threats to human dignity and well-being."[120] The social transformations inherent in globalization engage an evolving framework for health rights.[121] General Comment 14 is an initial, though incomplete, part of this evolving notion of the right to health.

Globalization theory offers a useful basis for considering both the fundamental causes of disease and the collective rights implicated by our interconnected world, acting as a starting point from which to proclaim these necessary rights and anchor a public

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117. *See* VanderWal, *supra* note 5, 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.").

118. Philip Alston, *Conjuring Up New Rights: A Proposal for Quality Control,* 78 Am. J. Int'l L. 607, 607. Alston cautions, 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"). This basis for dynamism in human rights is based on the legal maxim propounded by Roscoe Pound, "law must be stable and yet it cannot stand still." Roscoe Pound, Interpretations of Legal History 1 (1923).

119. *See* Habermas, *supra* note 3, 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) (emphasis in original)).

120. Alston, *supra* note 118, at 609.

121. *See* J. Herman Burgers & Rob Kroes, *Introduction Item: Social Transformation and Human Rights*, *in* Human Rights in a Pluralist World, *supra* note 5, at 167, 167 (assuming that "major processes of social transformation exert significant influences on approaches toward human rights and on compliance with them").

health response to global issues. Through globalization, "tension persists between the philosophy of neoliberalism, emphasizing the self-interest of market-based economics, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal."[122] 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.[123] 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...."[124] In the areas of health promotion and disease prevention, collective human rights offer a framework for addressing societal iniquities resulting from globalization, forcing national governments to be responsible to all their people rather than bowing to the rampant individualism bred by the engines of globalization.[125]

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.[126] Like many environmental protections,[127] public health,

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122. McMichael & Beaglehole, *supra* note 9, at 10.

123. *E.g.*, Anthony Giddens, The Third Way: The Renewal of Social Democracy (1998).

124. Lee, *supra* note 71, at 15 ("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. . . .").

125. This process of using globalized human rights processes to counteract globalized economic processes involves what Boaventura de Sousa Santos refers to as "localized globalism," in which "the specific impact of transnational practices and imperatives on local conditions . . . 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).

126. Dyna Arhin-Tenkorang & Pedro Conceição, *Beyond Communicable Disease Control*, *in* Providing Global Public Goods 484, 489 (Inge Kaul et al. eds., 2003); Beauchamp, *supra* note 19, 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*, 36 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,

based upon its non-divisible and non-excludable externalities, cannot easily be divided among individuals but can only be enjoyed in common with similarly-situated peoples.[128] 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.[129] 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 public health program. A collective human right is necessary to give meaning to this public good and provide for its realization under international law. This collective right is a right to public health.

At a programmatic level, a collective right to public health would buttress the long-term and sustainable health infrastructures necessary to address societal determinants of health.[130] While the state cannot easily be held accountable for meeting individual health needs—where such responsibility is increasingly being assumed by partnerships of public, private, and not-for-profit actors[131]—the state has far greater control over the underlying conditions for people to be healthy, a collective right which could be upheld at substantive and procedural levels under a human right to public health.

Substantively, state obligations would arise in connection with infectious and non-infectious disease surveillance, with national

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supra, at 491.

127. 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 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).

128. *See* VanderWal, *supra* note 5, 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.").

129. *See* Chen et al., *supra* note 22, 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").

130. 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 33, at 204.

131. Stuttaford, *supra* note 19.

epidemiological public health programs working together to stem disease for all.[132] In addition to disease prevention, such a right to public health would require states to create the programs necessary for health promotion,[133] as a "government possesses an obligation, within the constraints of its resources, to provide an environment conducive to the public's health and well-being."[134] Similarly, the preamble to the WHO Constitution declares that governments have a responsibility to provide both adequate health and social measures.[135] These social measures, as noted by Aart Hendriks,

> Entail[] 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.[136]

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132. *See* Mark W. Zacher, *Global Epidemiological Surveillance*, *in* Global Public Goods: International Cooperation in the 21st Century 266, 268–69 (Inge Kaul et al. eds., 1999).

133. WHO defines health promotion to include "the process of enabling people to increase control over, and to improve, their health." Constitution of the World Health Organization, July 22, 1946, *in* WHO, Basic Documents (40th ed. 1994), at Preamble [hereinafter WHO Constitution]; First Int'l Conf. on Health Promotion, Ottawa Charter for Health Promotion, 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 2, at 29 (noting that at a minimum, a state has a duty "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* United Nations, Population and Development, Programme of Action Adopted at the International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994; United Nations, Department of Public Information, Platform for Action and Beijing Declaration. Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995.

134. Gostin & Lazzarini, *supra* note 2, at xiv.

135. *Id.*

136. Hendriks, *supra* note 51, 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 cooperation with public or private organizations . . . (1) to remove as far as possible the causes of

Procedurally, a right to public health would guide states in their allocation of health resources.[137] In meeting 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-efficient yet effective delivery of life-saving services to the greatest number of people.[138] Further, a right to public health would provide concrete, measurable national indicators by which international treaty bodies could better gauge and adjudge states' annual reports on the realization of health rights, assuring that these governments would be held accountable for realizing health.

3. Harmonizing Individual and Collective Health Rights

Collective rights operate in ways similar to individual rights, often seeking the same goals.[139] However, rather than seeking the

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> 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.

Council of Europe, European Social Charter, art. 11 (1996).

137. *Compare* Lie, *supra* note 113 (noting that an individual right to health provides no basis for adjudicating competing claims for resource allocation), *with* Stuttaford, *supra* note 19, at 8 (suggesting that "viewing rights in a collective framework may assist in framing resource allocation decisions").

138. *See*, *e.g.*, Chapman, *supra* note 33, at 211 ("To be consistent with a human rights approach, these funds [for health expenditures] should be invested to bring about the greatest health benefit for the population."); *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 ["It is little use looking at the statistics to find out how many doctors and other auxiliary medical staff there are for a given number of the population; how many hospitals, clinics and beds are built or acquired every year, nor what percentage of the national budget is spent on providing health facilities to the population. It is necessary to ascertain how many benefit from these facilities."). 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 52, ¶ 10. As an example of highly economical implementation strategies inapplicable to the principle of progressive realization under the right to health, Hunt notes that states have an immediate obligation, without regard to resources, to prepare "a national public health strategy and plan of action." ECOSOC, *supra* note 8, ¶ 27.

139. *See* Obiora, *supra* note 115, at 396–97 ("Comparisions [sic] of empirical evidence suggest that one characteristic that radical Western

empowerment of the individual, collective rights act at a societal level to assure public benefits that cannot be fulfilled through individual rights mechanisms.[140] While Western scholars have often presupposed an opposition between individual and collective human rights,[141] 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 and complement each other. Yet this largely false dichotomy has led to the preeminence of individual curative interventions for health harms

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individualism shares with many other systems, where fundamental juridical, philosophical, political, and cultural traditions privilege the complex web of relations over the individual within, is a system of checks and balances which seeks to restrain the power elites and offer a measure of immunity to the individual. It appears that, even in worldviews without the dogmatic idiom of individual 'rights,' as in liberal democracies, there are indigenous structures designed to temper the exercise of authority and bind rulers to respect the human dignity of their subjects.").

140. 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, *supra* note 5, at 33–37; 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").

After the supremacy of individual rights in early United Nations treaties, collective rights received their first explicit recognition in the African human rights system, wherein African states memorialized communal rights in the Universal Declaration of the Rights of Peoples. 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). Since that time, scholars have put forth arguments for collective rights to, *inter alia*, development, environmental protection, humanitarian assistance, peace, and common heritage. Stephen Marks, *The Human Right to Development: Between Rhetoric and Reality*, 17 Harv. Hum. Rts. J. 137, 138 (2004). While some scholars refer to these collective rights as part of the third generation of human rights—part of a tripartite framework of first (civil and political), second (economic and cultural), and third (solidarity) generation rights, *id.*—the authors find 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.

141. *See* VanderWal, *supra* note 5, at 85–86 (noting objections to collective human rights in "Western circles"); Obiora, *supra* note 115, at 396 ("A peculiar feature of Western legal discourses and practices is the primacy of the individual over society.").

best served through public health mechanisms. With globalization impacting entire societies, collective rights and their corollary collective mechanisms become necessary to assure the collective action required to provide for the tools and shared benefits of public health. In refocusing efforts on health rights, the paradigm of individual health is no longer applicable to a globalized world. 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,"[142] combating the health disparities of a globalized world will require renewed focus on the collective social factors that facilitate the spread of disease. Creating societal interventions to combat these societal determinants of health will require broad public health infrastructures that move well beyond the individual curative model of medicine.

Despite widespread international acceptance of derogation from individual rights where necessary to secure public health,[143] Western libertarian 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.[144] Through globalization, this Western model has been transplanted to developing states.[145] 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.[146] As a consequence, global public health, and the individuals who make up the public, has

142. VanderWal, *supra* note 5, at 83.

143. Jacobson & Soliman, *supra* note 3, at 713 ("Writings on health and human rights consistently recognize that individual rights can be limited to protect public health."). The International Covenant on Civil and Political Rights explicitly permits derogation from individual negative rights where "provided by law, . . . necessary to protect public safety, order, *health* or morals or the fundamental rights and freedoms of others." International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, art. 12, S. Exec. Doc. E, 95–2 at 27 (1978), 999 U.N.T.S. 171, 176 (entered into force Mar. 23, 1976) (emphasis added).

144. *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").

145. McMichael & Beaglehole, *supra* note 9, 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.").

146. Annas, *supra* note 86, at 1780.

suffered.

Although individual and collective rights to health may at times conflict, these conflicts should have no greater impact on human rights than current conflicts between negative and positive rights.[147] 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. If individuals are bearers of a human right to health, societies then become the only possible bearers of a collective right to public health, with the collective right necessary to fulfill the individual right. That is, the individual and public components of health rights are not mutually exclusive but rather are interdependent.[148] In a globalized world, the collective enjoyment of public health is a precondition for an individual human right to health, with public health programs addressing the collective determinants of health outside of the control of the individual. The discourse of collective rights can be used to supplement individual rights in affirming the inherent equality and solidarity of all people. Thus, in the context of health policy, "popular sovereignty and [individual] human rights go hand in hand,"[149] with public health, as a collective right, working synergistically with individual health systems to guarantee the highest attainable standard of health for all.

C. International Law—The Globalization of Public Health

Globalization has channeled the spread of disease, connected societies in shared vulnerability, and highlighted the risks posed by inadequate domestic legislation.[150] Yet if globalization has presented challenges to health promotion and disease prevention, globalized

147. *See supra* notes 2–5 and accompanying text.

148. *See* VanderWal, *supra* note 5, at 90 (noting that "the rights of collectivities can be analyzed adequately and without loss of meaning in terms of individual rights").

149. Habermas, *supra* note 3, at 127.

150. Allyn L. Taylor, *Governing the Globalization of Public Health*, 32 J.L. Med. & Ethics 500, 501 (2004); 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); *see also* Fidler, *supra* note 11, at 13 (noting that "the distinction between national and international public health has been obliterated through the emergence and re-emergence of infectious diseases").

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 develop and maintain public health infrastructures.[151] 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.[152] Global collective action through international law is essential to develop the governance structures for "dealing with externalities that can take on global dimensions"[153] and thus are outside the control of individual states.[154] Whereas the United Nations Security Council has developed mechanisms for international security and the International Monetary Fund has developed mechanisms for economic stability, the World Health Organization (WHO) possesses the inherent capabilities to develop mechanisms of international cooperation for public health. Such international cooperation would coordinate international responses, minimize negative interdependencies between states, and avoid free-rider problems. This part proposes that states work together within WHO's treaty-making mandate to develop a governance structure for global public health.

The Universal Declaration of Human Rights 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

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151. Stiglitz, *supra* note 26, at 222 (noting that "[m]arkets cannot be relied upon to produce goods that are essentially public in nature"); Beauchamp, *supra* note 19, at 272 (arguing that markets have been "[f]atally deficient in protecting the health of the public"); *see also* Terry 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).

152. *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 (April 1, 2004) *summarized in* 98 Am. Soc'y Int'l L. Proc. 13, 13–16 (2004). For a description of the criteria that distinguish national from global public goods, see Arhin-Tenkorang & Conceição, *supra* note 126, at 491 for a description of polio elimination as a national public good in developed countries.

153. Stiglitz, *supra* note 26, at 223.

154. Anne-Marie Slaughter, *The Real New World*, 76 Foreign Aff., Sept.–Oct. 1997, at 183, 184; Chen et al., *supra* note 11, at 286–87.

realized."[155] Creating the "social and international order" necessary to uphold a right to public health will require international structures for facilitating cooperation in public health programs.[156] Health rights demand international cooperation. Under an expansive right to health and public health, each state bears an obligation to assist other states in addressing global health disparities.[157] General Comment 14 lends credence to this interpretation of the right to health, 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."[158] Nevertheless, the right to health, as an individual human right, cannot speak to the provision of public goods.[159] To meet these obligations, states must develop legal mechanisms under a collective right to public health to facilitate international flows of research, assistance, and cooperation.

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155. UDHR, *supra* note 43, art. 28.

156. *See* Cees Flinterman, *Three Generations of Human Rights*, *in* Human Rights in a Pluralist World, *supra* note 5, 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*).").

157. *See* ECOSOC, *supra* note 8, ¶ 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 52, ¶¶ 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. Citing article 12 of ICESCR, *supra* note 46, 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." Legality of the Use by a State of Nuclear Weapons in Armed Conflict, Advisory Opinion, 1996 I.C.J. 66, 144 (July 8) (Weeramantry, J., dissenting).

158. General Comment 14, *supra* note 52, ¶ 45.

159. *See supra* notes 126–129 and accompanying text*; see also* Anupam Chander, *Globalization and Distrust*, 114 Yale L.J. 1193, 1226 (2005) ("Human rights law, specifically, is difficult to characterize as a response to an n-person prisoners' dilemma.").

International treaty-making offers states the opportunity to work cooperatively to uphold health rights, challenging the globalization of disease through the "globalization of public health."[160] As states have become largely impotent to prevent disease through domestic legislation,[161] international health law has become necessary to provide the global public health infrastructure necessary to confront the globalization of disease.[162] In response to globalization, many international organizations will need to explore multilateral health governance structures as a means to safeguard public health.[163] Although the "failure of the internationalization of public health" is one of the primary pathologies of the re-emergence of infectious and noninfectious disease,[164] WHO's Framework Convention on Tobacco Control (FCTC)[165] has shown states the

160. *See* Fidler, *supra* note 55, at 2 (noting a "globalization of public health" to oppose harms to health resulting from economic globalization); Derek Yach & Douglas Bettcher, *Globalisation of Tobacco Industry Influence and New Global Responses*, 9 Tobacco Control 206, 206 (2000) (describing the "globalisation of public health," through which "a risk culture is emerging with the realisation that many problems are global, and that states cannot deal with these problems on their own").

161. *See* Giddens, *supra* note 13, at 126 ("All disembedding mechanisms take things out of the hands of any specific individuals or groups; and the more such mechanisms are of global scope, the more this tends to be so."); Dean T. Jamison et al., *International Collective Action in Health*, 351 Lancet 514, 515 (1998) ("Although responsibility for health remains primarily national, the determinants of health and the means to fulfill that responsibility are increasingly global."); *see also supra* notes 37–38 and accompanying text (discussing globalization's effects in creating a "race to the bottom" in domestic public health regulation).

162. Taylor, *supra* note 150, at 501 (citing R. Dodgson et al., Global Health Governance (2002)); 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."). *But cf.* Barrett, *supra* note 152, at 15 (doubting the effectiveness of international law for public health in the absence of mechanisms for assessing and enforcing financial contributions).

163. Taylor, *supra* note 150, at 500 ("[G]lobalization is creating a heightened need for new global health governance structures to promote coordinated intergovernmental action."). *But see* Petchesky, *supra* note 101, at 113 (noting that "transnational health and human rights movements have still not achieved an institutionalized process at the global level . . . that could enforce the principle of health as a human right superior to corporate property rights over life-saving medicines (or services)").

164. Fidler, *supra* note 11, at 17.

165. WHO Framework Convention on Tobacco Control, W.H.A. Res. 56.1,

benefits of international law in the field of health policy, facilitating effective multilateral public health measures to combat global disease. Through this delegation to WHO and restructuring of the extant contract between WHO and its states members, states were able to overcome domestic and collective-action problems to achieve a common good,[166] setting a valuable precedent for future international delegation in public health.

WHO is uniquely situated in centralized expertise and political influence to resolve issues of public health impervious to resolution at the state level,[167] a role that it has long filled through its drafting of successive International Health Regulations.[168] In adherence with a rationalist framework, states can be seen as less self-interested in the field of public health, delegating to WHO to constrain and shape state behavior in areas of policy agreement for mutual health protection. That is, WHO actions can become the result of state choice, with WHO itself becoming consequential in state decision-making.[169] This can allow WHO, acting in an agenda-

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World Health Assembly, 56th Ass., 4th plen. mtg, Agenda Item 13, Annex, WHO Doc. A56.VR/4 (May 21, 2003), http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf. Although the adoption of the FCTC—enabling states to overcome domestic and collective action problems to achieve a common good—should be seen as a great leap forward for public health, this first-ever treaty nevertheless focuses on trade at the expense of health, diminishing the treaty's moral weight in protecting health rights. *See* Crystal H. Williamson, *Clearing the Smoke: Addressing the Tobacco Issue as an International Body*, 20 Penn St. Int'l L. Rev. 587, 611 (2002) (noting that "participants [in FCTC drafting] themselves pointed out (and attempted to regulate) some matters that had decidedly more to do with trade than with health concerns").

166. *See* Varieties of Capitalism 10 (Peter A. Hall & David Soskice eds., 2001) (noting the importance of "institutions that reduce the uncertainty actors have about the behavior of others and allow them to make credible commitments to each other").

167. *See* Cook et al., *supra* note 52, at 192 ("[S]ince in the world's prevailing global economy few if any countries exercise full fiscal sovereignty, governments may be amenable to international persuasion and inducement to invest in such [public reproductive health] services compatibly with their human rights undertakings.").

168. Chen et al., *supra* note 11, at 284; David P. Fidler, *International Law*, *in* Global Public Goods for Health, *supra* note 127 at 177, 185 (recognizing the International Health Regulations as an example where WHO has allowed states to "use international law to establish procedures through which states and non-state actors come to grips with specific global public health problems").

169. For an explanation of the role of organizations in facilitating group interests and creating incentives for collective action, see generally Mancur Olson, The Rise and Decline of Nations 17–23 (1982); Jerry L. Mashaw,

setting capacity as a representative of the "community of states," to develop accepted norms independently, inducing a policy equilibrium that might not otherwise exist, resolving distributional conflicts, responding quickly to changes in global conditions, and facilitating interstate cooperation.[170]

Delegation to WHO poses several organizational advantages that alleviate the problems of disparate state policy while possessing inherent oversight controls that allow states to monitor and influence WHO progress in developing international health legislation. Before it is prepared for state ratification, states, acting through the World Health Assembly, can veto any offensive WHO action. The World Health Assembly, encompassing delegates of all member states and meeting at annual or special sessions, acts to adopt WHO conventions or agreements by a two-thirds majority vote, with each member state having one vote in the Assembly.[171] Even after a treaty is ratified, any treaty enforcement actions of WHO can be monitored *ex post*, with any outbreak of disease serving as a public "fire alarm" to states, calling attention to lapses in international public health policy without necessitating constant state observation and evaluation of every WHO action.[172] In addition, states can assert authority over WHO action *ex post* through budgetary allocations and bureaucratic appointments, with these *ex post* sanctions serving as *ex ante* incentives for WHO compliance with state policy preferences.[173]

Prodelegation: Why Administrators Should Make Political Decisions, 1 J. L. Econ. & Org. 81 (1985); F. Fenner et al., Smallpox and Its Eradication 422 (1988) (discussing the role of WHO in facilitating state cooperation in eradicating smallpox).

170. As an example of distributional conflict in public health, Chen et al. discuss the competing surveillance priorities surrounding emerging infections, wherein rich countries fear the importation of a new virus from poor countries while poor countries seek public health assistance for much more common endemic diseases. Chen et al., *supra* note 11, at 292.

171. WHO Constitution, *supra* note 133.

172. The "fire alarm" metaphor was first employed by Matthew McCubbins and Thomas Schwartz, who define fire alarms as "rules, procedures, and informal practices that enable individual citizens and organized interest groups to examine administrative decisions." Matthew D. McCubbins & Thomas Schwartz, *Congressional Oversight Overlooked: Police Patrols versus Fire Alarms*, 28 Am. J. Pol. Sci. 165, 166 (1984). Through this delegation to bureaucrats in the United States, McCubbins and Schwartz found that legislatures prefer less-visible, less-costly oversight, with fire alarms lowering the opportunity cost of legislation and allowing legislatures greater reward with less oversight.

173. *See* Barry R. Weingast & Mark J. Moran, *Bureaucratic Discretion or Congressional Control? Regulatory Policymaking by the Federal Trade*

An example of successful delegation to WHO is seen in the development and ratification of the FCTC. Although Article 19 of the WHO Constitution authorizes WHO to adopt conventions or agreements, WHO had never used this power before its promulgation of the FCTC in 2004.[174] Prior to the advent of the FCTC, only select Western states had enacted comprehensive tobacco control efforts.[175] Without a strong global leader, cooperative efforts against transnational tobacco corporations were not possible.[176]

Initially, because of the past reluctance of WHO to international law[177] and the modest level of global commitment to tobacco control, various commentators recommended that any WHO attempts to address the international tobacco pandemic involve only incremental standard setting.[178] Despite these initial doubts, WHO's expertise and independence allowed it to overcome obstacles to

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Commission, 91 J. Pol. Econ. 765, 769 (1983) (discussing *ex post* legislative control over U.S. bureaucracies).

174. Susan Connor, Legal Consultant, WHO, American Society of International Law Proceedings: Health, Human Rights and International Law (April 20-23, 1988) *summarized in* 82 Am. Soc'y Int'l L. Proc. 122, 129 (1990) ("We have the ability under the WHO Constitution to issue regulations and conventions that can be legally binding in form. We generally do not do that."). Prior to the FCTC, the UN had been the sole creator of conventions creating legally-binding obligations relating to health. *See, e.g.*, Convention on Elimination of All Forms of Discrimination Against Women, *supra* note 46, art. 18–20; Convention on the Rights of the Child, *supra* note 46, art. 52; ICESR, *supra* note 46, art. 12.

175. Allyn L. Taylor, *An International Regulatory Strategy for Global Tobacco Control*, 21 Yale J. Int'l L. 257, 268–273 (1996) (denoting several possible national tobacco control strategies). Even in the United States, a state noted for its advanced tobacco control efforts, public health statutes regulating tobacco have been faulted for their emphasis on political considerations rather than scientific reality. Clive Bates et al., *The Future of Tobacco Product Regulation and Labelling in Europe*, 8 Tobacco Control 225, 230 (1999) (noting that the U.S. Federal Trade Commission's regulation of tobacco content is scientifically flawed, legitimizing the "myth" of low-tar cigarettes).

176. *See* Kenji Shibuya et al., *WHO Framework Convention on Tobacco Control: Development of an Evidence Based Global Public Health Treaty*, 327 Brit. Med. J. 154, 156 (2003) (arguing that "the epidemic cannot be controlled by domestic policies alone").

177. *See* Taylor, *supra* note 48, at 303 (noting that "WHO's traditional reluctance to utilize law and legal institutions to facilitate its health strategies is largely attributable to the internal dynamics and politics of the organization itself").

178. *See, e.g.*, Taylor, *supra* note 175, at 285–86 (highlighting the effectiveness of an incremental and dynamic treaty model as compared with other types of international standard setting).

tobacco control in formulating the FCTC, permitting states to reach general principles of cognitive and normative consensus for addressing global tobacco. Using a "convention/protocol approach" to treaty-making, WHO intends to supplement the general obligations of the FCTC with several individualized protocols that will develop specific obligations for the respective aspects of tobacco control addressed by the FCTC.[179] Although the process of addressing the tobacco pandemic has just begun, WHO's efforts have paved the way for successful bureaucratic interventions to combat this heretofore insurmountable threat to public health.

As with tobacco, the processes of globalization have exacerbated many global health challenges while leaving individual states incapable of responding effectively in the absence of an institutionalized means of interstate cooperation.[180] With increasing issue complexity in the field of public health, necessitating rapid public health responses to emerging crises, the need for centralized expertise from a single, autonomous organ will only increase. Despite constraints on domestic sovereignty, states, particularly those without the necessary technical and organizational expertise, can overcome these public health crises through delegation. By delegating substantive lawmaking authority to WHO, public health

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179. Note by the Secretariat, *Future Protocol*, ¶ 1, *submitted to* The Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control, WHO Doc. A/FCTC/INB6/INF.DOC./2 (18 Jan. 2003) (noting that "the negotiation of a framework convention is not a complete process, but the beginning of one that will include the formulation of one or more protocols"); Luk Joossens, *From Public Health to International Law: Possible Protocols for Inclusion in the Framework Convention on Tobacco Control*, 78 Bull. W. Health Org. 930, 930–31 (2000); Laurence Boisson de Chazournes, Professor, University of Geneva, American Society of International Law Proceedings: International Law and Health, Two Approaches: The World Health Organization's Tobacco Initiative and International Drug Controls (April 2000) *summarized in* 94 Am. Soc'y Int'l L. Proc. 193, 194 (2000) ("In deciding that it would take the form of a framework convention, member states have indicated that the legislative process to be used will be of a continuing nature."); Daniel Bodansky, The Framework Convention/Protocol Approach 11, *submitted to* The Framework Convention on Tobacco Control WHO Doc. NCD/TFI/99.1 (1999), *available at* http://www.lancs .ac.uk/fss/law/intlaw/ibuslaw/docs/who_bodansky1999.pdf ("The framework convention/protocol approach allows law-making to proceed incrementally, beginning with a framework convention that establishes a general system of governance for an issue area, and then developing more specific commitments and institutional arrangements in protocols.").

180. *See supra* notes 26–36 and accompanying text (discussing the inadequacies of national public health structures in addressing global disease).

systems can benefit from WHO's greater technical specialization, credible long-term commitments, and political independence necessary for states to realize a collective human right to public health.

WHO has a vital role to play in developing global public health infrastructures, a role that could be augmented under the aegis of a human right to public health. Through the preamble to the WHO Constitution, states have declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," giving WHO the authority to examine health in its broadest conception: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[181] This conception of health necessitates examination of the underlying determinants of health through a rights framework,[182] an opportunity not taken with the FCTC.[183] Justifying public health controls under the authority of a human rights framework would provide WHO action with the normative mandate necessary to address globalization's harms to the underlying determinants of health. By examining threats to public health for what they are—violations of human rights—public health practitioners can build

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181. WHO Constitution, *supra* note 133, at Preamble. Nevertheless, the WHO Constitution is not viewed as anything more than aspirational in defining the right to health. Fidler, *supra* note 11, at 187 (citing Leary, *supra* note 44, at 489). *But cf.* Beaglehole & Bonita, *supra* note 49, at 223 ("The legal implications of the WHO definition of health are that nations have duties both to promote health, social and related services as well as to prevent or remove barriers to the realisation and maintenance of health.").

182. David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy*, 17 Harv. Hum. Rts. J. 99, 110 (noting that "[t]he preamble [of the WHO Constitution] expresses a vision for international health cooperation that places human rights at the center of attention, not the state and its interactions with other states"). Despite WHO's constitutional commitment to human rights, it has nevertheless been criticized for failing to operationalize human rights principles. Chapman, *supra* note 33, 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.").

183. Benjamin Mason Meier, *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 Yale J. Health Pol'y, L. & Ethics 137, 163 (2005) (arguing that "the FCTC never articulates the right to health as the normative justification for any of its obligations on states, robbing the FCTC of the moral authority necessary to enact comprehensive tobacco control programs"); *see also* Leary, *supra* note 50, at 167 (noting that WHO has "shown little interest in approaching health issues through the lens of human rights").

upon WHO's nascent international mechanisms to challenge global threats to health.

V. CONCLUSION

Without public health and the lives it protects and promotes, no other rights would be possible. Whether caused by an individual lack of curative care or a collective lack of public health, the resulting morbidity and mortality suffered represents a gross violation of human rights. Public health is a vital component of health rights, without which states could not assure the health of individuals. This Article has attempted to ground a human right to public health as a necessary pre-determinant for fulfilling health rights and addressing the harms of globalization.

Globalization is a transformative force for human rights, both for detrimental and beneficial ends. Detrimental to human rights, globalization processes have left developing states without the resources necessary to fulfill an individual human right to health. In this deregulated environment, it falls upon scholars to develop ways to protect and promote health rights given the realities and dynamics of the neoliberal political economy. Because the ills of globalization fall upon societal determinants of health, with whole nations serving as objects of development, it is at this societal level where health and human rights scholarship should be focused. The globalization of public health systems offers the prospect of reversing these injurious trends. Using a right to public health to catalyze state action, states can act multilaterally, through international law, to repel cross-border threats to health. By reframing health rights to acknowledge a collective right to public health, states can create the public health structures necessary to alleviate the inequitable health outcomes of globalization. This vision of health rights involves explicitly acknowledging the link between individual health and public health in international treaty law and identifying ways in which public health structures can impact the underlying determinants of health in advancing health status.

This Article has argued that public health is a right unto itself, not merely the basis for restricting other rights. While public health programs can impact individual rights, viewing public health only as a threat to individual rights loses sight of the role of public health in advancing collective rights. Incorporating a right to public health distinct from the right to health simply acknowledges the current dilemmas in upholding individual health rights while

addressing the neoliberal determinants of ill health. Thus, public health considerations should be part of any human rights impact assessment, wherein a collective right to public health can speak to deficiencies in both the formal public health system and underlying determinants of health. By emphasizing this indivisibility of rights in international law, states fulfill their role to secure the health of societies alongside individual rights, facing down shared threats to health in communal solidarity. Through legislative acknowledgment and judicial interpretation of this collective right, public health programs can foster equity in health between populations, engendering dignity and hope for the vulnerable and realizing the highest attainable standard of health.