HUMAN RIGHTS QUARTERLY

Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health

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ABSTRACT

Although there exists widespread recognition that the shared benefits of economic development can improve health, health advocates rarely appreciate the connections between the right to health and the right to development. The collective right to development, transcending the right to health's focus on the individual, offers public health actors an opportunity to work through development discourses to obligate and empower states to allocate public goods for the public's health. This article concludes that health scholars and advocates could employ the right to development to ensure that development policies guide states in realizing the highest attainable standard of health, fulfilling underlying determinants of health through the strengthening of national public health systems.

I. INTRODUCTION

Despite decades of support for international development programs, the persistence of poverty has remained an unsettling reality for billions around the world, limiting states in creating the conditions necessary for the health of their peoples. This inequitable suffering has served as a clarion call to scholars and activists working in the human rights tradition, a call made deafening by the pernicious imposition of neoliberal economic policies on developing states. With the rise of a health and human rights movement in public health scholarship, health advocates have joined human rights scholars in looking to the human right to health as a means of engendering salubrious development policy. If this human rights agenda is to find success in reversing the harms of neoliberal policy, it must now expand beyond the right to health. The existence of a vast interdisciplinary literature linking economic development with public health notwithstanding, health and human rights scholars have only begun to appreciate the intersections of the right to health with the right to development. This article finds that the collective right to development should be viewed as superseding an individual right to health, necessitating the provision of collective development as a means to realize the public's health.[1] Bounded by the disciplinary constraints of medicine, the resource constraints of the principle of progressive realization, and the individualistic constraints of the human rights regime, the right to health is normatively incapable of speaking to neoliberal development policy's denigration of underlying determinants of health. The right to development can address these collective processes of national development, providing a framework for increasing available resources, easing budgetary constraints on health systems, and providing equitably for underlying determinants of health. Transcending the right to health's focus on the individual, the collective right to development, as a vector of rights, offers public health actors an opportunity to work through international development discourses to empower individuals and states to allocate public goods for the public's health, realizing underlying determinants of health through national public health systems.

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1. Approaching "health" as a fundamental human right and the logical end of development processes, the authors examine only the association of economic development (as an independent variable) with health (as a dependent variable), rather than the inverse correlation favored by those approaching public health as a means to achieve economic ends. *Compare* World Health Organization, Comm'n on Macroeconomics and Health, Macroeconomics and Health: Investing in Health for Economic Development 25 (2001), *available at* http://www.emro.who.int/cbi/pdf/CMHReportHQ.pdf ("Because disease weighs so heavily on economic development, investing in health is an important component of an overall development strategy."), *with* Amartya Sen, Development as Freedom (2001) (finding the end goal of development to be individual fulfillment and capability for, *inter alia*, health).

Under the current framework of "rights-based approaches" to development, public health scholars and advocates have attempted to impose the individual human right to health on states to mitigate the injurious consequences of development policy implementation. Based largely on this individualistic framing of rights, however, the right to health has been ineffective in altering the neoliberal formulation of development policy, marginalizing the voices of public health in development debates. The common interpretation of the right to health as an individual right to health care and treatment has failed to address the underlying determinants of health that can only be achieved by the provision of public goods through public health systems. Addressing the public goods that underlie health requires a collective human rights framework, with rights held by both the individual and the state and duties borne by both the state and the international community. The collective human right to development provides such a framework for realizing health rights during development. Public health should embrace this effort and employ the right to development in pressing for equitable poverty alleviation and public health system protection as part of the development agenda.

This article proposes that the human right to development can be used as a tool to ameliorate underlying determinants of ill-health through development processes that bolster public health systems. In Part II, this study reviews evidence of the impoverishment of public health, delineating the links both between poverty and ill-health and between development and public health systems. Examining the prevailing public health responses to globalization, Part III analyzes the incomplete success of the individual human right to health—as part of a rights-based approach to development—in stemming the insalubrious ramifications of neoliberal development processes. Part IV discusses the rise of a collective right to development, chronicling its evolution in human rights jurisprudence and its application to public health goals. The argument culminates in Part V, which highlights the ways in which public health scholars and advocates could employ the right to development in creating legally-enforceable prescriptions for international development policy. The article concludes that the incorporation of public health advocacy and indices pursuant to the right to development would mainstream public health in development discourses and provide a normative framework for averting globalization's damage to public health systems and underlying determinants of health.

II. DEVELOPMENT AND HEALTH

Essential to making the case for the theoretical integration of the right to health within the right to development is a broader understanding of the empirical relationship between development and health. High rates of absolute

poverty and inequality within states have a profoundly negative impact on underlying determinants of health, affecting the health of entire populations. While development policies that reduce poverty and inequality have resulted in unparalleled improvements in public health, development policies that either (1) increase the number of people living in absolute poverty, (2) widen the degree of inequality, or (3) weaken public health systems are strongly associated with negative health outcomes.

A. Poverty—How a Lack of Development Impacts Public Health

The public health advancements arising from economic development have been reserved predominantly for the developed world. In the more than 200 years since the industrial revolution, the developed world has seen dramatic improvements in health.[2] Among developed nations, maternal and infant mortality rates have dropped dramatically,[3] life expectancies at birth have nearly tripled,[4] and the size of nations' respective populations have nearly quadrupled.[5]

In what is now the developed world, the eradication of absolute poverty and its attendant health conditions were instrumental in raising health outcomes. The reductions in infectious diseases at the beginning of the twentieth century, though often mistakenly attributed solely to advancements in medical technologies, resulted largely from broad improvements in economic development, higher standards of living, and the creation of social welfare programs.[6] Advances in nutrition, sanitation, and technologies have allowed

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2. As noted by economic historian Douglas North, "if we focus on the last 250 years, we see that growth was largely restricted to Western Europe and the overseas extensions of Britain for 200 of those 250 years." Douglas North, Nobel Prize Address (1993), *cited in* Gary M. Walton, A Brief History of Human Progress 6 (2004), *available at* http://www.fte.org/capitalism/introduction/02.html.
3. Walton, *supra* note 2, at 6.
4. E.A. Wrigley & R.S. Schofield, The Population History of England, 1541–1871: A Reconstruction (1981).
5. Prior to the modern period, population growth was largely held constant due to various checks such as epidemics, wars, and famines, as well as through chronic malnutrition and endemic disease. Abdel R. Omran, *The Epidemiologic Transition: A Theory of the Epidemiology of Population Change*, 49 Milbank Memorial Fund Q. 509 (1971); *see also* Samuel H. Preston, *The Changing Relation Between Mortality and Level of Economic Development*, 29 Population Stud. 231 (1975) (demonstrating that for the world as a whole, it took thousands of years for life expectancy at birth to rise from the low twenties to around thirty years in the mid-eighteenth century).
6. Simon Szreter, *Commentary: Rapid Economic Growth and "the Four Ds" of Disruption, Deprivation, Disease and Death: Public Health Lessons from Nineteenth-Century Britain for Twenty-First-Century China?*, 4 Tropical Med. & Int'l Health 146 (1999); Edward S. Golub, The Limits of Medicine: How Science Shapes Our Hope for the Cure 215 (1994); Thomas McKeown, The Role of Medicine: Dream, Mirage, or Nemesis? (1976).

for these unparalleled improvements in the human condition, heralding the rapid decline of malnourishment, infection, and poor nutrition that riddled pre-industrial Europe.[7] It is these public health advancements from economic development that have been reserved for the developed world. While the entire world has seen an upward trend in life expectancy at birth and other health indicators over the course of the past century, vast international public health inequalities persist, with developing countries continuing to experience high rates of infectious illnesses, shortened lifespan, and diminished quality of life, generating a vicious cycle of destitution and disease.

Although there continue to be global improvements in living standards, health, and well-being,[8] absolute poverty and its associated maladies remain the primary reasons for the failure of developing states to improve the health of their peoples.[9] As put forward by the World Health Organization (WHO): "Poverty wields its destructive influence at every stage of human life, from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all those who suffer from it."[10] At the end of the twentieth century, 1.2 billion people worldwide (20 percent of the global population) continued to live on less than $1/day purchasing power parity (PPP).[11] Adjusting this poverty line to a scantly less impecunious state of less than $2/day PPP more than doubles the number of those living in poverty to 2.8 billion people.[12] The health consequences of this extreme poverty remain dire: 14 percent of the global population (826 million) is undernourished, 16 percent (968 million) lacks access to safe drinking water, and 40 percent (2.4 billion) lacks basic sanitation.[13]

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7. Robert W. Fogel, *Economic Growth, Population Theory, and Physiology: The Bearing of Long-Term Processes on the Making of Economic Policy*, 84 Am. Econ. Rev. 369 (1994).
8. For their part, present day developing world countries have seen improvements in health indicators in the past 200 years, including decreased maternal and infant mortality rates and increases in life expectancy and population growth. World Health Organization, *Health and Development in the 20th Century*, *in* World Health Report: Making a Difference (1999), *available at* http://www.who.int/whr/1999/en/whr99_ch1_en.pdf.
9. Arthur Kleinman et al., *Introduction*, *in* Social Suffering ix, xx (Arthur Kleinman et al. eds., 1997) (noting that "poverty is the major risk factor" for AIDS, tuberculosis, and "most other forms of social suffering").
10. World Health Organization, Bridging the Gaps 5 (1995).
11. Purchasing power parity (PPP) is a measure of relative price level differences for one time period across countries, allowing for comparisons across countries that adjust for standards of living and relative prices of consumer goods and services, essentially creating a common currency. PPPs are calculated by first pricing a representative basket of goods and then the PPPs for the product groups are weighted and averaged to obtain PPPs at the aggregate level. *See* Michelle A. Vachris & James Thomas, *International Price Comparisons Based on Purchasing Power Parity*, Monthly Labor Rev., Oct. 1999, at 3; Organization for Economic Co-operation and Development, PPP FAQs, *available at* http://www.oecd.org/faq/0,2583,en_2649_34357_1799281_1_1_1_1,00.html.
12. For more information on these calculations, see Thomas W. Pogge, *Human Rights and Global Health*, 36 Metaphilosophy 183 (2005).
13. *Id.* (citing World Health Organization, World Health Report 2004 (2004)).

Globally, the two leading causes of disease burden in 2001 were perinatal conditions and lower respiratory infections (affecting 90 million and 86 million disability-adjusted life years respectively), both of which constitute poverty-related illnesses that are practically non-existent in high-income countries.[14] Widespread poverty, enabling damaging underlying determinants of health, has led to these injurious public health consequences throughout the developing world.[15] With nearly one-third of all deaths worldwide arising from these avoidable causes,[16] the endurance of underlying determinants of ill-health, namely the persistence of inequitable poverty, has stymied attempts to prevent this unnecessary sickness and death.

1. Underlying Determinants of Health

The rise of the "ecological model" in public health scholarship has led researchers to examine poverty as an underlying determinant of health, structuring detrimental health outcomes.[17] Through this appreciation of the broad, distal social conditions that underlie health,[18] the ecological model "implicates our collective responsibility for unhealthy behavior," with public health practitioners examining structural determinants of health, including "the causes of disease in the way society organizes itself, produces and distributes wealth, and interacts with the natural environment."[19]

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14. Colin D. Mathers et al., *The Burden of Disease and Mortality by Condition: Data, Methods, and Results for 2001*, *in* Global Burden of Disease and Risk Factors 45, 88 (Alan D. Lopez et al., eds., 2006), *available at* http://www.dcp2.org/pubs/GBD/3/FullText; http://www.dcp2.org/pubs/GBD/3/Table/3.14. The World Health Organization includes the following illnesses as those highly correlated with poverty: diarrhea; malnutrition; perinatal and maternal conditions; childhood diseases (measles, mumps, rubella); tuberculosis; malaria; meningitis; hepatitis; tropical diseases; respiratory infections (mainly pneumonia); HIV/AIDS; and STIs. Pogge, *supra* note 12, at 120–25 (citing World Health Organization, *supra* note 13).
15. Richard G. Wilkinson, *Income and Mortality*, *in* Class and Health: Research and Longitudinal Data (Richard G. Wilkinson ed., 1986) (noting the correlation between income and mortality).
16. Pogge, *supra* note 12 (citing World Health Organization, *supra* note 13).
17. Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: II. From Black Box to Chinese Boxes and Eco-Epidemiology*, 86 Am. J. Pub. Health 674 (1996).
18. *See* Anthony J. McMichael, *Prisoners of the Proximate: Loosening the Constraints on Epidemiology in an Age of Change*, 149 Am. J. Epidemiol. 887, 887 (1999) (advocating for a "social-ecologic systems perspective" to public health); Mervyn Susser, *Does Risk Factor Epidemiology Put Epidemiology at Risk? Peering into the Future*, 52 J. Epidemiol. & Community Health 608, 609–10 (1998).
19. Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 Colum. L. Rev. 59, 64 (1999); *e.g.*, Richard Parker & Peter Aggleton, *HIV and AIDS-related Stigma and Discrimination: A Conceptual Framework and Implications for Action*, 57 Soc. Sci. & Med. 13, 23 (2003).

This public health research draws on the work of social medicine[20]—a movement arising out the industrial revolution in pre-1848[21] Prussia and France and revitalized during the Second World War in Great Britain—which views medicine as an interdisciplinary social science necessary to examine how social inequalities shape the experience of disease.[22] With illness thought to have multiple social causes, social medicine scholars have long looked to social and political reform, rather than medicine, as a means of health promotion.[23] Eschewing personal medicine for "state medicine," John Ryle, the first academic chair in social medicine, argued in the aftermath of the Second World War:

> Among the more potent measures of protection may be included a national food policy, a national housing policy, improved working conditions, an improved and co-ordinated medical and health service, and social security legislation; and last but not least, a national education policy in which education for health—physical, mental, and moral—should come to play a far more significant part. These, rather than new hospitals and new specific remedies and surgical skills (much as we shall continue to need them), are among the true insurance policies for the advancement alike of human health and equity.[24]

While impugned through its association with socialism and communism,[25] social medicine has been rediscovered through an increased understand-

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20. Gerald M. Oppenheimer et al., *Health and Human Rights: Old Wine in New Bottles?*, 30 J. L. Med. & Ethics 522 (2002).
21. The year 1848 marks the wave of leftist revolutions that swept across European states, which, while largely failing to overthrow political regimes, resulted in vast changes in national social policies. With physicians taking a large part in the revolutionary discourses, public health comes to play a prominent role in post-1848 health policies despite the failure of the revolutions. *See* George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care 87 (1974).
22. Bryan S. Turner, *The Interdisciplinary Curriculum: From Social Medicine to Postmodernism*, 1 Soc. Health & Illness 5–7 (1990) (summarizing the history and tenets of social medicine); *e.g.*, Rudolf Ludwig Karl Virchow, Report on the typhus epidemic in Upper Silesia (1848), *in* Rudolf Ludwig Karl Virchow: Collected Essays on Public Health and Epidemiology 205, 310 (L.J. Rather ed., 1985) ("For there can now no longer be any doubt that such an epidemic dissemination of typhus had only been possible under the wretched conditions of life that poverty and lack of culture had created in Upper Silesia. If these conditions were removed, I am sure that epidemic typhus would not recur.").
23. John A. Ryle, Changing Disciplines: Lectures on the History, Method and Motives of Social Pathology 24 (1948); John A. Ryle, *The Meaning of Normal*, 1 Lancet 1, 5 (1947); René Sand, L'Économie Humaine par la Médecine Sociale 14 (1934) (defining social medicine to be "the preventive and curative art considered, both in scientific foundations as well as in its individual and collective applications, from the point of view of the reciprocal relations which link the health of man to his environment").
24. Ryle, Changing Disciplines, *supra* note 23, at 100.
25. Howard Waitzkin et al., *Social Medicine Then and Now: Lessons from Latin America*, 91 Am. J. Pub. Health 1592, 1592–97 (2001) (noting the influence of social medicine discourses in influencing the socialist call for improved labor and health conditions in Latin American states, focusing on the role of, *inter alia*, Salvador Allende in creating the Chilean national health service and Ernest (Che) Guevara in advancing "revolutionary medicine"); *e.g.*, Friedrich Engels, The Condition of the Working Class in England (W.O. Henderson & W.H. Chaloner trans., 1968).

ing of underlying determinants of health,[26] finding contemporary focus in understanding of "multi-causal" economic determinants of health and examinations of health through the lens of social class and other inequalities.[27] Exploring statistically the link between poverty and health, "[s]ociomedical investigation gave positive identification, number serving as its shorthand for fact, of the medical distance that separated the rich and the poor."[28] As such, these scholars have found that health is determined by changes in the social and environmental conditions brought about by economic development (e.g., improved nutrition and sanitation) rather than simply by scientific advancement in the form of targeted medical interventions for the elimination of specific diseases (e.g., through antibiotics and pharmacotherapies).[29] Under these theories, correlating health and disease with social circumstances, the ecological model for public health has sought to create structural interventions to correct for deficiencies in underlying social determinants of health.

This ecological model, gaining widespread acceptance in the public health community,[30] has become the focus of those seeking to improve health indicators through economic development, emphasizing the reduction of social inequalities rather than the provision of individual health ser-

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26. Jane Lewis, What Price Community Medicine? (1986) (noting the widespread use of the term "social medicine" beginning in 1942).
27. Michael G. Marmot et al., *Social/Economic Status and Disease*, 8 Ann. Rev. Pub. Health 111, 112–15 (1987) (explaining the mechanisms underlying the causal link between social class and health inequalities); Dorothy Porter & Roy Porter, *What Was Social Medicine? An Historiographical Essay*, 1 J. Hist. Soc. 90 (1988); Rosen, *supra* note 21, at 117 (defining social medicine to include "concepts of public responsibility in relation to matters of health for various socio-economic groups"); Howard Waitzkin, *The Social Origins of Illness: A Neglected History*, 11 Int'l J. Health Srvcs. 77 (1981).
28. William Coleman, Death Is a Social Disease: Public Health and Political Economy in Early Industrial France 304 (1982).
29. Thomas McKeown, The Origins of Human Disease (1988); *see also* McKeown, Role of Medicine, *supra* note 6, at 179 (arguing a "need for a shift in the balance of effort, from laboratory to epidemiology in recognition that improvement in health is likely to come in future, as in the past, from modification of the conditions which led to disease rather than from intervention in the mechanism of disease after it has occurred"); Szreter *supra* note 7, at 147; James Colgrove, *The McKeown Thesis: An Historical Controversy and Its Enduring Influence*, 92 Am. J. Public Health 725 (2002).
30. *See* Dana March & Ezra Susser, *The Eco- in Eco-Epidemiology*, 35 Int'l J. Epidemiol. 1379 (2006) (tracing the intellectual history of the ecological model); e.g., Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. Health & Soc. Behav. 80 (1995) (creating a meta-analysis of public health studies on underlying determinants of health pursuant to the ecological model). While there remain scholars who argue that access to health technology is likely more important to reducing mortality in the developing world than income growth, the preponderance of evidence in public health scholarship finds that economic growth that includes poverty reduction and emphasizes the building of public health systems will continue to improve public health in the developing world. Emily Grundy, *Commentary: The McKeown Debate: Time for Burial*, 34 Int'l J. Epidemiol. 529, 529 (2005).

vices.[31] By focusing on structural etiologies, often referred to as "structural violence,"[32] it becomes clear that "public health cannot be separated from its larger socioeconomic context."[33] Through disparities in resources, power, and prestige, the impoverished, often excluded from underlying determinants of population health and ineffectual in altering their life circumstances, find themselves incapable of determining their own health status.[34] Thus, it has become a maxim of public health played out in many settings that no matter the disease—acute, chronic, communicable, non-communicable—or from where it originates, it will inevitably descend the social gradient to become a disease of the poor.

In disrupting this longstanding connection between poverty and illness, public health scholars have argued that "[a]n integral part of bringing good health to all is the task of identifying and ameliorating patterns of systematic disadvantage that undermine the well-being of people whose prospects for good health are so limited that their life choices are not even remotely like those others."[35] Under this expansive ecological view of public health, programs and practitioners respond to the fundamental social structures affecting public and population health, addressing, *inter alia*, disease outbreaks, patterns of population growth, distributive justice, and deleterious lifestyle trends. Thus, while practitioners have developed varied interventions to influence proximate risk factors for health[36]—looking to improve individual

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31. Marmot et al., *Social/Economic Status and Disease*, *supra* note 27, at 112 ("[W]hatever individual differences there may be, there are broad social forces determining health and disease states."); Inequalities in Health: The Black Report 13–16 (Peter Townsend & Nick Davidson eds., 1982) (noting that even equal health care cannot overcome the damaging public health effects of social inequalities and recommending, for Britain, "a total and not merely a service-oriented approach to the problems of health" and "a radical overhaul of the balance of activity and proportionate distribution of resources within the health and associated services"); *see also* Nigel Oswald, *Training Doctors for the National Health Service: Social Medicine, Medical Education and the GMC 1936–48*, *in* Social Medicine and Medical Sociology in the Twentieth Century 59, 59, 76–77 (Dorothy Porter ed., 1997) (discussing the justifications for abandoning social medicine in the creation of the British National Health Service and criticizing the failure to incorporate social medicine into its mandate).
32. Paul Farmer has coined the term "structural violence" as a rhetorical tool to highlight the violence to health that arises from structural and power-based inequalities, including those rooted in gender, ethnicity, religion, and social class. *See generally* Paul Farmer, Pathologies of Power: Health, Human Rights, and the New War on the Poor (2003).
33. Ilan H. Meyer & Sharon Schwartz, *Social Issues as Public Health: Promise and Peril*, 90 Am. J. Pub. Health 1189, 1189 (2000).
34. *See* Deepa Narayan, Voices of the Poor: Can Anyone Hear Us? (2000).
35. Lawrence O. Gostin & Madison Powers, *What Does Social Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 Health Aff. 1053, 1054 (2006) (citing M. Powers & R. Faden, Social Justice: The Moral Foundations of Public Health and Health Policy (2006)).
36. Lawrence O. Gostin, *Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann*, 29 J. L. Med. & Ethics 121, 122–23 (2001) (discussing various views of the determinants of public health).

knowledge, money, and power—almost all agree that the overarching improvements in public health goals could best be achieved through changes in underlying economic conditions.[37]

2. Economic Development as a Means to Improve Health

Given this link between poverty and damage to underlying determinants of health, health scholars long held that economic development programs would lead inexorably to improved conditions for public health, noting the positive relationship between gross domestic product (GDP) and rising life expectancies at birth.[38] Since the earliest days of the Industrial Revolution, studies have overwhelmingly pointed to the role of economic development as a fundamental mechanism for sustainable improvements in the public's health.[39] However, scholars have recently come to recognize that national economic figures alone (primarily measured in terms of a country's GDP) do not accurately capture the concept of development as a broad social, political, and cultural change.[40] This has led to a shift in thinking away from purely economic development (measured in terms of aggregate GDP) toward the creation of "human development" (measured through a human development index (HDI) that takes into account, *inter alia*, life expectancy at birth and literacy)[41] as a broader measure of human

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37. *See* Link & Phelan, *Social Conditions*, *supra* note 30, at 81 (creating a meta-analysis of the epidemiologic basis for understanding underlying determinants of health, criticizing medical discourses for their "focus on the connection of social conditions to single diseases via single mechanisms at single points in time," and arguing that such a framework "neglects the multifaceted and dynamic processes through which social factors may affect health and, consequently, may result in an incomplete understanding and an underestimation of the influence of social factors on health").

38. Why Are Some People Healthy and Others Not?: The Determinant of Health of Populations (Robert G. Evans et al. eds., 1994); Bruce Link & Jo Phelan, *Fundamental Sources of Health Inequities*, *in* Policy Challenges in Modern Health Care 71 (D. Mechanic et al. eds., 2005).

39. William Coleman, *supra* note 28, at 284–92 (1982) (noting the work of Louis-René Villerme and Alexandre-Jean-Baptise Parent-Duchatelet in challenging Jean-Jacques Rousseau's supposition that modernization would be harmful to health); *see also* Benoiston de Châteauneuf, Recherches sur les Consommations en Tout Genre de la Ville de Paris en 1817 Comparées avec Ce Qu'elles Étaient en 1789 (1820) (noting that death spared the rich more than the poor at all stages of life but especially in the younger and the more advanced years).

40. *See generally* Karel Holbik, *Measuring Human Development*, 51 Am. J. Econ. & Soc. 493 (1992).

41. United Nations Development Programme (UNDP), Economic Growth and Human Development: Human Development Report 1 (1996), *available at* http://hdr.undp.org/reports/global/1996/en/. The HDI is a measure of life expectancy at birth (longevity), adult literacy and the combined primary, secondary, and tertiary gross enrollment (knowledge), and GDP per capita or purchasing power parity (US$) (standard of living). *Id.* at 106. Thus, improved health in the form of greater longevity constitutes a principal measure of the degree of human development.

well-being.[42] Reanalyzing development from this perspective has produced striking discontinuities in how different states convert national income into salutary opportunities for its peoples.[43]

Scholars working in the social medicine school have argued that health improvement requires that national financial growth be accompanied by appropriate social reforms.[44] In the context of examining underlying determinants of health, it has become clear that the social, cultural, political, and material changes that accompany the development process are the causal agents responsible for the steady reduction in avoidable forms of morbidity and mortality.[45] On the basis of this empirical finding, public health scholars have elucidated the pathways through which economic development results in a decrease in the number of people living in absolute poverty and allows for improvements in underlying determinants of health, including clean water, sanitation, electricity, and food security.[46] Conceptualizing public goods through these pathways, changing modes of production are seen to restructure social relations away from traditional sources of family support and toward wage labor, forcing individuals to turn to the state to meet their demands for systems.[47] As the affluence of the nation increases, the state becomes increasingly capable of meeting these demands, with the formalization of the economy increasing the tax base and allowing for an

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42. In its 1980 World Development Report, the World Bank defines human resource development, or human development, as encompassing "education and training, better health and nutrition and fertility reduction." World Bank, Poverty and Human Development: World Development Report 32 (1980). The subsequent UNDP Human Development Reports are more explicit in redefining the meaning of growth to capture human well-being and not solely economic growth. *E.g.*, UNDP, Economic Growth and Human Development *supra* note 41, at 1 ("Human development is the end—economic growth a means.").
43. Cuba, the former USSR, and the Kerala state of India stand out as striking examples of locales where total per capita income has remained low and yet indicators of health and well-being are high. *See* Aviva Chomsky, "*The Threat of a Good Example": Health and Revolution in Cuba*, *in* Dying for Growth: Global Inequality and the Health of the Poor 3, 6–7 (Jim Yong Kim et al. eds., 2000) (Cuba); K. Anand et al., "*Development" Is Not Essential to Reduce Infant Mortality Rate in India: Experience from the Ballabgarh Project*, 54 J. Epidemiol. & Community Health 247–53 (2000) (Kerala). This success points to the existence of particular intervening mechanisms through which health may be maximized even with limited resources.
44. Dorothy Porter & Roy Porter, *What Was Social Medicine? An Historiographical Essay*, 1 J. Hist. Soc. 90 (1988).
45. Preston, *supra* note 5; *see also* J.C. Caldwell, *Mortality in Relation to Economic Development*, 81 Bull. World Health Org. 831 (2003).
46. Omran, *supra* note 5. However, given that changes to underlying determinants of health come "bundled" in a package that improves outcomes across a range of diseases, it is often difficult to disentangle the exact mechanisms that lead to improved health at the population level.
47. Fred C. Pampel & John B. Williamson, *Age Structure, Politics, and Cross-National Patterns of Public Pension Expenditures*, 50 Am. Soc. Rev. 782, 785–86 (1985); Harold L. Wilensky, The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures (1975).

increase in the size of the public economy, including spending on public goods.[48] In this sense, the size of a state's public economy and its capacity to govern may be used as indicators of a state's political development, or its institutional "reach," which become vital for the provision of public goods, among them the establishment of public health systems to regulate underlying determinants of health.

B. Public Goods and Public Health Systems

Evolving discourses on economic development as a means of ensuring underlying determinants of health has led to synoptic public health analyses of social structure under the ecological model for public health.[49] In doing so, these analyses "pushed [public health scholars] away from . . . early preoccupation with diverse forms of risk behavior, understood in largely individualistic terms, toward a new understanding of vulnerability as socially, politically, and economically structured, maintained, and organized."[50] Through these holistic discourses, there grew an appreciation of the public health system as a public good.[51] Among public goods contributing to the public's health, scholars and practitioners have emphasized a variety of shared social, environmental, and structural factors—including clean water and air, food, shelter, energy, sanitation, education, employment, wealth, health infrastructures, social stability, and security from violence and discrimination—finding these underlying determinants of health more important than medicines and health services in preventing disease and promoting public health at a societal level.[52] Given this broader construction of health

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48. Gosta Esping-Andersen, *The Three Political Economies of the Welfare State*, 26 Can. Rev. Soc. & Anthropology 10, 21 (1989).
49. *Supra* notes 30–37 and accompanying text (discussing the ecological model's focus on underlying determinants of health).
50. *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).
51. Richard G. A. Feachem & Jeffrey D. Sachs, Global Public Goods for Health: The Report of Working Group 2 of the Commission on Macroeconomics and Health (2002), *available at* http://whqlibdoc.who.int/publications/9241590106.pdf. *See also* Ronald Labonte & Ted Schrecker, *Globalization and Social Determinants of Health: Promoting Health Equity in Global Governance* (part 3 of 3), 3 Globalization & Health 7, 7 (2007) (noting that, "[w]hether global or regional, many public goods for health, such as communicable disease control (including vaccination) and control of antibiotic resistance, are conspicuously undersupplied in the marketplace").
52. *See* 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); Anthony McMichael et al., *Global Environment*, *in* Global Public Goods for Health: Health Economic and Public Health Perspectives 106 (Robert Smith et al. eds., 2003). For a larger discussion of public goods, public health as a public good, and the role of human rights in realizing public goods, see *infra* Part V.A.

determinants, public health systems can be seen to alleviate harmful societal determinants of health by assuring the provision of constituent public goods necessary for beneficial health outcomes.[53]

In this sense, public goods produce collective benefits that support society as a whole. Economic theory defines pure public goods as non-rivalrous (the consumption by one individual does not diminish the consumption available to others) and non-excludable (it is difficult or impossible to exclude others from the benefits of the public good).[54] Based on these characteristics, public goods are sometimes characterized as "market failures" because they suffer from a "free rider problem," known historically as the "tragedy of the commons": everyone, in the pursuit of individual self-interest, will have a perverse incentive to take advantage of common assets without contributing to their upkeep, thereby depleting them for all.[55] Thus, public goods will be undersupplied without a means of collective action.[56] For example, left to market forces, public health systems such as sanitation, education, electricification, and public health research and surveillance systems would likely remain critically underfunded and unrealized.[57] Given this market failure, government intervention assists in overcoming these collective action dilemmas for health, coordinating the contribution to and provision of necessary public goods.[58] This recognition of public goods for health forces a reconsideration of liberal theories of justice (which regards health as a product of nature),[59] leaving room for the interpretation of health as a non-natural primary good,[60] and therein, the consideration of various public goods as underlying structural determinants of health.[61]

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53. Michael Faust & Inge Kaul, *Global Public Goods and Health: Taking the Agenda Forward*, 79 Bull. World Health Org. 869 (2001).
54. Joseph E. Stiglitz, The Theory of International Public Goods and the Architecture of International Organizations 1–9 (Third Meeting of the United Nations High Level Group on Development Strategy and Management of the Market Economy, Background Paper No. 7, 1995); Joseph. E. Stiglitz, *IFIs and the Provision of International Public Goods*, 3 Cahiers/Papers 116 (1998); *see also* Mancur Olson, The Logic of Collective Action (1965) (noting that one characteristic of goods—non-excludability—defines all public goods).
55. Stiglitz, *The Theory of International Public Goods*, *supra* note 54.
56. Elinor Ostrom, *How Types of Goods and Property Rights Jointly Affect Collective Action*, 15 J. Theoretical Pol. 239, 239 (2003).
57. Stiglitz, *The Theory of International Public Goods*, *supra* note 54, at 1 (citing national defense, police protection, and research as those goods and services typically classified as public goods).
58. *Id.* (recognizing that "providing public goods is now viewed as one of the central responsibilities, indeed, one of the central rationales, for government").
59. *E.g.*, John Rawls, A Theory of Justice 62 (1971) (noting that "other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure, they are not so directly under [society's] control").
60. Martha C. Nussbaum, *Human Functioning and Social Justice: In Defense of Aristotelian Essentialism*, 20 Pol. Theory 202, 233 (1992).
61. Norman Daniels, *Justice, Health, and Health Care*, *in* Medicine and Social Justice: Essays on the Distribution of Health Care 6 (Rosamond Rhodes, et al. eds., 2002).

Public health systems—governmental infrastructures for the public's health, including "all the activities whose primary purpose is to promote, restore, or maintain health"[62]—are best positioned to provide these public goods for health,[63] fulfilling the collective rights of peoples to the "conditions in which people can be healthy."[64] Operating under an expansive, ecological view of public health, public health systems (themselves public goods) respond to the fundamental social structures affecting public and population health, addressing, *inter alia*, environmental harms, patterns of population growth, distributive justice and other inequalities, and deleterious lifestyle trends.[65] By examining the underlying political, social, and behavioral determinants of health inequalities, public health research is applied by local, national, and global governance structures to create the public health systems necessary to stem health inequities and improve the health of the public as a whole.[66]

Yet despite the recognized importance of these public health systems, the neoliberal development paradigm's pursuit of national economic growth at the expense of human development undermines the supply of public goods, affecting entire societies. With this economic model for globaliza-

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62. World Health Organization: The World Health Report 2000: Health Systems—Improving Performance 1 (2001). While the term "health systems" is often used in its narrow sense to signify the delivery of health care, the authors herein use the term to include such systems that are supportive of the prevention of illness and promotion of public health, including, but not limited to: water and sanitation systems; basic infrastructure, such as roads and electrification; various social protection schemes, including pensions and insurance; public health surveillance systems; and additional public programs, among them education and housing. This broad understanding of health systems is in keeping with the concept of primary health care as laid out in the 1974 Declaration of Alma-Ata to include, at a minimum: "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs." Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 Sep. 1978, art. VII.3, *reprinted in* World Health Organization, Primary Health Care: Report of the International Conference on Primary Health Care (1978) [hereinafter Declaration of Alma-Ata]. For a discussion of the consequences of the Declaration of Alma-Ata in international law, see *infra* notes 265–270 and accompanying text.

63. *See* Lynn P. Freedman, *Achieving the MDGs: Health Systems as Core Social Institutions*, 48 Dev. 19, 21 (2005) (defining the scope of public health systems and finding health systems to be "core social institutions").

64. Institute of Medicine, The Future of Public Health 7 (1988).

65. WHO Commission on Social Determinants of Health, Challenging Inequity Through Health Systems: Final Report, Knowledge Network on Health Systems 5–11 (2007), *available at* http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf (summarizing evidence across disciplines to conclude that health systems are social determinants of health and health equity).

66. Anthony J. McMichael & Robert Beaglehole, *The Changing Global Context of Public Health*, 356 Lancet 495, 495 (2000).

tion determining the structure of development programs, "tension persists between the philosophy of neoliberalism, emphasising the self-interest of market-based economics, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal."[67]

C. Neoliberal Development Programs Harm Public Health

Although there lies great potential in economic development for improving the public's health, current international development programs, as facets of neoliberal economic policy, have crippled public health systems and diminished their ability to prevent disease and promote health. Belying their advancement as a source of national development—and consequently, a solution to global poverty[68]—these neoliberal development programs have resulted in collective health harms at the societal level.[69] In harming health, modern processes of economic development impact public health through myriad proximal and distal mechanisms,[70] and through these multiple, overlapping processes,[71] serve to exacerbate disparities in health between rich and poor.[72] The global and national changes brought about by international development policies have denied states the sovereignty necessary to control and sustain their own development and health.[73] Further, despite neoliberal globalization's rhetorical homage to individualism,[74]

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67. *Id.* at 496 (footnote omitted).
68. *E.g.*, David Dollar & Aart Kraay, Growth Is Good for the Poor (2000).
69. Mark Weisbrot et al., *The Scorecard on Development: 25 Years of Diminished Progress*, *in* Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life 179 (Vicente Navarro ed., 2007).
70. For an explanation of the difference between proximal and distal mechanisms, see supra notes 36–37 and accompanying text.
71. *See* Link & Phelan, *Social Conditions*, *supra* note 30, at 81 (noting the "multifaceted and dynamic processes through which social factors may affect health").
72. *See* Joyce V. Millen et al., *Introduction: What Is Growing? Who Is Dying?*, *in* Dying for Growth, *supra* note 43, at 6–7 ("[S]pecific 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."); Sarah Macfarlane et al., *Public Health in Developing Countries*, 356 Lancet 841, 841–42 (2000).
73. *See* David Coburn, *Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-Liberalism*, 51 Soc. Sci. & Med. 135 (2001) (noting that globalization has undermined the welfare state); *see also* Stephen Gill, *Globalisation, Market Civilisation, and Disciplinary Neoliberalism*, 24 Millennium: J. Int'l Stud. 399, 406 (1995); Branko Milanovic, *The Two Faces of Globalization: Against Globalization as We Know It*, 31 World Dev. 667, 668 (2003).
74. Robert E. Mazur, *Realization or Deprivation of the Right to Development Under Globalization? Debt, Structural Adjustment, and Poverty Reduction Programs*, 60 Geo Journal 61, 64 (2004) (noting globalization policy's emphasis on individualism and limited government) (*citing* Tony Evans, *Citizenship and Human Rights in the Age of Globalization*, 25 Alternatives 415 (2000)).

globalization, in tragic irony, has taken responsibility for health out of the control of the individual, predetermining harm at the societal level and robbing individuals of the autonomy necessary for individual health.[75] Thus, while globalization has resulted in improvements in technology and health services for some, various globalized economic processes are correlated with widening health gaps within states and among states in the developed and developing world.[76]

1. Evolving Development Paradigms

With the end of the colonial period and beginning of the development "industry" in the early 1950s,[77] it was largely assumed that developing states would develop economically without great difficulty and much in the same way as states in the West had developed.[78] In order to achieve this presumptive development, developing states were pressed to follow the precepts of classical economic trade theory, which holds that countries should focus national economic growth in areas in which they possess a comparative advantage.[79] For the developing world, this would involve specializing in agriculture and the export of raw materials, whereas developed world countries would continue to specialize in the export of lucrative manufactured and finished products.[80]

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75. Parker, *supra* note 50, at 41.
76. *See generally* Norman Daniels et al., Is Inequality Bad for Our Health? (Joshua Cohen & Joel Rogers eds., 2000); Mark G. Field et al., *Neoliberal Economic Policy, "State Desertion" and the Russian Health Crisis*, *in* Dying for Growth, *supra* note 43, at 155. *But cf.* McMichael & Beaglehole, *supra* note 66, at 495 (noting the beneficial effect of increased literacy, sanitation, and nutrition, among other factors, on public health); Jolly, *supra* note 69 (noting reductions of child mortality in developing states even during the economic decline of the 1980s).
77. The development industry took shape when the membership of the United Nations was increasing as a result of the numerous countries that gained independence from 1948–1966. As described by Peter Uvin,

    > the notion was born that it was possible and necessary to organize and accelerate economic and social change—and that it was the duty of the world to make that happen. Thus, scholars began thinking about how to "modernize" so-called backward economies, while bureaucrats began spending money on development projects and infrastructure programs.

    Peter Uvin, Human Rights and Development 12 (2004).
78. This concept is perhaps best represented in Walt Rostow's economic growth model in which he lays out the five stages of growth through which societies inevitably progress from traditional societies (characterized by subsistence agriculture and a high degree of fatalism), to the preconditions for, and eventual "take-off" of, the economy (industrialization) that ultimately culminates in the ideal of the drive to maturity and the thriving of a system of "high mass consumption." Walt W. Rostow, The Stages of Economic Growth: A Non-Communist Manifesto (1960).
79. Colin Leys, *Samuel Huntington & the End of Classical Modernization Theory*, *in* Rise and Fall of Development Theory 64 (James Currey ed., 1996).
80. Stuart Hall, *The Rest and the West: Discourses and Power*, *in* Modernity: An Introduction to Modern Societies 185 (Stuart Hall et al. eds., 1996) (criticizing the traditional/modern dichotomy of states).

As this thinking became empirically suspect (and attacked as a form of "neocolonization"),[81] various competing theories arose to guide development policy. Beginning in the late 1950s, developing world economists began to argue that poor countries would be unable to develop unless they replaced imports from the rich North with their own domestic production.[82] These arguments laid the theoretical groundwork for import substitution industrialization (ISI) policies—the protection of domestic industries through tariffs and quotas, coupled with a fixed monetary exchange rate[83]—which developing states adopted throughout the 1960s.[84] Despite the patriotic allure of these policies, economic crises in Latin America in the late 1970s, blamed on state protectionist policies and repression of the free market,[85] led states to turn from the ISI system.[86] In this normative vacuum, neoliberalism, an economic theory stressing the preeminence of free markets with minimal government intervention, replaced ISI in the early 1980s as the hegemonic development paradigm.[87]

The neoliberal economic model has since become largely synonymous with the concept of globalization, wherein the term globalization is used with reference to the spread of neoliberal economic policies for development.[88] In adherence with these neoliberal development policies, most development-seeking states have converged toward specific, discrete economic "reform" strategies—including marketization, liberalization, privatization,

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81. Billy Dudley, *Decolonisation and the Problems of Independence*, *in* The Cambridge History of Africa 1940–1975, at 52 (Michael Crowder ed., 1984) (noting the neocolonial dependence of the export-driven economy in post-colonial Africa).
82. *E.g.*, Raúl Prebisch. Towards a Dynamic Development Policy for Latin America (1963).
83. *See* Henry J. Bruton, *A Reconsideration of Import Substitution*, 36 J. Econ. Lit. 903, 904 (1998) (arguing that "[t]o industrialize, given the existence of already industrialized and highly productive economies (the North), the countries of the South must protect their economies from imports from the North and concentrate on putting in place new activities that will produce an array of manufactured products currently imported").
84. *See* Leys, *supra* note 79 (describing the theory underlying ISI: that reducing trade would bring about "autocentric" national economic growth).
85. Bruton, *supra* note 83, at 904. *But see* Naomi Klein, The Shock Doctrine: The Rise of Disaster Capitalism 156 (2007) (arguing that the crisis of hyperinflation in Latin America "was the result of two main factors, both with roots in Washington financial institutions": (1) the insistence on passing on illegitimate debts accumulated under dictatorships to new democracies and (2) the decision of the US Federal Reserve to allow interest rates to soar, massively increasing the size of those debts).
86. *See generally* Jose Antonio Ocampo, *Latin America and the World Economy in the Long Twentieth Century*, *in* The Great Divergence: Hegemony, Uneven Development and Global Inequality (K.S. Jomo ed., 2006).
87. For a discussion of how neoliberalism spread globally, *see generally* Beth Simmons & Zachary Elkins, *The Globalization of Liberalization: Policy Diffusion in the International Political Economy*, 98 Am. Pol. Sci. Rev. 171 (2004).
88. Julia Elyachar, *Empowerment Money: The World Bank, NGOs, and the Value of Culture in Egypt*, 14 Pub. Culture 493, 494 (2002) (noting that although globalization encompasses far more than economic development policies, globalization has largely become a metaphor for development).

and decentralization—turning control over national economic systems (and by extension, social justice programs) to the whims of international markets.[89] Whether created by the International Monetary Fund (IMF), the World Bank, or trade agreements (usually in exchange for loan-based debt assistance),[90] these neoliberal policy changes—requiring states to implement, *inter alia*, fiscal adjustment, private property institutions, and exchange rate reform—aim to free developing economies from state government planning. Through what has become known as the "Washington Consensus,"[91] these international economic organizations have adopted development policies mandating fiscal austerity, privatization, and market liberalization among loan recipients, enforcing these processes on developing states through the harbinger of many of the ills of globalization: structural adjustment programs (SAPs).[92] In conditioning loans on the basis of SAP reforms, the IMF imposed structural changes on developing states, often prescribing the same cuts in government expenditure to each state without consideration of state economic needs or the impact of adjustment on health or other social policies.[93] These mandated cuts under loan conditionalities have had the

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89. Ronald Chen & Jon Hanson, *The Illusion of Law: The Legitimating Schemes of Modern Policy and Corporate Law*, 103 U. Mich. L. Rev. 1, 11–12 (2004) (noting that "as new replaced old in the political arena, a revolution was taking place within economics, with scholars like England's John Maynard Keynes and his American student John Kenneth Galbraith supplanted by the competing ideas of Friedrich von Hayek of the 'Austrian School' of economics and Milton Friedman and other members of his 'Chicago School'").

90. 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 crises of the late 1970s and early 1980s, the role of these organizations was largely reframed to resolve the economic crises of the Third World, with the intent of helping Third World economies to "'return to growth' and, most importantly, to continue making interest payments [to First World countries]." John Gershman & Alec Irwin, *Getting a Grip on the Global Economy*, *in* Dying for Growth, *supra* note 43, at 11, 20. For detailed explanations of the differential roles of the IMF and World Bank in development discourses, see Joseph E. Stiglitz, Globalization and Its Discontents 7–25 (2002).

91. John Williamson, *Democracy and the "Washington Consensus,"* 21 World Dev. 1329 (1993) (describing tenets of the "Washington Consensus"). Charles Gore defines the Washington Consensus broadly to include development policy changes intended for states to "(a) pursue macroeconomic stability by controlling inflation and reducing fiscal deficits; (b) open their economies to the rest of the world through trade and capital account liberalization; and (c) liberalize domestic product and factor markets through privatization and deregulation." Charles Gore, *The Rise and Fall of the Washington Consensus as a Paradigm for Developing Countries*, 28 World Dev. 789, 289–90 (2000).

92. For a discussion of the role of SAPs in damaging public health systems, see *infra* Part II.C.3.

93. Carol Welch, *Structural Adjustment Programs and Poverty Reduction Strategy*, 4 Foreign Pol'y in Focus 1 (2000) (noting that, unlike the World Bank's consideration of environ-

effect of de-emphasizing of the role of the state and the provision of public goods in development, dismantling the Keynesian or demand-side economic policies adopted at the end of the Second World War[94] and reifying individualism through market-led growth.[95] As a result of these processes, economic globalization has diminished state control over the lives of their peoples in ways unprecedented in the history of national governance.[96]

In light of evidence highlighting the failures of SAPs to produce even the expected economic growth,[97] the World Bank and IMF have embarked on a new strategy that emphasizes poverty reduction from the bottom-up rather than top-down SAPs. As part of this strategy, Poverty Reduction Strategy Papers (PRSPs), required to be produced by all recipients of debt relief,[98] now form the basis of international development lending to the least developed countries.[99] Rather than imposed from the outside, PRSPs are to be written by the countries themselves, and the finished products are then endorsed by the IMF and World Bank, partially conditioned on the state's demonstration of an adequately participatory process in PRSP drafting. However, while the aim of these PRSPs is to increase participation in the development process,

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mental and social changes, SAP lending considers only the economic conditions that will assure international credit-worthiness); *see also* Manuel Castells, The Rise of the Network Society 137, 141 (2d ed. 2000) ("These policy recommendations (in fact, impositions) were based on pre-packaged adjustment policies, astonishingly similar to each other, whatever each country's specific conditions."). Stiglitz, Globalization and Its Discontents, *supra* note 90, at 24 (noting that development policy for developing states is often influenced by developed countries within the IMF with conscious neglect of developing states' expressed wants).

94. Stiglitz, Globalization and Its Discontents, *supra* note 90, at 16 (noting that "the Keynsian (sic) orientation of the IMF, which emphasized market failures and the role for government in job creation, was replaced by the free market mantra of the 1980s, part of a new 'Washington Consensus'—a consensus between the IMF, the World Bank, and the US Treasury about the 'right' policies for developing countries—that signaled a radically different approach to economic development and stabilization"). For its part, the developed world also has seen a significant retrenchment in welfare states as a result of a shift from Keynesian economic policies to supply-side economic policies. *See generally* Carles Boix, Political Parties, Growth and Equality (1998).

95. Boix, *supra* note 94.

96. *See* William F. Felice, *The Viability of the United Nations Approach to Economic and Social Human Rights in a Globalized Economy*, 75 Int'l Aff. 563, 586 (1999) ("The forces of economic globalization are perhaps causing more fundamental transformations of our planet's economic and social life than at any time since the Treaty of Westphalia in 1648.").

97. *See infra* notes 103–111 and accompanying text (discussing evidence of the failure of SAPs to alleviate poverty).

98. *See* Gobind Nankani et al., *Human Rights and Poverty Reduction Strategies: Moving Towards Convergence?*, *in* Human Rights and Development: Towards Mutual Reinforcement 475, 475–77 (Philip Alston & Mary Robinson eds., 2005) (discussing the discourses that gave rise to the Poverty Reduction Strategy Papers (PRSP) approach).

99. *See generally* Frances Stewart & Michael Wang, *Poverty Reduction Strategy Papers Within the Human Rights Perspective*, *in* Human Rights and Development: Towards Mutual Reinforcement, *supra* note 97, at 447 (2005) (analyzing whether PRSPs are supportive of a human rights-based approach to development).

the PRSPs have been criticized as merely a continuation of the same SAP system under the guise of a participatory, poverty-focused process.[100] Undercutting their purported emphasis on the poor, these strategies emphasize the importance of individual initiative for poverty reduction, neglecting the provision of public goods known to ameliorate underlying causes of disease.[101] The long-term effects of these PRSPs have yet to be seen.[102]

2. Poverty & Inequality—How Inequitable Development Impacts Public Health

Despite the promise of these development programs, current neoliberal economic policy has not resulted in the predicted decreases in poverty and ancillary benefits to public health[103] while leading to greater health inequalities within and among states.[104] As recognized by Mary Robinson,

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100. *E.g.*, *id.* at 447, 468 (noting that, far from being participatory, the consultations around PRSPs are "selective, missing or underrepresenting important groups and carried out too rapidly to allow considerable inputs from outside the government. . . . A review of the content of programmes suggests only marginal changes compared with previous structural adjustment programmes").

101. David Booth, *Are PRSPs Making a Difference?: The African Experience*, 21 Dev. Pol'y Rev. 131 (2003); *see* Ben Fine, *The Developmental State and the Political Economy of Development*, *in* The New Development Economics: After the Washington Consensus 101, 112 (Ben Fine & K. S. Jomo eds., 2006) (noting that the concept of social capital "allows the World Bank to broaden its agenda whilst retaining continuity with most of its practices and prejudices which include the benign neglect of macro-relations of power, preference for favored NGOs and grassroots movements, and decentralized initiatives").

102. K.S. Mohindra, *Healthy Public Policy in Poor Countries: Tackling Macro-economic Policies*, 22 Health Promotion Int'l 163, 167 (2007) (noting that there is no consensus on the influence of PRSPs on public health).

103. Milanovic, *Two Faces of Globalization*, *supra* note 73, at 676 (noting that "the last two decades, which witnessed expansion of globalization, are, in terms of overall growth and income convergence between poor and rich countries, vastly less successful than the preceding two decades"); Mary Robinson, *What Rights Can Add to Good Development Practice*, *in* Human Rights and Development: Towards Mutual Reinforcement, *supra* note 98, at 25–26 (2005) ("An unprecedented number of countries actually saw their human development indicators slide backwards in the 1990s. . . . The picture that emerges is increasingly one of two very different groups of countries: those that have benefited from more open markets, free movement of capital, and new technologies and those that have been left behind.").

104. *See* WHO Commission on Social Determinants of Health, Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution: Final Report to the Commission on Social Determinants of Health 34–115 (2007), *available at* http://www.who.int/social_determinants/resources/globlalization_kn_07_2007.pdf (summarizing evidence across disciplines to identify pathways through which globalization has exacerbated inequalities in morbidity and mortality). 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 UN 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." *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental*

"[t]he picture that emerges is increasingly one of two very different groups of countries: those that have benefited from more open markets, free movement of capital, and new technologies and those that have been left behind."[105] While poverty has decreased substantially in much of East Asia (especially China),[106] poverty reduction in Latin America has stagnated[107] and much of the former USSR, East and Central Europe, and sub-Saharan Africa has regressed.[108] Where poverty reduction has taken place, it has occurred largely in countries that have not followed Washington Consensus policies.[109] Thus, under the system of neoliberal economic liberalization implemented over the last twenty years, both relative and absolute poverty[110] have actually

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Health: Report of the Special Rapporteur, Paul Hunt, U.N. ESCOR, Comm'n. on Hum. Rts., 59th Sess., Agenda Item 10, ¶ 51, U.N. Doc. E/CN.4/2003/58 (13 Feb. 2003) [hereinafter *Report of the Special Rapporteur* (13 Feb. 2003)] (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).

105. Robinson, *supra* note 103, at 26.

106. The East Asian "miracle" economies, notably South Korea, Singapore, and Taiwan, are prime examples of countries that, in a period of thirty years, transitioned from low-income countries with high birth and high death epidemiologic dynamics to high-income countries with epidemiological patterns equivalent to the rest of the developed world. *See* World Bank Policy Research Report, The East Asian Miracle: Economic Growth and Public Policy (1993). Moreover, while many countries experience an increase in inequality in the early stages of development, which can be detrimental to health, the East Asian countries developed in a manner that was labor intensive and pro-poor. Thus, reductions in inequality came not from redistribution *per se*, but largely from reducing the levels of absolute poverty. *See* Robert Wade, Governing the Market: Economic Theory and the Role of Government in East Asian Industrialization (2003).

107. Joseph Stiglitz, *The Post Washington Consensus Consensus* (Initiative for Policy Dialogue Working Paper, 2004) (noting that growth in Latin America during the 1990s—the decade of reform—was just half of what it was in the 1960s and 1970s, the decades marked by the "failed" policies of import substitution).

108. *See, e.g.*, Steve Dowrick & Muhammad Akmal, *Contradictory Trends in Global Income Inequality: A Tale of Two Biases*, 51 Rev. Income & Wealth 201 (2005); William Easterly, The Lost Decades: Developing Countries, Stagnation in Spite of Policy Reforms 1980–1998 (2001), *available at* http://www.worldbank.org/research/ growth/pdfiles/lostpercent20decades_joeg.pdf, *cited in* Milanovic, *Two Faces of Globalization*, *supra* note 73, at 668. For specifics on the former USSR and Eastern Europe, see Joseph Stiglitz, *Preface*, *in* The New Russia: Transition Gone Awry xvii–xxiii (L. Klein & M. Pomer eds., 2001); Joseph Stiglitz & David Ellerman, *Not Poles Apart: "Whither Reform?" and "Whence Reform?,"* 4 J. Pol. Reform 325 (2001).

109. Milanovic, *Two Faces of Globalization*, *supra* note 73, at 676 (noting that, "the attempt to explain divergence of incomes by 'eliminating' the countries with 'bad' policies and focusing solely on those with 'good' policies is flawed because the successful countries, and China in particular, did not follow the orthodox economic advice"); Wade, Governing the Market, *supra* note 105 (arguing that while advocates of the Washington Consensus argue that the East Asian "tigers" developed through purely free markets, it was in fact the deliberate industrial policies of governments that gave incentives to export manufacturers, thereby catalyzing growth).

110. *See* Michael G. Marmot, Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy (2004) (distinguishing absolute and relative poverty). Marmot finds that while a certain degree of material wealth in a country may eliminate the

increased within countries, compounded internationally by increasing rates of globalization-engendered inequality among countries.[111]

This economic inequality is highly detrimental to public health, and even when societies experience growth at the national level, additional economic increases do little to improve the health of the general population when this wealth is not shared across society.[112] For many developing countries, the rapid introduction of market-oriented policies and concomitant urban migration has led to a bifurcation of employment opportunities, with wealthy elites benefiting disproportionately from economic growth.[113] The poor, who rely on wage labor, have seen their earnings drop relative to the wealthy.[114] Neoliberal economic policies have exacerbated inequality expecially within countries where development is specifically designed only to influence high income sectors of the society, with the hope that subsequent growth would "trickle down" to lower classes.[115] While some have argued that the process of economic development is inherently inequality inducing[116]—a

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burden of infectious illnesses that mainly affect those living in absolute poverty, relative poverty continues to have a profound affect on the health outcomes across groups, wherein "how much money you have is not as important as how much you have relative to others in society." *Id.* at 67.

111. *See* Ichiro Kawachi & Sarah Wamala, *Poverty and Inequality in a Globalizing World, in* Globalization and Health 125 (Ichiro Kawachi & Sarah Wamala eds., 2006) (providing an overview of the empirical evidence demonstrating an increase in inequality within and between countries). This correlation is not due solely to improvement in the developed world but also to worsening conditions in the developing world, especially among the poor and marginalized. Robert Hunter Wade, *Is Globalization Reducing Poverty and Inequality?*, 32 World Dev. 567 (2004). Thus, inequality has increased in countries that have adopted neoliberal economic packages largely because, while a few benefit handsomely, the majority remains poor and, in many cases, a large portion of the vulnerable middle class has fallen into poverty, increasing rates of absolute poverty even as GDP grows. Vincent Navarro, *Comment: Whose Globalization?*, 88 Am. J. Pub. Health 742, 742 (1998); Jeffrey Sachs, The End of Poverty: Economic Possibilities for Our Time 26–27 (2005).
112. Ichiro Kawachi & Bruce P. Kennedy, The Health of Nations: Why Inequality is Harmful to Your Health (2002).
113. *See generally*, *id.*
114. *Id.*
115. Navarro, *supra* note 111, at 742 (noting that under globalization, "governments must create conditions favorable to the mobility of commerce, investments, and financial transactions, through policies that include, among others . . . developing fiscal policies that favor high-income sectors of the population, which are assumed to be those most able to save and therefore to invest (with the supposition that the riches at the top will 'trickle down' to the rest of the population)"); *see also* Giovanni Berlinguer, *Globalization and Global Health*, 29 Int'l J. Health Svcs. 579, 579 (1999) (noting that "economic globalization today means accumulation of capital and power in the hands of just a few actors, with international finance prevailing over all other interests and 'unprecedented increase of inequalities in today's world'").
116. Simon Kuznet famously observed in 1955 that inequality generally follows an inverted U-shape—it increases in the early stages of economic development, achieves a peak and then declines over time once a country has reached a point of post-industrialism. *See generally*, Simon Kuznets, *Toward a Theory of Economic Growth, in* National Policy for Economic Welfare at Home and Abroad (Robert Lekachman ed., 1955). Subsequent

necessary evil that must be endured in the short run to produce long-term benefits—neoliberal economic policies ensure such inequity where they spurn the very forces that will eventually lead to long term growth and greater economic equalization, namely the support of public goods and public health systems.

Neoliberal economic reforms that are primarily focused on increasing growth simply for debt repayment and are intended to benefit only a small subset of the population fail to contribute to the production of public goods that is necessary for improvements in public health outcomes. Throughout the world, where countries have industrialized and increased their GDP, differential risk for health threats has endured through economic privilege and structural inequities in built environments.[117] While globalization offered the promise of economic growth and its resulting benefits to health,[118] the harsh realities of globalization have led to uneven distributions of wealth and increases in poverty.[119] 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."[120] Even the select states that

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work has demonstrated that this decline in inequality results from popular demands for redistribution and increases in the size of the public economy. *E.g.*, Daron Acemoglu & James Robinson, *Why Did the West Extend the Franchise? Democracy, Inequality, and Growth in Historical Perspective*, 115 Q. J. Econ. 1167 (2000). Thus, development theory has long held to the notion that equality, in particular democratically-driven equality, is detrimental to growth. Roberto Perotti, *Growth, Income Distribution, and Democracy: What the Data Say*, 1 J. Econ. Growth 149 (1996); Torsten Persson & Guido Tabellini, *Is Inequality Harmful for Growth?*, 84 Am. Econ. Rev. 600 (1994).

117. Kevin M. Fitzpatrick & Mark LaGory, Unhealthy Places: The Ecology of Risk in the Urban Landscape (2000).

118. Robert McCorquodale & Richard Fairbrother, *Globalization and Human Rights*, 21 Hum. Rts. Q. 735, 743 (1999) (noting that, in theory, "economic growth will increase protection of economic rights because economic growth brings increased access to health care, food, and shelter, either directly through employment and increased income or indirectly through the improvement and extension of these facilities to more people"); *see generally* World Health Organization & World Trade Organization, WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat 23 (2002), *available at* http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf (noting the effects of trade liberalization on health, including reduced tariffs, which may result in lower prices for medical equipment and changing international patent protections, affecting the price of medications and vaccines).

119. Manuel Castells, End of Millennium 73–82 (2d ed. 2000) (charting the rise of intrastate and interstate inequality in what is termed the "rise of the fourth world"); McCorquodale & Fairbrother, *supra* note 118, 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.").

120. Millen et al., *supra* note 72, at 7. *But cf.* David Dollar, *Is Globalization Good for Your Health?*, 79 Bull. World. Health Org. 829 (2001) (finding that "percentage changes in incomes of the poor, on average, are equal to the percentage changes in average incomes").

have achieved national-level growth as a result of neoliberal policies have done so on the backs of the urban poor, most of whom have not shared in the prosperity of their substantially wealthier countrymen,[121] widening inequality and detrimentally impacting the public's health.[122] Because globalization operates at a collective level without regard for individual benefit, "those who suffer 'adjustment costs'—lost jobs, higher food prices, and inferior health care—acquire no special claim to a share of the collective benefits of efficient markets."[123]

As an underlying determinant of health, social inequality has been shown, across a range of studies, to drive down public health indicators.[124] Countries with higher socioeconomic inequality produce greater health inequality between groups, and "middle-income groups in relatively unequal societies have worse health than comparable or even poorer groups in more equal societies."[125] Given this latter finding, the evidence suggests that socioeconomic inequality has a powerful causal effect independent of absolute poverty.[126] Although most studies of the relationship between inequality and health have focused on differences in health status within advanced industrial countries,[127] social scientists have recently begun to elucidate the mechanisms through which inequality harms the public's health in low and middle income countries, looking to the effect of inequalities on

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121. Mike Douglass et al., *Urban Poverty and the Environment: Social Capital and State-Community Synergy in Seoul and Bangkok, in* Livable Cities?: Urban Struggles for Livelihood and Sustainability 31, 36 (Peter Evans ed., 2002) (examining the case of Bangkok).
122. Wade, *Is Globalization Reducing Poverty*, *supra* note 111; Shaohua Chen & Martin Ravallion, *How Have the World's Poorest Fared Since the Early 1980s?* (World Bank Policy Research Working Paper 3341, 2004); Martin Ravallion, *Growth, Inequality and Poverty: Looking Beyond Averages*, 29 World Dev. 1803 (2001).
123. Jack Donnelly, Universal Human Rights in Theory & Practice 201 (2d ed. 2003).
124. *See, e.g.*, R.G. Wilkinson, *Income Inequality, Social Cohesion, and Health: Clarifying the Theory—A Reply to Muntaner and Lynch*, 29 Int'l J. Health Svcs. 525 (1999); Michael Marmot, *Epidemiology of Socioeconomic Status and Health: Are Determinants Within Countries the Same as Between Countries?*, 896 Annals New York Academy of Sciences 16 (1999); Ichiro Kawachi, *Social Capital and Community Effects on Population and Individual Health*, 896 Annals New York Academy of Sciences 120 (1999); Marmot, Status Syndrome, *supra* note 110; Michael G. Marmot & R.G. Wilkinson, Social Determinants of Health (2d ed. 2006).
125. Daniels et al., *supra* note 76, at 3.
126. *Id.*; Michael G. Marmot et al., *Health Inequalities Among British Civil Servants: The Whitehall II Study*, 337 Lancet 1387, 1392 (1991) (noting a gradient in the association of mortality with class, with higher social/job status leading to better health behaviors and thus improved health outcomes).
127. *E.g.*, George T.H. Ellinson, *Income Inequality, Social Trust, and Self-Reported Health Status in High-Income Countries*, 896 Annals New York Academy of Sciences 325 (1999); Inequalities in Health: The Black Report, *supra* note 31. These studies find that once poverty-related infectious illnesses have been reduced, inequality has a particular effect on rates of chronic disease across populations. Marmot, Status Syndrome, *supra* note 110; Inequalities in Health: The Black Report, *supra* note 31, at 23.

crime and violence,[128] dual epidemics of chronic and infectious illnesses,[129] and unequal use of health care services.[130] As societies become deeply stratified, contradictory epidemics are seen to emerge, as, for example, in the instance of under- and over-nutrition existing side by side.[131] These correlations and in-depth causal studies make clear that growth which decreases inequality, particularly by raising up the most impoverished, should improve public health more than policies that increase inequality to pursue similar levels of growth.[132]

3. Neoliberalism and Public Health System Deterioration

Globalization offered the promise of economic growth and its resulting benefits to health,[133] but global financial institutions have proven themselves a detriment to public health and health systems. In the context of neoliberal economic policy implementation, international development policies have become associated with national policies that promote markets at the expense of health and social welfare programs. Despite the necessity of economic development for the realization of social justice goals, the development

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128. *See generally*, Ching-Chi Hsieh & M.D. Pugh, *Poverty, Income Inequality, and Violent Crimes: A Meta-analysis of Recent Aggregate Data Studies*, 18 Crim. Just. Rev. 182 (1993) (demonstrating through a meta-analysis of thirty-four studies from both the developing and developed world that the relationship between income inequality and both homicide and violent crime is robust).
129. *See, e.g.*, Buddha Basnyat & Lalini Chandika Rajapaksa, *Cardiovascular and Infectious Diseases in South Asia: The Double Whammy*, 328 Brit. Med. J. 781 (2004).
130. Debra J. Lipson, *The World Trade Organization's Health Agenda: Opening up the Health Services Markets May Worsen Health Equity for the Poor*, 323 Brit. Med. J. 1139, 1139 (2001).
131. *E.g.*, Champaklal C. Jinabhai et al., *Changing Patterns of Under- and Over-Nutrition in South African Children: Future Risks of Non-Communicable Diseases*, 25 Ann. Tropical Paediatrics: Int'l Child Health 3, 3 (2005) (finding that "moderate stunting co-exists with overweight and obesity suggests that patterns of under- and over-nutrition in South African children are changing and might indicate the early stages of a complex nutritional transition").
132. The East Asian model can serve as a superior example of how development can proceed in an inequality-reducing manner. Felice, *The Viability of the United Nations Approach*, *supra* note 96, at 592 ("Most observers have concluded that the rapid reduction of poverty in South-East Asia was fundamentally due to public provision of social services including public education and basic health care."). As a result of equality-promoting policies, these countries currently have some of the lowest gini-coefficients (a measure of inequality in income distribution that ranges from "0" representing perfect equality to "10" representing perfect inequality) in the world and are rivaling other advanced industrial countries in their health indicators. Branko Milanovic, *A Simple Way to Calculate the Gini Coefficient, and Some Implications*, 56 Econ. Letters 45 (1997); Joseph E. Stiglitz, The East Asian Miracle: Economic Growth and Public Policy (1996); Joseph E. Stiglitz, *Some Lessons from the East Asian Miracle*, 11 World Bank Res. Obs. 151 (1996).
133. McCorquodale & Fairbrother, *supra* note 118, at 743; *see generally* World Health Organization & World Trade Organization, *supra* note 118.

necessary for health is being undertaken through development programs that undercut the ability of the state to provide for the public's health through health systems.[134]

First, through SAPs and subsequent neoliberal programs, the IMF has evicerated the developing state public health systems necessary to respond to the overwhelming disease burdens of poverty and inequality. Through these SAPs, the IMF is able to "demand cuts in government expenditure, including axing or abolishing programmes for education, health, housing and public sector development, like sewage disposal and public housing."[135] These market-oriented policy changes, taken to service debt without regard to economic and social rights,[136] have acted to impinge state sovereignty, weaken the welfare state, and limit public action to provide for basic life-sustaining resources.[137] As a result, these state public health systems lack the laboratories and trained personnel for diagnosis and surveillance of disease, treatment of chronic illnesses, and prevention of drug resistance. Emigration of skilled workers, including health workers, as a result of deteriorating economic conditions constitutes an additional damage to health systems,[138] undercutting returns on human capital investments through educational and

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134. Lincoln C. Chen & Giovanni Berlinguer, Challenging Inequities in Health: From Ethics to Action 34, 40 (2001) ("Private markets, unconstrained and inadequately regulated, are perhaps the most powerful globalizing force driving inequities in health.").
135. Tony Evans, *A Human Right to Health*, 23 Third World Q. 197, 210 (2002); *see* Gill, *supra* note 73, at 408 (noting the larger role of SAPs in pushing states to "exercise monetary restraint, cut budgets, repay debts, balance their international trade, devalue their currencies, remove subsidies and trade and investment barriers and, in so doing, restore international credit-worthiness"); Mazur, *supra* note 74, at 65 ("SAPs generally entail reductions in government spending, privatization, higher interest rates, currency devaluation, reduction of tariffs and other trade barriers, and liberalization of foreign investment regulations and labor laws."). *But cf.* Jennifer Prah Ruger, *The Changing Role of the World Bank in Global Health*, 95 Am. J. Public Health 60, 68 (2005) (noting that the World Bank has recently moved away from endorsing SAPs).
136. Donnelly, Universal Human Rights, *supra* note 123, at 233; *see also* Mazur, *supra* note 74, at 64 ("[A]ccording to the neo-liberal conception of citizenship . . . civil and political rights must be prioritized in order to provide the condition for wealth creation."); Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social, and Cultural Rights*, 16 Hum. Rts. Q. 693, 694 (1994) (noting that "the globalization of the world economy and the influence of international financial institutions have weakened the national policy levers needed to implement economic, social, and cultural rights").
137. *See* Richard Falk, *Interpreting the Interaction of Global Markets and Human Rights*, *in* Globalization and Human Rights 72 (Alison Brysk ed., 2002) ("The neoliberal ideological climate of opinion induces the social disempowerment of the state, shifting responsibility for human betterment increasingly to the private sector."). *See also* Leo Panitch, *Rethinking the Role of the State*, *in* Globalization: Critical Reflections 83 (James H. Mittelman ed., 1996). This denial of life-saving public services for the poor as a result of privatization has come to be known as "service apartheid." Mazur, *supra* note 74, at 61.
138. Devesh Kapur & John McHale, The Global Migration of Talent: What Does it Mean for Developing Countries?, Center for Global Development Brief (Oct. 2005) (noting that skilled worker emigration rates substantially increased during the 1990s).

training systems.[139] With many of the social justice responsibilities of government relinquished in exchange for the myopic profit-seeking of transnational corporations (TNCs), these developing state governments face enormous difficulties in making the long-term budgetary commitments necessary for improvements in public health systems and health care infrastructures.[140] In this deregulated environment, in which states have privatized their only institutionalized means of preventing disease and promoting health, neither infectious nor non-infectious diseases can be controlled.[141]

Second, mandated health sector efficiency controls have resulted in cost recovery schemes that have had a dramatic impact on countries' health services and individuals' utilization of those services. Through neoliberal adjustment programs, "[h]ealth sectors . . . became prime targets for reform,"[142] and under these reforms, the World Bank and IMF have enforced policies on states for the prioritization of medicine, privatization of health care, and decentralization of responsibility for services.[143] This has brought about the privatization of health care for all but the poorest peoples and user fees in the few remaining public facilities. With the World Bank operating under the assumptions that health services are "price-elastic"[144] and often "frivolously" overutilized if provided at no cost, the imposition of user fees on previously free health services was presented as a potential "cost recovery scheme" for governments.[145] Evidence to date, however, suggests

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139. *Id.*

140. *Cf.* Ruger, *Changing Role of the World Bank*, *supra* note 135, at 67 (noting the increased financial support (loans, credits, and grants) of the World Bank for health, nutrition, and population programs).

141. McMichael & Beaglehole, *supra* note 66, at 497.

> [A]lthough responsibility for healthcare and the public-health system remains with national governments, the fundamental social, economic, and environmental determinants of population health are becoming increasingly supranational . . . [t]his global combination of liberal economic structures and domestic policy constraint promotes socioeconomic inequalities and political instability, each of which adversely affects population health.

Id.; *see* Audrey Chapman, *Core Obligations Related to the Right to Health*, *in* Core Obligations: Building a Framework for Economic, Social, and Cultural Rights 185, 215 (Audrey Chapman & Sage Russell eds., 2002) (stating that global trends reflecting greater gaps and inequalities in access to health care reflect a number of factors, including the effects of the privatization methods of the IMF as well as a lowered governmental commitment to public health); *see also* U.N. Millennium Project, Task Force on Child Health and Maternal Health, Who's Got the Power? Transforming Health Systems for Women and Children 96–97 (2005) (highlighting deficiencies in market-based approaches to health systems), *available at* http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf.

142. Freedman, *Achieving the MDGs*, *supra* note 63, at 21.

143. Chen & Berlinguer, *supra* note 134, at 41; *e.g.*, Meredeth Turshen, Privatizing Health Services in Africa (1999).

144. Jim Yong Kim et al., *Public Debt and Private Suffering in Peru*, *in* Dying for Growth, *supra* note 43, at 127 (finding that individuals are equally as unlikely to seek treatment if fees were increased by public or private providers).

145. Ruger, *Changing Role of the World Bank*, *supra* note 135, at 68 (noting criticism of the World Bank for promoting unsuccessful user fees for health services); *see also* Freedman,

that user fees and the privatization of health care have not been successful in increasing government revenues and have frequently generated sharp declines in service utilization.[146] This decreased service utilization as a result of user fees, compounded by the privatizing effects of the global intellectual property regime for pharmaceutical products,[147] has been implicated in the decline of national public health indicators.[148]

Finally, these intellectual property regimes of the World Trade Organization (WTO) often prevent states from reasonably providing affordable medications and treatments for their peoples. The 1994 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) specifically amended the General Agreement on Trade and Tariffs (GATT) to provide international patent protection for pharmaceutical products, a twenty-year minimum duration on patent protection, transitional periods with exclusive marketing rights, and enforcement of intellectual property ownership through a binding WTO judicial panel.[149] Although an exception exists within TRIPS to allow for compulsory licensing (generic production without prior patent licensing) or parallel importation (state importation of drugs from other lower-priced states without the patent holder's permission) of pharmaceuticals during public health emergencies,[150] no state has yet to invoke this clause

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Achieving the MDGs, *supra* note 63, at 22 ("In practice, whether services were officially public or private, whether users could afford it or not, all health care now required cash, with the poorest often simply priced out of the market, even for emergency life-saving services.").

146. *See* Andrew Creese & Joseph Kutzin, Lessons from Cost-Recovery in Health, Forum on Health Sector Reform Discussion Paper No. 2 (noting that the expectations of increased revenues from cost recovery schemes were far too optimistic, that successes have been limited to small-scale projects, and that the introduction of user fees has, in many cases, been followed by sharp declines in service utilization). *But see* M. Gregg Bloche, *Is Privatization of Health Care a Human Rights Problem*, *in* Privatisation and Human Rights in the Age of Globalisation 225–26 (Koen de Feyter & Felipe Gómez Isa eds., 2005) (arguing that privatization of health services can be good for health care).

147. Shubha Ghosh, *Pills, Patents, and Power: State Creation of Gray Markets as a Limit on Patent Rights*, 14 Fla. J. Int'l L. 217, 222–23 (2002) ("With respect to the case of the pharmaceutical industry, human rights and intellectual property rights are in seemingly irreconcilable conflict. Through high prices, patent owners are denying access to life-saving or pain-reducing drugs. Since patent owners are granted a very strong, if not absolute, right to exclude, the only way to grant access to the drugs is by limiting the rights of the patent owners.").

148. *See* Kim et al., *supra* note 144; *see also* Marcos Cueto, The Return of Epidemics: Health and Society in Peru during the Twentieth Century (2001) (noting increasing prevalence of multi-drug resistant tuberculosis and cholera as a result of user fees).

149. Agreement on Trade-Related Aspects of Intellectual Property Rights, 15 Apr. 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, Legal Instruments—Results of the Uruguay Round, 33 I.L.M. 81 (1994) [hereinafter TRIPS].

150. In response to the growing HIV/AIDS crisis and its destabilization of entire regions of the world, World Trade Organization (WTO) states met in 2001 during the current Doha Round of negotiations to negotiate what has come to be known as the Doha Declaration on the TRIPS Agreement and Public Health (Doha Declaration). In the Doha Declaration, state delegates reaffirmed that:

successfully.[151] As a result of pressure from powerful Western states, this patent protection under the WTO (rather than the more appropriate World Intellectual Property Organization) has handed TNCs the enforceable sanctions necessary to compel state compliance with rigid intellectual property protections and thereby elevated corporate cupidity over the imperatives of public health.[152] In yielding innovation to the corporate sector, the current patent regime discourages research for those diseases of greatest importance to developing states—not just medicines for the diseases endemic to developed states.[153] Only through research mechanisms for medicines necessary to treat "tropical" or "orphan" harms can public health systems incentivize the development of appropriate life-saving medications for neglected diseases[154] and make these medications physically and economically accessible to all who need them.

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

World Trade Organization, Declaration on the TRIPS Agreement and Public Health of 14 Nov. 2001, WT/MIN(01)/DEC/2, 41 I.L.M. 755 (2002), *available at* http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.pdf. [hereinafter Doha Declaration]; *see also* World Trade Organization, The Separate Doha Declaration Explained, *available at* http://www.wto.org/english/tratop_e/trips_e/healthdeclexpln_e.htm.

Rosalind Pollack Petchesky attributes the success of this position at the Doha conference to weakened US opposition on the subject as a result of the United States' own public consideration of compulsory licensing for the generic form of the drug Cipro in the face of the intentional anthrax dispersals of September 2001. Rosalind Pollack Petchesky, Global Prescriptions: Gendering Health and Human Rights 106 (2003). Despite this fleeting weakness in its negotiating position, Petchesky notes that the United States has systematically attempted to undercut consensus on the Declaration since the Doha conference. *Id.* at 107.

151. Frederick M. Abbott, *The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health*, 99 Am. J. Int'l L. 317 (2005) (discussing the WTO's definition of compulsory licensing and parallel importation); *see, e.g.*, Zita Lazzarini, *Making Access to Pharmaceuticals a Reality: Legal Options Under TRIPS and the Case of Brazil*, 6 Yale Hum. Rts. & Dev. L.J. 103, 133 (2003).

152. *See id.* at 112 (noting that "TRIPS was drafted following extensive lobbying by international pharmaceutical manufacturers and reflects many values favorable to large multi-national corporations").

153. *See* Sachs, *supra* note 111 (recognizing the difficulty of technological diffusion across climate zones). *See generally* Global Forum for Health Research, Monitoring Financial Flows for Health Research 2005: Behind the Global Numbers (2006), *available at* http://www.globalforumhealth.org/Site/000_Home.php.

154. *See* Sachs, *supra* note 111, at 3 (advocating, from an economic development perspective, that "policy solutions for tropical underdevelopment will require a much greater national and international focus on technological innovation directed at the problems of tropical ecology"); *see also* Paul Hunt, Neglected Diseases: A Human Rights Analysis (2007), *available at* http://www2.essex.ac.uk/human_rights_centre/rth/docs/Neglected%20Diseases.pdf (discussing the human rights implications of neglected diseases); Neglected Tropical Disease Coalition, Winning the Fight Against Neglected Tropical Diseases, *available at* http://www.neglectedtropicaldiseases.org/#.

For these and other reasons,[155] the dramatic and unprecedented scaling back of the government's role in providing social services, particularly public health services, has reversed many of the health gains achieved in developing countries in the last fifty years,[156] leaving debilitated national public health infrastructures (with a shortage of qualified health workers[157] and a limited arsenal of effective drugs[158]) that cannot bear the burden of modern disease.[159] As a result, in the decades since the Washington Consensus was first implemented, these neoliberal policies have decimated fragile health and social infrastructures in countries throughout Africa, Asia, and Latin America,[160] leaving their peoples "poorer and less healthy."[161] Despite repeated WHO efforts to address these global disparities in health, many developing countries remain structurally impotent to fulfill the improved public health capabilities experienced in the developed world.[162]

While public health scholarship has come to appreciate the role of structural forces in determining health status, development discourses have

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155. For a more complete enumeration of the links between neoliberal policy and public health systems, see Benjamin Mason Meier, *Employing Health Rights for Global Justice: The Promise of Public Health in Response to the Insalubrious Ramifications of Globalization*, 39 Cornell Int'l L.J. 711, 714–33 (2006).
156. *See* Mazur, *supra* note 74, at 66 ("Debt-related cuts in health, nutrition, and literacy programs are undoing the results of years of development efforts.").
157. *See* Macfarlane et al., *supra* note 72, at 844 (recognizing that "an underpaid, poorly motivated, poorly organised [sic], and increasingly dissatisfied [medical] workforce also poses the greatest threat to [health sector] reform").
158. *See* David P. Fidler, International Law and Infectious Diseases 16 (1999) ("With rare exceptions, antimicrobial drugs made available globally have had no significant impact on their intended targets.").
159. *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.").
160. Mahmood Monshipouri, Democratization, Liberalization & Human Rights in the Third World 54 (1995); *see* Chapman, *supra* note 141, at 212 (noting that "poor countries are . . . cutting back on investments in the health sector, often in response to IMF austerity plans"). The experience of Peru is typical of this inequitable dichotomy. Kim et al., *supra* note 144, at 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 impoverished Peruvians. "By imposing the criterion of choice on people who are in no position to exercise it," Kim et al. note that "health-care reformers have prioritized financial outcomes over health outcomes, and further imperiled the health of the poor." *Id.* at 152.
161. 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 43, at 91, 92 (noting how SAP programs—cutting or abolishing social expenditures, including health services and public health systems—have contributed significantly to health disparities between the rich and poor). *Compare* Allan McChesney, *The Promotion of Economic and Political Rights: Two African Approaches*, 24 J. Afr. L. 163, 181 (1980) (discussing African national successes in providing curative and public health services prior to the structural adjustment period).
162. Fidler, International Law and Infectious Disease, *supra* note 158, at 12.

not incorporated these public health theories and research in creating programs to alleviate poverty and reduce inequality. This is due, in part, to the inability of public health scholars and advocates to address these debates through development processes because the right to health, as part of a rights-based approach to development, has remained mired in largely ineffective individualistic discourses that emphasize health care over underlying determinants of health. Public health scholars, employing this individual right to health—a right drafted at an unrepresentative time, when advances in medicine and curative technology led physicians to believe that a state of "complete" health was possible[163]—have been unable to respond to globalization's health harms and influence the development debate. In reengaging this debate for the public's health, it is imperative that international law take account of changing understandings of health, codifying the collective obligations necessary to respond to the unhealthy societal manifestations of development programs.

III. RIGHTS-BASED DEVELOPMENT: FAILURE OF THE INDIVIDUAL RIGHT TO HEALTH TO ACCOUNT FOR DAMAGES TO THE PUBLIC'S HEALTH

The profound impact that neoliberal economic policies have wrought on health systems and public health indicators in the developing world speaks to the necessity of integrating social justice principles in development discourses. Through a rights-based approach to development, scholars and activists have attempted to employ international legal obligations to create social justice frameworks that would structure development in a manner that does not violate individual human rights.[164] As defined by the Office of the High Commissioner for Human Rights,

> A rights-based approach [to development] is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human

163. Charles O. Pannenborg, A New International Health Order 82 (1979) (noting that advances in medicine "initiated the absolute disease-orientation thereby creating the coterminality of health and medicine" (citations omitted)); Mervin Susser, *Ethical Components in the Definition of Health*, 4 Int'l J. Health Services 539 (1974).

164. Julia Hausermann, A Human Rights Approach to Development (1998); *e.g.*, Janet Dine, Companies, International Trade and Human Rights (2005) (highlighting the experience of Argentine advocates in challenging the prescriptions of the IMF on the grounds that they lead to the violation of certain economic, social, and cultural rights guaranteed in the Argentine constitution). For a description of the evolution of the language of "rights-based development," see Andrea Cornwall & Celestine Nyamu-Musembi, *Putting the "Rights-Based Approach" to Development into Perspective*, 25 Third World Q. 1415, 1420–23 (2004).

> rights. [Essentially, a] rights-based approach integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development.[165]

Thus, a rights-based approach to development, placing obligations on the state to realize individual rights,[166] is concerned with the modalities through which the process of development is carried out, rather than focused on any particular end product or outcome.[167] And yet, as concluded by Tony Evans, "[t]he grip of the liberal consensus remains powerful and may not yield readily to the suggestion that the institutions and organisations that support globalisation need reorientation towards supporting socioeconomic [rights] claims."[168] In the case of the public health ramifications of development, advocates and states have attempted, with limited success, to reform the development processes of globalization through a rights-based approach to development under the individual right to health.[169]

Despite the lofty language of "the highest attainable standard of health" in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to health has been advanced as an individual right, focusing on individual access to health services at the expense of collective health promotion and disease prevention programs through public health systems.[170] Given its focus on medicine—which "reduces the unit analysis to the individual and thus obscures social causes amenable to societal-level interventions"[171]—this limited, atomized right to health has not been effective in mandating that states recognize individual health as a fundamental human

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165. Rights-Based Approaches, U.N. Office of High Commissioner for Human Rights, *available at* http://www.unhchr.ch/development/approaches-04.html, *reprinted in* Robinson, *supra* note 103, at 38.
166. *See* Nankani et al., *supra* note 98, at 480 (noting flaws in rights-based strategies in their overreliance on the state).
167. According to Stephen Marks, a rights-based approach to development can be further distinguished from six other approaches to development: 1) The holistic approach; 2) The social justice approach; 3) The capabilities approach; 4) The right to development approach; 5) The responsibilities approach; and 6) The human rights education approach. *See* Stephen P. Marks, *The Human Rights Framework for Development: Seven Approaches* (François-Xavier Bagnoud Ctr. for Health & Human Rights, Harvard Sch. of Pub. Health, Working Paper No. 18, 2003), *available at* http://www.hsph.harvard.edu/fxbcenter/FXBC_WP18—Marks.pdf.
168. Evans, *supra* note 135, at 212.
169. *See* Paula Braveman & Sofia Gruskin, *Poverty, Equity, Human Rights and Health*, 81 Bull. World Health Org. 539, 542 (2003) ("The health sector must strengthen its capacity for active, ongoing monitoring and become an effective advocate to raise awareness of the potential implications of development policies for health equity and human rights and to call for appropriate action."). *See also infra* note 198.
170. Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 Colum. Hum. Rts L. Rev. 101, 104 (2005).
171. Waitzkin et al., *Social Medicine*, supra note 25, at 1598.

right,[172] where individuals and communities lack even the basic international legal standing to hold states and international development organizations accountable for their failure to uphold the right to health.[173] This constrained and unenforced right to health has not broken into development discourse,[174] enabling globalization's legacy of deteriorating national public health systems that have abandoned vulnerable populations and left governments unable to address an expanding set of societal health claims.[175]

In the sixty years since human rights were first codified, public health has developed from a medical model to a social/ecological model,[176] but international law has not kept pace with these changes. Despite developments in public health since the original drafting of the ICESCR, the right to health, through processes of "path dependence,"[177] remains fixed on a curative or clinical model of health,[178] advancing individual medical solutions to problems known to require societal change through public health

172. David P. Fidler, *International Law and Global Public Health*, 48 U. Kan. L. Rev. 1, 40 (1999) (noting that "these debates [surrounding the right to health] have not advanced the right to health much as a matter of international law").
173. Aart Hendriks, *The Right to Health in National and International Jurisprudence*, 5 Eur. J. Health L. 389, 391–92 (1998) (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. 29 (2002) (arguing that economic, social, and cultural rights should be recognized to the same extent as are civil and political rights).
174. *See, e.g.*, Integrating Human Rights into Development: Donor Approaches, Experiences and Challenges, OECD Development Dimension Series (2006), *available at* http://www.oecd.org/document/24/0,3343,en_2649_34565_37045656_1_1_1_1,00.html.
175. Katarina Tomasevski, *Health*, *in* 2 United Nations Legal Order 859, 859 (Oscar Schachter & Christopher C. Joyner eds., 1995) ("There is no agreement on the specific obligations of States in providing access to health care to all of its population, let alone whether it is obliged to undertake the provision of health care services at all."); Lynn Freedman, *Strategic Advocacy and Maternal Mortality: Moving Targets and the Millennium Development Goals*, 11 Gender & Dev. 97, 103–04 (2003).
176. *See supra* notes 17–33; *see also* Inequalities in Health: The Black Report, *supra* note 31, at 44.
177. Path dependence is a concept from the social sciences, denoting a state in which "contingent events set into motion institutional patterns or event chains that have deterministic properties" and hamper evolutionary advancement. James Mahoney, *Path Dependence in Historical Sociology*, 29 Theory & Society 507, 507 (2000); *see also* Gerald Alexander, *Institutions, Path Dependence, and Democratic Consolidation*, 13 J. Theoretical Politics 249 (2001) (reviewing "path dependency" in the political science literature to explain why political outcomes persist over time and remain difficult to change).
178. As noted by Audrey Chapman:

> Historically, health systems were developed on a curative or clinical model of health. More recently, advances in epidemiological research have sensitised [sic] 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 141, at 187.

systems.[179] These dichotomized medicine-public health discourses have contributed to ambiguity in implementing the right to health,[180] and while public health has evolved to meet changing health needs, the right to health, as an individual right, remains incapable of evolving to meet this changing collective conception of health.

A. Individual Rights Are Powerless to Protect Public Health Systems

An individual rights framework—an extension of the self-interested paradigm of the market-based global economy—has proven incompetent to speak to neoliberal development in directing state policy for social justice programs.[181] Traditional human rights scholarship views "man" as "a separate isolated individual who, as such and apart from any social context, is bearer of rights."[182] This vision of human rights is rooted in employing autonomy as a means to realize human dignity.[183] In the case of public health, however, neoliberal economic policy, despite its emphasis on individualism,[184] has taken health out of the control of the individual, determining harm

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179. Dan E. Beauchamp, *Public Health as Social Justice*, *in* Health and Social Justice 267, 270 (Richard Hofrichter ed., 2003) ("Market-justice [as opposed to social justice] is perhaps the major cause for our over-investment and over confidence in curative medical services . . . But the prejudice found in market-justice against collective action perverts these scientific advances into an unrealistic hope for 'technological shortcuts' to painful social change." (citation omitted)); *see also* Chapman, *supra* note 141, at 213 (*citing* Anne E. Platt, Worldwatch Institute, Worldwatch Paper No. 129, Infecting Ourselves: How Environmental and Social Disruptions Trigger Disease 10 (1996)).

180. Chapman, *supra* note 141, 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.").

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

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

Donnelly, Universal Human Rights, *supra* note 123, at 201–02.

182. Koo VanderWal, *Collective Human Rights: A Western View*, *in* Human Rights in a Pluralist World: Individuals and Collectivities 33, 83 (Jan Berting et al. eds., 1990).

183. Martha C. Nussbaum, *Nature, Function, and Capability: Aristotle on Political Distribution*, *in* Aristoteles' Politick 152, 165 (Günther Patzig ed., 1990); *see also* Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 Yale J. L. & Humanities 273, 289 n.70 (2006) (noting that various approaches to medical ethics, including the "capability approach," have emphasized "choice" "because it embodies a respect for individual autonomy"); 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)).

184. *See* Mazur, *supra* note 74, at 64.

at the societal level.[185] As seen through the underlying determinants of communicable disease,[186] non-communicable disease (e.g., tobacco use, obesity),[187] and other illnesses, neoliberal economic policy has impinged the right of the informed individual to make healthy choices for him or herself, denying the freedom of choice pivotal to a "capability approach" to the right to health.[188]

With the individual as the sole rights-holder, human rights organizations have faced difficulties in finding a discursive space to enter the development debate.[189] For example, a rights-based approach is likely to give priority to gross violations to a small number of individuals' human rights over less severe but more pervasive violations during development.[190] As argued by William Felice, "[s]een only as individual entitlements, human rights are a difficult conceptual framework from which to tackle structural violence in the global economy."[191] Although public health systems, as public goods, are vital to the provision of public health programs in responding to globalization, an individual right is normatively incapable of providing for the realization of these public goods. Combating the health inequalities of a globalized world through human rights will require renewed focus on the collective social determinants of health that facilitate the onset and spread of disease, not simply individual rights.

Compounding the inapplicability of these individual rights, the traditional human rights system regards the state as the sole duty-bearer for realizing rights,[192] a rights framework incongruous with modern development pro-

185. *See* Parker, *supra* note 50, at 41.
186. Fidler, International Law and Infectious Disease, *supra* note 158, 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."); Allyn L. Taylor, *Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 33 Hous. L. Rev. 1327, 1328 (1997) ("Advances in and widespread accessibility to rapid transportation and international commerce have obliterated former national reliance on the geographic isolation of microbial hazards."(citations omitted)).
187. Derek Yach et al., *The Global Burden of Chronic Disease*, 291 J. Am. Med. Ass'n 2616, 2617–18 (2004).
188. Amartya Sen, *Development as Capability Expansion*, *in* Human Development and the International Development Strategy for the 1990's (Keith Griffin & John Knight eds., 1990); *see also* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183.
189. *See* Uvin, *supra* note 77, at 131 ("If claims exist, methods for holding those who violate claims accountable must exist as well. If not, the claims lose meaning.").
190. Cornwall & Nyamu-Musembi, *supra* note 164, at 1417.
191. Felice, *The Viability of the United Nations Approach*, *supra* note 96, at 585.
192. The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 20 Hum. Rts. Q. 691, 692 (1998) [hereinafter Maastricht Guidelines] ("[A]s a matter of international law, the state remains ultimately responsible for guaranteeing the realization of these rights.").

cesses. This was not always so. The 1948 Universal Declaration of Human Rights provides that "[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."[193] Following this, Article 2 of the ICESCR includes the role of "international assistance and cooperation, especially economic and technical" in ensuring the progressive realization of rights.[194] Despite this prescient language predating the modern era of economic globalization, no state has since pressed international claims on this basis, and advocates have been left to use economic and social rights as a rhetorical cudgel against the hapless development-seeking state.[195] That is, individual rights have proven ineffective against state action where the state is not primarily responsible for the plight of its peoples.[196] Because this approach employs human rights for harms that have already occurred at the national level, it has been ineffective both in preventing harm at the international level before it has occurred and in responding to the irreparable national harms of structural adjustment.[197] While the state retains a great deal of control over some rights, realizing economic and social rights during development processes necessitates that the state itself be able to enforce rights against those parties with far greater control over underlying determinants of health. 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 an individual right for the public goods comprising of a public health system, and no state can make a claim against the international system *ex ante* for the subversion of the rights of its peoples.

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193. Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess., art. 28, U.N. Doc. A/810 (10 Dec. 1948) [hereinafter UDHR]. Despite this recognition of the importance of an international order conducive to realizing human rights, states intentionally excluded from this "social and international order" language that would have had the greatest impact on health—an economic order. *See* Falk, *supra* note 137, at 61, 71.
194. International Covenant on Economic, Social and Cultural Rights, *adopted* 16 Dec. 1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, art. 2, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, 8 (*entered into force* 3 Jan. 1976) [hereinafter ICESCR]. For a discussion of the principle of progressive realization in article 2 of the ICESCR, *see infra* Part III.B.2.
195. *E.g.*, People's Health Movement, The Assessment of the Right to Health and Health Care at the Country Level (Oct. 2006), *available at* http://www.phmovement.org/files/RTH_assmt_tool.pdf (evaluating and criticizing state compliance with the right to health as a result of changes inherent in development).
196. *See supra* notes 134–162 and accompanying text (describing how neoliberal development programs have weakened state control over public health indicators).
197. For example, once development programs have been implemented and privatization has taken place, no state heretofore has been held responsible for either the act of privatizing or the rights violations of these private actors in the provision of public goods. Bloche, *supra* note 146, at 223.

B. The Incomplete Success of the Right to Health

While public health scholars and activists have attempted to employ the right to health as part of this rights-based approach to development,[198] the promise of the right to health has largely proven illusory in development discourse. Founded upon the non-derogable right to life,[199] the Universal Declaration on Human Rights (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."[200] In 1966, the United Nations legislatively embodied the economic and social parameters of this right in the ICESCR, which elaborates the right to health in Article 12.1 to include "the right of everyone to the enjoyment of *the highest attainable standard of physical and mental health*."[201] To achieve the full realization of this right, Article 12.2 of the ICESCR requires states to take affirmative steps necessary for "(a) [t]he provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) [t]he improvement of all aspects of environmental and industrial hygiene; (c) [t]he prevention, treatment, and control of epidemic, endemic, occupational and other diseases; [and] (d) [t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[202] However, "since the listed measures constitute goals as opposed to actions that member nations must take,"[203] this treaty language provides

198. World Health Organization, Human Rights, Health and Poverty Reduction Strategies (2005) [hereinafter WHO, Human Rights, Health & Poverty]; Office of the United Nations High Commissioner Human Rights, Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation (2006).

199. Virginia A. Leary, *Implications of a Right to Health, in* Human Rights in the Twenty-First Century: A Global Challenge 481, 487 (Kathleen E. Mahoney & Paul Mahoney eds., 1993) ("It does not strain imagination to consider the 'right to health' as implicit in the right to life."); UDHR, *supra* note 193, art. 3 ("Everyone has the right to life, liberty and the security of person.").

200. UDHR, *supra* note 193, art. 25(1).

201. ICESCR, *supra* note 194, art. 12(1) (emphasis added). Although this article focuses largely on the ICESCR, based upon its seminal and widely-accepted enunciation of the right to health, international treaty law has also recognized a right to health in, *inter alia*, Article 24 of the Convention on the Rights of the Child, adopted 20 Nov. 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, art. 24, U.N. Doc. A/44/49, 144 U.N.T.S. 123, 123–52 (*entered into force* 2 Sept. 1990) (1989); the Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* 18 Dec. 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, arts. 11(1)(f), 12, 14(2)(b), 1249 U.N.T.S. 13, 18–19 (*entered into force* 3 Sept. 1981); and Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, *adopted* 21 Dec. 1965, art. 5(e)(iv), 660 U.N.T.S. 195, 220–21 (*entered into force* 4 Jan. 1969). While these and other bases of national and international law recognize a right to health, see *Report of the Special Rapporteur* (13 Feb. 2003), *supra* note 103, ¶ ¶ 11–20, these interpretations all stem from the cornerstone right elaborated in Article 12 of the ICESCR.

202. ICESCR, *supra* note 194, art. 12(2).

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

little guidance as to the specific scope of states' obligations,[204] creating, at best, an "imperfect obligation" on states in implementing the right to health.[205] Outside of these sweeping platitudes enunciated in international law, what specifically is meant by the "highest attainable standard of health?"[206] While states and treaty bodies have come to different interpretations as to what health services should be included within the core content of the right to health,[207] the right has been stymied in its ability to influence underlying determinants of health because of (1) its focus on medical services, (2) the contingent nature of obligations pursuant to the principle of progressive realization, and (3) the individual framework for its realization, limiting its ability to evolve to encompass the public health systems determinative of health.

1. Historical Origins of Right to Health as Right to Medicine

The right to health was borne of a unique and unrepresentative moment in the history of ideas surrounding health, leaving it inapplicable to current public health dilemmas.[208] Discourses on health rights veered away from the social medicine focus of public health and toward curative health care

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204. Robert Beaglehole & Ruth Bonita, Public Health at the Crossroads: Achievements and Prospects 223 (1997) (noting that the UDHR and ICESCR, "although important and legally binding in international law, do not make it easy to determine the specific obligations involved"); *see* Chapman, *supra* note 141, at 193 (noting the "confusion and controversy about the nature and scope of the right to health" and that "few countries . . . utilise its norms as a framework for formulating health policy").
205. Michael Kirby, *The Right to Health Fifty Years On: Still Skeptical?*, 4 Health & Hum. Rts. 7, 13 (1999). For a description of Emanuel Kant's ethical notion of "imperfect obligations" to human rights, see Amartya Sen, *Elements of a Theory of Human Rights*, 32 Phil. & Pub. Aff. 315, 317–18 (2004).
206. Although the "highest attainable standard" of health is to be achieved, the term "health," unlike in the WHO Constitution, is not defined by the ICESCR. Henrik Karl Nielsen, The World Health Organisation: Implementing the Right to Health 18 (1999). While WHO personnel had proposed the defining language of the WHO Constitution for Article 12 of the ICESCR—defining health as "a state of complete physical, social and mental well-being, and not merely the absence of disease of infirmity"—this language was ultimately abandoned. Philip Alston, *The United Nations' Specialized Agencies and Implementation of the International Covenant on Economic, Social and Cultural Rights*, 18 Colum. J. Transnat'l L. 79, 88 (1979).
207. *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health*, General Comment No. 14, U.N. ESCOR, Comm. on Econ., Soc. & Cult. Rts., 22nd Sess., Agenda Item 3, ¶ ¶ 43–44, U.N. Doc. E/C.12/2000/4 (2000) *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument [hereinafter General Comment 14]. For a discussion and analysis of General Comment 14's elaboration of the right to health, see *infra* Part III.B.3.
208. This focus on the origins of the right to health in medical norms is not to exclude the myriad international relations factors that contributed to this language and the language of all rights embodied in the ICESCR. For a discussion of some of these factors, see generally Brigit C.A. Toebes, The Right to Health as a Human Right in International Law (1999).

during and immediately following the Second World War, the time at which the right to health was codified, first in the UDHR and subsequently in the ICESCR. Heightened by a sense of unlimited possibility for the advancement of science—a sense that all the world's ills could be solved by the hand of the knowing physician, operating one person at a time through the tools of medicine—this era is part of what has come to be known as the "golden age of medicine."[209] From this medicalized conception of health, rooted in the scientific spirit of the post-War era, the right to health was created simply as a right to the individual medical treatments then thought to be singularly necessary for achieving the highest attainable standard of health.[210] Through path dependency, these formative events in creating the right to health impact contemporary institutions for health rights,[211] with the right to health's focus on medicine and healthcare excluding the systems required for the public's health.[212]

The codification of health as a human right begins, as with all modern human rights frameworks, in the context of the Second World War. In considering a freedom from want, one of the "Four Freedoms" popularized during the War,[213] medical scholars saw a place to advance the cause of medicine through human rights. By the 1940s, newly-discovered therapies had been shown to produce dramatic successes in the control of disease and promotion of health.[214] The Second World War highlighted the unlimited possibilities

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209. Turner, *supra* note 22, at 9 ("It is common in the history of medicine to argue that the Golden Age of scientific medicine was located in the period 1910 to 1950 in which Flexnerian medicine was never significantly challenged; this period was also one in which the general metropolitan hospital came to dominate the health-care system, as that location within which scientific medical practice had its primary focus.").
210. In the context of several developed states, this manifested itself in the creation of national systems of medical services. *See, e.g.*, Sir William Beveridge, Social Insurance and Allied Services: Report by Sir William Beveridge 158–63 (1942) (proposing the creation of what would become the British National Health Service).
211. Mahoney, *supra* note 177; Alexander, *supra* note 175, and accompanying text (noting the role of historical institutionalism in asserting the prevalence of path dependency). The reasons underlying the path dependence of the right to health in its curative conceptualization are too multifaceted for a complete review in the present article but will be explored in far greater detail in a forthcoming book by the lead author.
212. *E.g.*, Kevin M. de Cock et al., *Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21st Century*, 360 Lancet 67 (2002) ("Human rights based approaches to HIV/AIDS prevention might have reduced the role of public health and social justice, which offer a more applied and practical framework.").
213. On 6 January 1941, US President Franklin Delano Roosevelt announced to the world that the post-War era would be founded upon four "essential human freedoms": freedom of speech, freedom of religion, freedom from fear, and freedom from want. 87 Cong. Rec. 44, 46–47 (1941), *reprinted in* The Public Papers and Addresses of Franklin D. Roosevelt: 1940, 672 (Samuel I. Rosenman ed., 1941). As Roosevelt conceived of it, a freedom from want must be couched in the language of freedom with the understanding that "necessitous men are not free men." President Franklin Roosevelt's Message on the State of the Union, 11 Jan. 1944, 90 Cong. Rec. 55, 57 (1944).
214. Eskild A. Peterson, *Emerging Infectious Disease*, 156 Archives Internal Med. 124, 125 (1996).

of medicine, which had previously suffered from lingering suspicions of its reliability in promoting health.[215] Notwithstanding the horrors of Nazi physicians,[216] physicians throughout the world had employed their healing art in ways that preserved life and improved health on the battlefield and beyond. Combined with an understanding of hygiene and improvements in sanitary conditions, it was felt that infectious disease could be controlled and would soon run its course within developed civilizations.[217] With medical therapies cutting into the spread of infectious diseases under nascent national health services and with eugenics providing a framework for considering health to be genetically, not socially, driven, public health programs began to lose relevance and were displaced by the medical profession's individual treatments.[218]

This medicalized discourse would develop the right to health as a right to those medical treatments then thought to bring about the "end of disease."[219] As the medical profession reached new heights in its policy participation in states throughout the world (creating what has been termed an "aristotechnocracy," built upon the unique legitimacy of technological expertise in solving global problems),[220] these physicians, bound together by social and systemic solidarity,[221] employed bonds of global mutual iden-

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215. *See* Pannenborg, *supra* note 163, at 196 ("Whereas many 'practitioners' prior to the legalization of medicine enjoyed a most dubious recognition and social position, this changed rapidly from the moment that its technological advances were able to purport its assertions to be the saving discipline of man."); *see also* Philip J. Hilts, Protecting America's Health: The FDA, Business, and One Hundred Years of Regulation 23–34 (2003) (describing the rise of medicine in the United States).
216. United States v. Karl Brandt, Trials of War Criminals Before the Nuremberg Military Tribunals (1948), *quoted in* Jay Katz, Experimentation with Human Beings: The Authority of the Investigator, Subject, Professions, and State in the Human Experimentation Process 292 (1972); *see also* Telford Taylor, Opening Statement of the Prosecution, 9 Dec. 1946, *reprinted in* George J. Annas & Michael A. Grodin, The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation 67 (1992) ("The defendants in this case are charged with murders, tortures, and other atrocities committed in the name of medical science . . . To their murderers, these wretched people were not individuals at all. They came in wholesale lots and were treated worse than animals.").
217. Pannenborg, *supra* note 163, at 82 (noting that advances in medicine "initiated the absolute disease-orientation thereby creating the coterminality of health and medicine" (citations omitted)); Mervin Susser, *Ethical Components in the Definition of Health*, 4 Int'l J. Health Services 539 (1974).
218. Taylor, *supra* note 186, at 1332 ("The remarkable success of public health interventions during this century led to a perception of victory over infectious diseases in industrialized states and, concomitantly, a decline in public and scientific interest in microbial threats." (citations omitted.)); Pannenborg, *supra* note 163, at 85.
219. Edward Tenner, Why Things Bite Back: Technology and the Revenge of Unintended Consequences 74 (1997) (noting the 1967 comments of US Surgeon General William Stewart that the world had reached the "time to close the books on infectious diseases").
220. Pannenborg, *supra* note 163, at 196 (commenting that "world-wide social self-assertion of the profession . . . appeared to be strong enough to withstand all political and socio-economic upheavals").
221. *Id.* at 195–96.

tification to create the international legal structures governing healthcare. These practices and technologies would frame conceptions of a right to health. With public health and social medicine thought to be a product of the pre-antibiotic era, this medical view restricted the right to health to that which could be performed by physicians–health care. Ignoring previously-recognized societal determinants of health,[222] international development organizations, driven by the larger "medical-industrial complex"[223] that had sprung from the Second World War, furthered this biomedical vision of health to emphasize antibiotics, medical technologies, and large, centralized, private urban hospitals,[224] a trend only exacerbated by the advent of globalization.[225]

Left without a public health framework for health, the ICESCR memorialized perennially an ambiguity in that which is the very object of the right,[226] fixing the definition of health upon contemporary assumptions that such a definition included only measures for health care.[227] Unlike the social medicine focus of the non-binding Constitution of the World Health Organization,[228] this right to health in the ICESCR would be operationalized as a right to medicine and medical services,[229] suggesting that "a right claim to equal *health* is best construed as a demand for equality of access

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222. Oswald, *supra* note 31, at 61 ("Doctors were used to responsibility only for individuals who were in the role of patient and the idea that they might accept an obligation to whole communities involved a radical change in attitude and in the organization of medical services."); Dorothy Porter, *The Decline of Social Medicine in Britain in the 1960s*, *in* Social Medicine and Medical Sociology in the Twentieth Century, *supra* note 31, at 97, 111–13 (noting the ways in which physicians caused medicine to preempt social medicine).
223. Barbara Ehrenreich & John Ehrenreich, The American Health Empire: Power, Profits and Politics (1970).
224. Golub, *supra* note 6, at 215 ("After the Second World War, the promise of specific therapies became a dramatic reality with antibiotics and immunizations—exemplified in the mind of the public by penicillin and the Salk vaccine.").
225. *See* Letter from Alison Katz to Margaret Chan (Jan. 2007) (on file with lead author) (arguing that "WHO has fallen victim to neoliberal globalization" in being forced into public-private partnerships for assuring health care).
226. *See* Norman Daniels, Just Health Care 78 (1985); *compare* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 312–18 (arguing that the right to health requires a, "universally shared norm of health in order to establish a framework for making interpersonal comparisons").
227. Maurice King, *Person Health Care: The Quest for a Human Rights*, *in* Human Rights in Health 227 (Ciba Foundation Symposium Series 1974). *But see* Bloche, *supra* note 146, at 208 (finding that medical care is only a minor part of the right to health, reasoning that "'medical service and medical attention in the event of sickness' is last on the list" of provisions in article 12 of the ICESCR).
228. WHO, Constitution, Preamble (22 July 1946), *reprinted in* WHO, Basic Documents 1 (40th ed. 1994) ("Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.").
229. *See* King, *supra* note 227.

or entitlement to health *services.*"[230] This obligation of conduct toward the individual, rather than an obligation of result to the public, has diminished the importance of collective public health systems.[231] With this services-based definition of the right to health, states have employed individual health services for problems requiring collective health systems, serving to benefit only a select few while reinforcing the injurious consequences of poverty.[232] Contrasted with a public goods vision of public health, medical goods and services have been conceptualized as private commodities[233] and thereby amenable to privatization and patent frameworks.[234] As a result of this conceptualization of health as health services, the right to health has remained fixed in a medicalized conception of health obligations, commodifying determinants of health in ways inimical to human dignity, particularly when such a right is implemented—as has been the case through neoliberal economic policy—through privatized health care based around an inequitable payment structure that denies care to those in greatest need.[235]

2. Progressive Realization: Resource Constraints on the Right to Health

Overlying any discussion of state obligation for health is the principle of progressive realization. As a result, realization of healthy conditions is de-

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230. Daniels, *supra* note 226, at 7. *But see* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 280–87 (theorizing the right to health to imply equity in health as opposed to equity in health care).
231. *See* Pannenborg, *supra* note 163, at 198 (noting that the right to health is judged by the technology put toward it (obligation of conduct) rather than the health benefit derived from it (obligation of result)). For a discussion of the distinction between obligations of conduct and obligations of result, see *infra* notes 484–94 and accompanying text.
232. *See* Maria Stuttaford, *Balancing Collective and Individual Rights to Health and Health Care*, L. Soc. Just. & Global Dev. 5, 8 (2004) (noting that "a rights based approach focuses on the interests of the individual rights-holder and excludes the interests of the community and that this may lead to disproportionate benefits to the informed and articulate and to those with the greatest resources at their disposal" (citations omitted)).
233. Clare Bambra et al., *Towards a Politics of Health*, 20 Health Promotion Int'l 187, 189 (2005) (noting a pervasive definition of health spawned by Western capitalism that has viewed health "as a commodity that individuals can access either via the market or the health system"); World Health Organization, Commission on Intellectual Property Rights, Innovation and Public Health, Public Health, Innovation and Intellectual Property Rights (2006), *available at* http://www.who.int/intellectualproperty/documents/thereport/en/index.html.
234. *See supra* notes 149–154 and accompanying text.
235. *See* Nankani et al., *supra* note 98, at 484 (arguing that "the precept of country ownership resonates with human rights principles on a number of counts"). *But see* Bloche, *supra* note 146, at 218 (finding that "[h]uman rights law is agnostic on the question of whether this care should be provided or paid for through public, private, or mixed mechanisms" and arguing that privatization of health care poses no concerns under the right to health).

pendent on national resources,[236] resources that the individual right to health cannot effectively take into account in national implementation of development programs. Because of this shifting standard for realization of health, the principle of progressive realization has hobbled efforts to create standards, indicators, or benchmarks for operationalizing the right to health.[237]

Beyond providing for the minimum core content of the right to health, the contested level below which the right would lose all significance,[238] the right to health requires only that states take steps toward the "progressive realization" of the right to health.[239] The ultimate result sought to be achieved is clearly the "full realization" of all human rights; however, this objective is qualified by the principle of progressive realization, acknowl-

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236. Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 Hum. Rts. Q. 156, 177 (1987) ("It is the state of a country's economy that most vitally determines the level of its obligations as they relate to any of the enumerated rights under the Covenant [ICESCR].").

237. Rajeev Malhotra & Nicolas Fasel, Quantitative Human Rights Indicators: A Survey of Major Initiatives 27 (2005); Helen Watchirs, *Measuring the Implementation and Health Effects of Law*, 30 J.L. Med. & Ethics 716, 718 (2002). For a survey of preliminary proposals on indicators, see *infra* note 256 and accompanying text.

238. General Comment 14, *supra* note 207, ¶ 44. According to rights scholars, the essential minimum core content of an economic, social, or cultural right "corresponds with an absolute minimum level of human rights protection, a level of protection which States should always uphold independent of the state of the economy or other disruptive factors in a country." Hendriks, *supra* note 173, at 394 (1998). While not originally implemented through the ICESCR, scholars, based upon the preparatory documents of the ICESCR, have developed a doctrine of "minimum core" to concretize economic, social, and cultural rights in the face of the principle of progressive realization. The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, U.N. Doc. E/CN.4/1987/17, Annex (2–6 June 1986), *reprinted in* 9 Hum. Rts. Q. 122 (1987). As noted subsequently by the CESCR, "[i]n order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations." U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. and Cultural Rights [CESCR], The Nature of States Parties Obligations (Art. 2, ¶1): Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 3, ¶10, U.N. Doc. E/1991/23 (5th Session, 1990), *available at* http://cesr.org/low/generalcomment3 [hereinafter General Comment 3]. However, the lack of consensus on even these core obligations has stifled implementation of the right to health. *See* Bloche, *supra* note 146, at 218 n.44. For a discussion of core obligations within General Comment 14's interpretation of the right to health, see *infra* notes 284–292 and accompanying text.

239. ICESCR, *supra* note 194, art. 2. The "progressive realization" standard of the ICESCR must be judged in comparison to the uncompromising language of the ICCPR, which mandates that states "undertake[] to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant . . ." International Covenant on Civil and Political Rights, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, at art. 2, U.N. Doc. A/6316 (1996) [hereinafter ICCPR]. In comparing the two covenants, Louis Henkin has commented on the "subtle but conscious and pervasive difference in tone and in the terms of legal prescription" in the ICESCR. Louis Henkin, The Age of Rights 33 (1990).

edging that the full realization of rights is not a substantive result that can be achieved instantaneously for many states and focusing upon the procedures by which states can implement their legal obligations over time. In accordance with the principle of progressive realization, enacted through Article 2 of the ICESCR, a state must take steps to operationalize the right to health only "to the *maximum of its available resources*, with a view to *achieving progressively* the full realization of the rights."[240] Through the linkages between both the 'available resources' standard and 'achieving progressively' provision, the universality of human rights loses its rigidity in the context of health.[241]

Referred to collectively as the "principle of progressive realization," this principle acknowledges, in the case of the right to health, that states will undertake different health interventions based on their respective resources and consequently that states will enjoy vastly different standards of health.[242] Under the ICESCR's contingent obligations under 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."[243] Given these constraints, the right to health should be seen as inherently resource dependent.[244] While states must take certain immediate steps toward meeting each goal of the ICESCR (and cannot backslide from any steps taken),[245] the full realization of the right to health

240. ICESCR, *supra* note 194, art. 2 (emphasis added).

241. *But see* Scott Leckie & Anne Gallagher, *Why a Legal Resource Guide for Economic, Social, and Cultural Rights?*, *in* Economic, Social, and Cultural Rights: A Legal Resource Guide xiii, xviii (Scott Leckie & Anne Gallagher eds., 2006) (noting that the "'available resources' standard" nevertheless "obliges States Parties to ensure minimum subsistence rights for everyone, regardless of the level of economic development in a given country and is by no means intended as an escape clause for less developed countries").

242. *See* Matthew C.R. Craven, International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development 115 (1995) ("Given the variety of economic, social, and legal systems that exist among the States parties to the Covenant, and their different levels of development, it is natural that the approach of each State will vary according to the circumstances in which it finds itself.").

243. General Comment 14, *supra* note 207, ¶ 31; Fidler, International Law and Infectious Disease, *supra* note 158, 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.").

244. Eleanor D. Kinney, *Lecture, The International Human Right to Health: What Does This Mean for Our Nation and World?*, 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.").

245. General Comment 3, *supra* note 238, ¶ 9. Even this Pyrrhic victory in proscriptions on backsliding has not come without criticism. *See* Robinson, *supra* note 103, at 35 (noting criticisms that this limitation makes the principle of progressive realization seem "unilinear: it assumes that progress must be continuous, and that it is never acceptable for policy makes to 'go backwards' at one point in order to go forwards later on").

may be achieved progressively over an indefinite period of time.[246] Thus, 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,"[247] leaving the right to health largely hortatory,[248] dismissed by critics as merely "aspirational."[249] States have taken advantage of this unfettered standard of conduct, with many states offering reflexive claims of resource constraint in defense of their spending and health policy priorities.[250]

Despite this principle of progressive realization, scholars have nevertheless attempted to create binding enforcement mechanisms while remaining in accordance with the sliding scale of obligations of the right to health. In gauging application of this, however, what is meant by "maximum available"?[251] Can there ever be a violation of the right to health or is a state's margin of discretion[252] so limitless as to preclude violation? To find enforceable obligations for the right to health, scholars have considered obligations for health interventions as being on a continuum,[253] providing a measure of

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246. *See* Alston & Quinn, *supra* note 236, at 172–77 (finding in the *travaux préparatoires* for the ICESCR no effort to employ the principle of progressive realization merely to hinder realization of the rights therein).

247. Timothy Stoltzfus Jost, Readings in Comparative Health Law and Bioethics 4 (2001); *see also* Obijiofor Aginam, Global Health Governance: International Law and Public Health in a Divided World 39 (2005) (noting that the "vagueness" of the principle of progressive realization "has offered an escape route to state parties to the ICESCR, thus leading to the unfortunate conclusion that the right to health is an illusion").

248. Lawrence Gostin & Jonathan Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, *in* Health and Human Rights: A Reader 54 (Jonathan M. Mann et al. eds., 1999) (noting that the concept of a human right to health "has not been operationally defined"); Virginia Leary, *Concretizing the Right to Health: Tobacco Use as a Human Rights Issue*, *in* Rendering Justice to the Vulnerable 161, 162 (Fons Coomans et al. eds., 2000) ("The efforts to clarify the right to health have often been either too theoretical or, alternatively, too detailed and unfocused, resulting in the widespread view that the right to health is an elusive concept and difficult to make operational.").

249. Evans, *supra* note 135, at 199–203 (noting the liberal consensus on human rights "accepts civil and political claims as human rights but relegates socioeconomic claims, including the right to health, to the status of aspirations").

250. *E.g.*, Mehlika Hoodbhoy et al., *Exporting Despair: The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya*, 29 Fordham Int'l L.J. 1, 26–28 (2005) (analyzing Kenya's defense of resource constraints in implementing the right to health for reproductive health).

251. As described by Robert Robertson,

> This phrase establishes the tangible response states must make to the challenge of realizing ICESCR rights. However, its use as a measuring tool for state compliance is problematic; it has little more definition today than when it was first written. It is a difficult phrase—two warring adjectives describing an undefined noun. "Maximum" stands for idealism; "available" stands for reality. "Maximum" is the sword of human rights rhetoric; "available" is the wiggle room for the state.

Robertson, *supra* note 136, at 694.

252. Maastricht Guidelines, *supra* note 192, at 694 (noting that states should be permitted a "margin of discretion in selecting the means for implementing their respective obligations").

253. Kinney, *supra* note 244, at 1457.

discretion to states in pleas of resource scarcity but, through various theoretical frameworks for resource allocation, not offering states unbridled discretion to the extent that it serves to nullify all obligations.[254] While such a framework on a continuum advances health rights by acknowledging that continuous improvements in health technologies will alter state obligations, it fails to set any theoretical framework for considering and prioritizing the efficacy or cost-effectiveness of a state's health expenditures.[255] Consequently, despite several attempts to construct practical indicators for the right to health,[256] this theoretical vacuum has created a situation in which a state can neither violate nor uphold the right to health, holding states accountable for only a modicum of effort in fulfillment of their treaty obligations.

With this contingent standard for state obligations, the ICESCR has set the conditions for a "flawed enforcement mechanism," through which no state can be held to account for its failure to achieve healthy conditions beyond the minimum core of the right to health.[257] Although the principle of progressive realization shifts the burden of proof to the state to show "that it has mobilized its resources to meet the needs of the most vulnerable,"[258] because enforcement of the ICESCR is accomplished largely through self-reporting by state parties, with a monitoring body that has no authority to judge state reports or sanction states for non-compliance,[259] no "international

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254. Alston & Quinn, *supra* note 236, at 177; *e.g.*, Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 312–25 (applying an Aristotelian "capability approach" in operationalizing the progressive realization of the right to health).
255. *See* Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy, and Law*, 15 Cornell J.L. & Pub. Pol'y 403, 474–81 (2006) (analyzing the "efficiency-equity tradeoff" in creating a framework for allocating health resources).
256. *See, e.g.*, *Report of the Special Rapporteur, Paul Hunt, on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, U.N. GAOR, 62d Sess., Provisional Agenda Item 72 (b), ¶ ¶ 33–44, U.N. Doc. A/62/214 (2007); Todd Landman, *Measuring Human Rights: Principle, Practice, and Policy*, 26 Hum. Rts. Q. 906 (2004); *see also* Aart Hendriks, *The Right to Health Promotion and Protection of Women's Right to Sexual and Reproductive Health Under International Law: The Economic Covenant and the Women's Convention*, 44 Am. U. L. Rev. 1123, 1138 (1995) ("Indicators are not only a yardstick with which to measure State compliance, but through the formulation of socio-economic indicators, it seems possible to attune the core content of a social right to a country's level of development.").
257. George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 Vand. J. Transnat'l L. 1295 (2005) (finding fault in the right to health in its indeterminacy, justiciability, and progressive realization, with the latter flaw acting to the detriment of the former two); *see, e.g.*, Robertson, *supra* note 136, at 702 (recognizing that "an international body cannot substitute its judgement [sic] for that of a state government where resource allocations are being made").
258. Felice, *The Viability of the United Nations Approach*, *supra* note 96, at 573.
259. *See* R. Andrew Painter, *Human Rights Monitoring: Universal and Regional Treaty Bodies*, *in* Administrative and Expert Monitoring of International Treaties 49, 53 (Paul C. Szasz ed., 1999) (noting that "[t]he absence of any inter-state or individual petition procedures reflects the margin of appreciation given to states parties in their efforts to 'progressively achieve' the [ICESCR's] substantive rights"). *But cf.* Alston & Quinn, *supra* note 236, at

body has any power under the ICESCR to proclaim a state party is in violation of its obligations under the right to health or to order more money be spent on health or different health policies be pursued."[260] In lieu of effective indicators or international adjudication of treaty implementation, scholars have advocated the use of national adjudication[261] and shaming of national governments by non-governmental organizations under the vague standards set by the right to health.[262] These enforcement mechanisms, operating outside of international legal bodies (and sometimes out of human rights discourse entirely), have met with mixed results,[263] necessitating renewed scholarly emphasis on accountability for and enforcement of the right to health.[264]

3. Contemporary Jurisprudence on the Right to Health: From Alma-Ata to General Comment 14

In examining the evolution of state duties since the time of the ICESCR, states have faced a dramatic expansion of obligations under the right to health, followed by equally dramatic contraction of these obligations at the beginning of the neoliberal era. Soon after the ICESCR entered into force in 1976, states came together to specify national health obligations at the 1978 International

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178 (noting, based on the *travaux préparatoires* to the ICESCR, that "a number of delegations indicated that they did not consider that a state party's subjective determination as to what constitutes an adequate resource allocation is entitled to complete deference"). For a larger discussion of the international reporting process for the right to health, see the authors' discussion of the Committee on Economic, Social and Cultural Rights, *infra* Part III.B.3.

260. Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 Chic. J. Int'l L. 105, 108 (2002); *see also* Bloche, *supra* note 146, at 222 n.55 ("Legal accountability for violating the right to health by failing to provide adequate medical care is more metaphorical than literal since there are no international enforcement mechanisms.").

261. *See* Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 Am. J. Pub. Health 1156 (2005).

262. *See, e.g.*, Commonwealth Medical Association, Monitoring and Promoting the Right to Health: A Manual for NGOs (2000); Judith Asher, The Right to Health: A Resource Manual for NGOs (2004), *available at* http://shr.aaas.org/Right_to_Health_Manual/index.shtml (select "entire pdf"). *But cf.* Robinson, *supra* note 103, at 33 ("Many human rights organizations now recognize the need to go beyond 'naming and shaming' alone.").

263. *Compare* George J. Annas, *The Right to Health and the Nevirapine Case in South Africa*, 348 New Eng. J. Med. 750 (2003) (noting the South African Constitutional Court's decision in support of the right to health to lead to the provision of AZT to HIV-positive pregnant women), *with* Torres, *supra* note 260, at 114 (noting that the Venezuelan government's disregard of the Venezuelan Supreme Court's decision in *Cruz Bermúdez et al. v Ministerio de Sanidad y Asistencia Social*—where the court held that the government's failure to provide those living with HIV/AIDS with access to antiretroviral therapies violated their right to health—contributes to the widespread perception that the right to health is symbolic rather than vital to the life of the nation").

264. *See* Lawrence O. Gostin, *The Human Right to Health: A Right to the "Highest Attainable Standard of Health,"* Hastings Ctr. Rep., Mar.–Apr. 2001, at 29 (advocating scholarship "to examine the meaning and enforcement of social and economic rights").

Conference on Primary Health Care, issuing the Declaration of Alma-Ata as a way of memorializing those duties.[265] The Declaration of Alma-Ata was an expansive, though non-binding, leap forward in concretizing health rights, creating a model of state responsibility for universal access to primary health care by laying out specific, essential government obligations for achieving the highest attainable standard of health. Shortly after the Declaration of Alma-Ata, however, the Washington Consensus (or neoliberal model of development) ensued, wherein states altered international law for health to reflect the norms of neoliberal globalization theory, including, *inter alia*, (1) the WHO narrowing the meaning of health in line with globalization's emphasis on the individual, (2) SAPs limiting state capacity to support public health systems, and (3) the TRIPS Agreement reifying medicine as a private commodity.[266] A belated attempt to reverse this neglect of public health was made in 2000 when the United Nations Committee on Economic, Social and Cultural Rights (CESCR) took up these evolving issues in its first General Comment on the right to health, General Comment 14.

Returning to the period shortly after the promulgation of the right to health in the ICESCR, the WHO and the United Nations International Children's Emergency Fund (UNICEF) held an international conference to discuss this new right to health from the perspective of national public health obligations. This international conference, with representatives from 134 state governments, adopted the Declaration on Primary Health Care, a document that has come to be known as the 1979 Declaration of Alma-Ata (based on its provenance).[267] The Declaration of Alma-Ata recognizes the necessity of broad-based socioeconomic development in order to build sustainable, comprehensive primary health systems that would allow for the gradual improvement of health in the developing world. To attain the goal of "health for all,"[268] the Declaration of Alma-Ata sought to rectify inequalities in health status both within and between states,[269] enumerating seven

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265. Declaration of Alma-Ata, *supra* note 62.
266. *See generally* Théodore H. MacDonald, Health, Trade and Human Rights (2006) (arguing that globalization has irreparably altered the means to realize rights for the public's health).
267. Declaration of Alma-Ata, *supra* note 62.
268. *Id.* This "health for all" language is based on the World Health Assembly's 1977 Declaration, "Health for All by the Year 2000," which reaffirmed health as a basic human right and committed states to "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." *See* WHA 30.43, *reprinted in* World Health Organization, Global Strategy: Health for All by the Year 2000 (1985). Subsequent to the Declaration of Alma-Ata, the World Health Organization Executive Board in January 1979 invited member states of the WHO to use the Declaration of Alma-Ata as the basis for formulating national policies in meeting the goals of Health for All by the Year 2000.
269. *See* Marmot et al., *Social/Economic Status and Disease*, *supra* note 27, at 114 (noting the Declaration of Alma-Ata's focus on the elimination of social inequalities in health).

specific government duties for essential aspects of primary health care, including: "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs."[270]

Despite this delineation of the components necessary for primary health systems, an ongoing debate has raged among states and development organizations regarding the preference for narrow, vertical interventions to tackle specific health problems over the provision of basic health systems, most notably improved sanitation, nutrition, and education.[271] Proponents of comprehensive primary health systems have developed an empirical consensus that selective health care merely constructs narrow, technocratic approaches that emphasize "Band-Aid solutions" rather than fundamental change in the root causes of poor health (for example, providing oral rehydration solutions to infants and children rather than creating systems for safe water and sewage).[272] Spurning this consensus, developed states and certain international organizations have nevertheless preferred the cost and evaluative prospects of limited technical interventions.[273] As such, the interventions that arose shortly after the Declaration of Alma-Ata and into the neoliberal era have not contributed to the development of health systems and infrastructure but rather have created a dependency of developing world populations on Western medications and

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270. Declaration of Alma-Ata, *supra* note 62, § VII. Based upon this seminal declaration, some health advocates found primary health care, with its seven constituent components, to represent the "minimum core content" of the human right to health. *See Report of the Eighth and Ninth Sessions of the Committee on Economic, Social and Cultural Rights*, U.N. ESCOR, Comm. On Econ., Soc. & Cult. Rts., 8th & 9th Sess., Supp. No. 3, ¶ 316, U.N. Doc. E/1994/23 (1994) (statement by Margareta Skold, World Council of Churches). *But see* Nielsen, *supra* note 206, at 24 (arguing that "the Alma-Ata Declaration does not appear to contribute to the clarification of the minimum core approach").

271. For more on this debate, see Marcos Cueto, *The Origins of Primary Health Care and Selective Primary Health Care*, 94 Am. J. Public Health 1864 (2004).

272. *See generally* Laurie Garrett, *The Challenge of Global Health*, Foreign Aff. Jan.–Feb. 2007, at 14 (concluding that "efforts should focus less on particular diseases than on broad measures that affect populations' general well-being"); Cueto, *supra* note 271, at 1870 (noting that "to supporters of comprehensive primary health care, oral rehydration solutions were a Band-Aid in places where safe water and sewage systems did not exist. However, this intervention, together with immunization, became popular with agencies working in developing countries, partly thanks to an important achievement: the global eradication of smallpox in 1980").

273. Cueto, *supra* note 271, at 1871 (noting that "US agencies, the World Bank, and UNICEF began to prioritize some aspects of GOBI [growth monitoring, oral rehydration techniques, breast-feeding, and immunization], such as immunization and oral rehydration solutions").

foreign aid, further depleting these states of the health systems and government workforce necessary for sustained public health.[274]

In 2000, the CESCR, the legal body charged with drafting official interpretations of and monitoring state compliance with the ICESCR,[275] examined these issues surrounding the right to health in drafting General Comment 14.[276] Finding the right to health to be subject to evolution over time,[277] the CESCR sought to interpret the individual right to health in light of shifting definitions of the concept of health,[278] drawing together the interdependent positive (economic, social and cultural) and negative (civil and political) rights frameworks that impact a state's ability to respect, protect, and fulfill the right to health.[279] It had become clear in examinations of state health

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274. Randall Packard, *Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World, in* International Development and the Social Sciences (Frederick Cooper & Randall Packard eds., 1997).

275. In 1985, the United Nations Economic and Social Council (ECOSOC), the body charged with this task in the ICESCR, created the CESCR as a subsidiary organ to undertake its review of "reports on the measures which [states parties] have adopted and the progress made in achieving the observance of the rights recognized [in the ICESCR]." ICESCR, *supra* note 194, art. 16. For an analysis of the evolving role of the CESCR in interpreting the ICESCR, see Scott Leckie, *The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform, in* The Future of UN Human Rights Treaty Monitoring 129 (Philip Alston & James Crawford eds., 2000).

276. General Comment 14, *supra* note 207. The CESCR, like many universal treaty bodies, has developed a series of general comments to "reflect the experience gained by the Committee in its consideration of a significant number of reports, and deal with specific articles of the Covenant or particular issues raised under it." U.N. Office of the High Commissioner for Human Rights, Manual on Human Rights Reporting Under Six Major International Human Rights Instruments 265, U.N. Doc. HR/PUB/91/1, U.N. Sales No. GV.E.97.0.16 (1997), *available at* http://www.unhchr.ch/pdf/manual_hrr.pdf.

277. Petchesky, *supra* note 150, at 119 ("In its May 2000 Comment, the CESCR also presents a view of the right to health, like human rights generally, as historically situated and evolving over time.").

278. General Comment 14, *supra* note 207, ¶ 10 ("Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope."). *E.g.*, Toebes, *supra* note 208, at 17–18 (finding that it is "more appropriate to abbreviate a 'right to the highest attainable standard of physical and mental health' to a 'right to health' than to a 'right to health care'" and finding the former to be more expansive and encompassing the latter); *But cf.* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 313 (recognizing that General Comment 14 "did not elaborate . . . on different accounts of health or the meaning of a high attainable standard in a world of diverse individuals with variable genetic and biological capacity").

279. The CESCR accounts for these positive and negative components of the right to health by laying out a tripartite framework through which states must respect, protect, and fulfill the right to health. Under a state obligation to "respect" the right to health, a state must not interfere with the negative rights necessary to realizing health. Looking beyond the state and its agents, the obligation to "protect" the right to health requires a state to ensure that others, including non-state actors, do not violate this right. Lastly, the obligation to "fulfill" the right to health mandates that a state must take positive measures to ensure the full enjoyment of the right to health. General Comment 14, *supra* note 207, ¶ ¶ 33–37; *see also* Craven, *supra* note 242, at 110 (noting that this

policies that a focus only on individual medical interventions pursuant to the right to health would have little effect on morbidity and mortality in a globalizing world.[280] How would the right to health incorporate evolving public health frameworks for disease prevention and health promotion in the context of development discourse? To accommodate public health's emphasis on underlying determinants of health under the ecological model, General Comment 14, "the most authoritative statement on the meaning of the right to health,"[281] goes a long way toward acknowledging collective rights through its modernization of state obligations under Article 12 of the ICESCR.[282]

With the CESCR viewing the curative conception of health in Article 12 as anachronistic in light of modern understandings of health disparities,[283] the CESCR had already begun to look to health disparities at the societal level, starting with its examination of principles of equity in the provision of curative care.[284] This collective framework for examining health was consistent with the CESCR's expanding review of violations of economic, social, and cultural rights through a national lens, scrutinizing national public health indicators rather than individual ailments and treatments.[285] Through its previous review of country reports,[286] the CESCR had 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.[287] A general comment provided

framework, applied to all economic, social and cultural rights, serves "to counteract some of the traditional assumptions that tended categorically to distinguish economic, social, and cultural rights from civil and political rights").

280. *Supra* Part II.A.1.

281. Gostin, *The Human Right to Health*, *supra* note 264, at 29.

282. Additionally, in 2002, the Commission on Human Rights appointed a Special Rapporteur, Paul Hunt, with a mandate to focus on the right to health. In 2003 the Special Rapporteur issued a preliminary report in which he outlined his general approach to the mandate, extending the logic of General Comment 14 and focusing on a number of underlying determinants of health related to the realization of the right to health. *Report of the Special Rapporteur* (13 Feb. 2003), *supra* note 104.

283. Chapman, *supra* note 141, at 189 ("[T]here is now far greater awareness than at the time the [ICESCR] was drafted that health status reflects a wide range of non-medical factors.").

284. General Comment 14, *supra* note 207, ¶ 43 (finding the "core obligations" of the right to health to include an "*equitable distribution of all health facilities, goods and services*" (emphasis added)).

285. *See* General Comment 3, *supra* note 238, ¶ 10 (noting that "a State Party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the [ICESCR]."). For criticisms of this approach, see *supra* notes 257–260 and accompanying text.

286. ICESCR, *supra* note 194, art. 16(1); *see also* Toebes, *supra* note 208, at 140–58 (discussing the CESCR's country review process).

287. See Felice, *The Viability of the United Nations Approach*, *supra* note 96, at 569 ("The UN CESCR has been described as 'having one of the most developed and potentially effective reporting mechanisms of all the human rights supervisory bodies.' This was accidental." (citing Craven, *supra* note 242, at 103)); Bloche, *supra* note 146, at 209 ("Both official and scholarly interpreters of the right to health tend toward a population-wide, utilitarian view when considering whether particular government actions respect,

the CESCR with an opportunity to develop jurisprudence regarding collective interpretations of the right to health, obviating the need to scrutinize country reports for individual level violations of an ambiguous right.

In General Comment 14, the CESCR implicitly acknowledges a correlation between individual and public health, expanding the list of core obligations under the right to health to include aspects of public health systems[288] and finding access to public goods and information as necessary components of the right.[289] Even where Comment 14 does not explicitly label its strategies as a form of public health, it nevertheless solidifies the public health underpinnings of the right to health, holding that there exist government responsibilities for addressing "underlying determinants of health."[290] According to the text of Comment 14, the right to health codified in Article 12 of the ICESCR extends

> [N]ot only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[291]

Thus, through General Comment 14, the CESCR has elaborated specific entitlements to several underlying determinants of health within the right to health, implementing these standards through its continuing examination of mandated national public health strategies and plans of action.[292]

Furthermore, in expounding on the obligations necessary to fulfill these constituent rights, General Comment 14 speaks not only to the individual as a bearer of rights, but also specifically to a state responsibility to assist

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protect, or fulfill the right. General Comment 14 . . . takes such an approach in setting forth 'core obligations' to promote health."); *e.g.*, Rebecca J. Cook et al., Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law 189–90 (2003) (noting the CESCR's criticism of Gambia for inadequate maternal and child public health services).

288. General Comment 14, *supra* note 207, ¶ ¶ 43–44 (enumerating core obligations of the right to health and obligations of "comparable priority"); *see also* Lawrence O. Gostin & Lance Gable, *The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health*, 63 Md. L. Rev. 20, 112 (2004) (noting that General Comment 14 "directly mention[s] population-based health obligations that fit well within the traditional public health paradigm").

289. Chapman, *supra* note 141, 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 [sic] epidemiological data").

290. *Report of the Special Rapporteur* (13 Feb. 2003), *supra* note 103, ¶ 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 207, ¶ 11)).

291. General Comment 14, *supra* note 207, ¶ 11. For a diagrammatic analysis of those obligations included in and excluded from the right to health under General Comment 14, *see* Lawrence O. Gostin, Public Health Law and Ethics: A Reader 98 fig. 8 (2002).

292. General Comment 14, *supra* note 207, ¶ 43(f).

"communities," "group[s]," and "population[s]."[293] In addressing the subject of public health directly, 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."[294] This semi-colon linkage between collective rights and public health evidences a link between the individual right to health and disease prevention and health promotion, the twin hallmarks of public health practice.[295] These formulations of international law indicate that the CESCR has found the right to health to include far more specific collective public health mandates on states beyond individual primary health care. For states to create an environment conducive to good health, thereby realizing the "highest attainable standard of health" for their peoples, they must, as in the Declaration of Alma-Ata, employ an expansive health system, fulfilling both the economic, social, and cultural rights and the civil and political rights that underlie the public's health.[296]

In spite of this novel interpretation of the right to health,[297] the expansive language of General Comment 14 is insufficient to establish a collective right to public health systems under Article 12 of the ICESCR. General Comment 14 places public health systems squarely under the aegis of the right to health, focusing the majority of its normative weight behind aspects of health services (specifically, their availability, acceptability, accessibility, and quality),[298] not public health systems, advocating action, for example, "to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of *health facilities, goods and services*." [299] Like much contemporary human rights scholarship, it supports an individual right while acknowledging that human rights are

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293. *Id.* ¶ 37.
294. *Id.* ¶ 59, n.30.
295. *See supra* Part II.B (discussing the role of disease prevention and health promotion in public health systems).
296. *See* Stephen P. Marks, *Jonathan Mann's Legacy to the 21st Century: The Human Rights Imperative for Public Health*, 29 J. L., MED. & ETHICS 131, 136–137 (2001) (noting General Comment 14's recognition that civil and political rights also determine health status).
297. *See* CRAVEN, *supra* note 242, at 104 ("The breadth of subjects covered by the Covenant, combined with the lack of case law (whether national or international) in certain vital areas such as health and nutrition, mean that significant importance has to be placed upon the Committee's *'creative' or 'interpretative' functions*." (emphasis added)).
298. General Comment 14, *supra* note 207, ¶ 12; *see also* Sofia Gruskin & Bebe Loff, *Do Human Rights Have a Role in Public Health Work?*, 360 LANCET 1880, 1880 (2002) (noting how the availability, acceptability, accessibility, and quality factors relate to health care). *But cf.* Gostin, *The Human Right to Health*, *supra* note 264, at 29 (finding that, in addition to health services, the 'availability' of the normative content of the right to health also "refers to the existence of the basic conditions necessary for health").
299. General Comment 14, *supra* note 207, ¶ 35.

necessarily embedded in their social context[300] and, therefore, "individual human rights are characteristically exercised, and can only be enjoyed, through collective action."[301] As a result, General Comment 14 has faced criticism for "going far beyond what the treaty itself provides and what the states parties believe to be the obligation they have accepted,"[302] reinforcing admonitions that the proclamation of new human rights through magnanimous misinterpretation trivializes the human rights regime, delegitimizing more firmly established rights.[303]

By virtue of the individual nature of the right it interprets, General Comment 14 cannot adequately obligate states, and cannot at all obligate the international community, to protect public goods through public health systems. While General Comment 14 has accomplished a great deal "in clarifying the normative content of the right to health,"[304] its interpretations of the ICESCR lack the self-executing authority and detailed, explanatory reasoning necessary to create collective obligations for public health, adding to the ambiguities and criticism that have long shadowed the right to health.[305] As an interpretive body, the CESCR is intended merely to lay out programmatic recommendations for those states seeking to uphold an individual right to health.[306]

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300. Donnelly, Universal Human Rights, *supra* note 121, at 114 ("*Enjoyment* of individual human rights will be greatly fostered by a healthy social environment and supportive social institutions." (alteration in original)).
301. *Id.* at 25.
302. Katherine Gorove, Office of the Legal Advisor, US Dep't of State, Remarks at the Ninety-Eighth Annual Meeting of the American Society of International Law: *Shifting Norms in International Health Law* (1 Apr. 2004), *summarized in* 98 Am. Soc'y Int'l L. Proc. 18, 20 (2004); *see also* Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?*, 98 Am. J. Int'l L. 462, 494 n.229 (2004) (noting that the CESCR's "recent views on social issues, such as its opposition to restrictive abortion laws [in General Comment 14], find no support in the text of the Covenant or in its negotiating history").
303. *See* Philip Alston, *Conjuring up New Human Rights: A Proposal for Quality Control*, 78 Am. J. Int'l L. 607, 607 (1984). As argued by Alston,

> [R]eason for serious concern with respect to current 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. Indeed, some such rights seem to have been literally conjured up, in the dictionary sense of being "brought into existence as if by magic."

Id. (citation omitted).
304. Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. Int'l L.J. 325, 330 (2003).
305. *Supra* notes 203–207, 247–250 and accompanying text. *See also* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 273 ("One would be hard pressed to find a more controversial or nebulous human right than the 'right to health.'"); Gostin, *supra* note 264, at 29 ("Considerable disagreement exists, however, as to whether 'health' is a meaningful, identifiable, operational, and enforceable right, or whether it is merely aspirational or rhetorical.").
306. *See* Aginam, *supra* note 247, at 37 ("Any inquiry aimed at unmasking the reason(s) why these efforts [to concretize the contents of the right to health] are still largely marginalized and peripheral in international policy making would inevitably indict the current

Because of the failure of the CESCR to advance a coherent theoretical basis for its obligations, denying General Comment 14 a normative conceptualization of the evolving nature of the right to health,[307] states have taken regressive liberties in their "progressive realization" of public health systems, with the CESCR's legislative overreaching permitting reactive state practice in dereliction of General Comment 14's public health recommendations, hampering the advancement of individual health rights for the public's health.[308]

Although the ecological model has gained widespread acceptance among public health scholars, the failure of General Comment 14 to impact state development processes in responding to societal problems through the tools of public health systems has led public health scholars and advocates to turn away from the right to health and toward practical interventions[309] and non-legal mechanisms for internalizing collective moral norms for social justice.[310] In developing varied practical interventions to influence the underlying structural determinants of health affected by insalubrious development, public health advocates have recently turned to non-legal, top-down standards set through the Millennium Development Goals.

C. Millennium Development Goals—A Non-Legal Response to the Failure of Rights-Based Development

Given the failure of a rights-based approach in alleviating the harmful ramifications of neoliberal globalization policies, health advocates have sought the moral suasion of non-obligatory international discourse in responding to international development practices. An example of this is seen in the 2000 Millennium Development Goals (MDGs), which states have created as a framework for a massive, global campaign to advance human development,

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international system, which has failed to adequately empower the United Nations Committee on Economic, Social, and Cultural Rights."); *cf. Report of the Special Rapporteur* (13 Feb. 2003), *supra* note 103, ¶ 7 (noting that "the right to health can enhance health policies and also strengthen the position of health ministries at the national level").

307. *See* Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 274 ("[W]hile General Comment No. 14 . . . provides the most reliable report on the right to health, it too, by necessity and purpose, lacks a systematic philosophical grounding for the right to health.").

308. Chapman, *supra* note 141, at 193.

309. Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 276 (noting that "traditional health policy analysis has often focused more on the means to health—questions of the organization, financing and delivery of medical care—than on health itself"); *see, e.g.*, Farmer, *supra* note 32 (arguing for the practical need to "scale up" public sectors for the provision of essential medicines and interventions for public health).

310. *See, e.g.*, Ruger, *Toward a Theory of a Right to Health*, *supra* note 183, at 278, 312–25 (seeking the internalization of moral norms on an individual county basis as a non-legal means of redistributing resources and enforcing the goals of the right to health at the collective level).

including the alleviation of poverty. The MDGs are largely an outgrowth of the International Development Goals (IDGs), an earlier Organisation for Economic Co-operation and Development (OECD) effort put forward in 1996 to distill a set of operational goals for development in the twenty-first century.[311] While the seven original IDGs (all of which are incorporated in the MDGs) draw their inspiration from a variety of UN conferences, including human rights conferences,[312] the resulting Millennium Declaration was intentionally formulated to avoid the obligations of international law.[313] In 2000, the United Nations, joined by the IMF, World Bank, OECD, and the G7 and G20 countries, announced eight Millennium Development Goals[314] as part of the Millennium Declaration, laying out development goals for states to achieve by 2015. In creating these prescriptions for development policies responsive to the needs of the developing word,[315] four of the eight MDGs involve improvements in health—including the reduction of maternal and infant mortality, the prevention of HIV infection, and the eradication of hunger—and one is specific to development. For each goal, the United Nations has outlined a number of targets and indicators by which to assess its realization.[316] While these MDGs have been criticized for not taking a legal approach to human rights and for the selection of maternal and infant mortality over health systems more generally, the MDGs have become a favored tool in linking health with development.

Insofar as realization of the MDGs assists in reducing poverty and engendering targeted investments in health services, these goals can be seen to facilitate the realization of the right to health in the context of develop-

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311. For further information related to each IDG, *see* 2000: A Better World for All, Setting the Goals, *available at* www.paris21.org/betterworld/setting.htm.
312. Shantayanan Devarajan et al., *Goals for Development: History, Prospects and Costs* 4 (World Bank, Policy Research Working Paper 2819, 2002), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=636102.
313. World Health Organization, *WHO on the Track of the United Nations' Goals: The Millennium Development Goals, in* The Mandate of a Specialized Agency of the United Nations Ch 2 (2003), *available at* http://www.gfmer.ch/TMCAM/WHO_Minelli/P2-2.htm#_ftnref16. Although the Millennium Declaration makes reference to human rights, the MDGs are not advanced as international law or rights legally binding on states. Robinson, *supra* note 103, at 29, 41.
314. United Nations, Millennium Development Goals (2000), *available at* http://www.un.org/millenniumgoals/index.html [hereinafter MDGs].
315. United Nations Millennium Declaration, *adopted* 8 Sept. 2000, G.A. Res. 55/2, U.N. GAOR, 55th Sess., Supp. No. 49, ¶ 5, U.N. Doc. A/RES/55/2 (2000) (noting the goal of the MDGs "to ensure that globalization becomes a positive force for all the world's people" through "policies and measures, at the global level, which correspond to the needs of developing countries and economies in transition and are formulated and implemented with their effective participation").
316. Among the aforementioned health-related goals, eight of the eighteen targets and eighteen of the forty-eight indicators relate directly to health. Kelley Lee et al., *The Challenge to Improve Global Health: Financing the Millennium Development Goals*, 291 J. Am. Med. Ass'n 2636, 2636 (2004).

ment. However, because the MDG regime attempts to address specific health conditions through the influence of moral authority—not an obligation to address underlying determinants of health through legal authority—it has been ineffective in guiding state responses during development negotiations.[317] First, the MDGs focus on specific goals, which fail to address the underlying determinants that lead to adverse health conditions or the public health systems that can alleviate those determinants.[318] Because the MDGs do not focus on health systems, states often attempt to meet them by focusing on scaling up efforts among the better-off as a way to raise national level indicators.[319] This goal-oriented paradigm has abetted the rise of short-term, financially-insufficient foreign donor initiatives that deliver services in vertical programmes outside of health systems, further minimizing the role of national public health infrastructures in states that have abandoned sustainable health systems in exchange for the fleeting benefits of charitable medicine.[320] For example, based on this model, the World Bank and donor states have invested in financial support (loans, credits, and grants) for individual health services that have no bearing on poverty-related health determinants,[321] justifying their denigration of the public provision of health systems simply by finding

317. As Philip Alston notes, the global development agenda under the MDGs and human rights commitments, while they have a great deal in common, resemble "ships passing in the night" in that they have failed to work together despite their common destinations. Philip Alston, *Ships Passing in the Night: The Current State of the Human Rights and Development Debate as Seen Through the Lens of the Millennium Development Goals*, 27 Hum. Rts. Q., 755 (2005); *compare* Cornwall & Nyamu-Musembi, *supra* note 164, at 1418 ("For some of those involved with promoting rights-based approaches, it is precisely because of referents in a set of internationally agreed legal documents that talking of rights provides a different, and potentially more powerful, approach to development . . . a view that lending these practices the support of internationally agreed legislation does change the way in which they come to be viewed by development agencies and national governments.").

318. Freedman, *Achieving the MDGs*, *supra* note 63, at 19 ("The MDGs have been criticized for their conventional approach to health. The goals and quantitative targets, all pegged to the year 2015, are disease-specific or condition-specific."). *But cf. id.* at 20 (finding a "hidden opportunity" in the MDGs for a "new respect for the role of health systems in creating or reinforcing poverty and, conversely, in building a democratic society").

319. Alaka Singh, *Strengthening Health Systems to Meet MDGs*, 21 Health Pol'y & Planning 326, 327 (2006) (advocating that developing and strengthening health systems is a "second best" outcome that can come from the MDGs, enabling institutional and systemic changes necessary to sustain progress on the "higher order" MDGs).

320. *Supra* notes 271–274 (discussing public health debates between health services and health systems); *see also* Garrett, *supra* note 272 (arguing that because foreign donor funds "are largely uncoordinated and directed mostly at specific high-profile diseases—rather than at public health in general—there is a grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground"); Freedman, *Achieving the MDGs*, *supra* note 63, at 22–23 (noting the "tendency, especially among donors, to favour [sic] initiatives that can go around the facility-based public health system" and arguing that health services are less "sustainable" than health systems).

321. *See generally* Priorities in Health (Dean T. Jamison et al. eds., 2006).

no connection between economic development and health improvement.[322] Second, in the absence of any form of legal accountability under the MDGs, states and nongovernmental actors have faced no hard constraints on their decision-making authority vis-à-vis development.[323] Consequently, this approach—a top-down "one-size-fits-all" moral approach to state responsibility—has empowered few and changed little, with forecasts predicting that these hortatory goals are unlikely to be met by 2015. Third, and most crucial for health rights, because the MDGs address "the central role good health can play in macroeconomic development and growth,"[324] international organizations have focused on public health as a means to promote economic development, inverting the rights-based causal link between development and health and refocusing normative goals in health policy to view morbidity and mortality as intermediaries on the path to economic development rather than health as a human right and end unto itself.[325]

For rights scholars to advance disease prevention and health promotion, they must look beyond individual rights and non-legal frameworks to create collective international legal obligations commensurate to a public health-centered approach to development and poverty alleviation. In creating the legal obligations necessary to spur development supportive of the public's health, health scholars and activists must move beyond the tools of the individual right to health to consider the frameworks of the collective right to development.

IV. THE RIGHT TO DEVELOPMENT

Whereas the right to health is enshrined in Article 12 as a second generation individual right, subject to progressive realization within the constraints of a state's "maximum available resources,"[326] the right to development, a

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322. *See id.* at 34 ("[A] look at the history of the unprecedented gains in human health in the 20th century reveals that improvements in health are not dependent upon economic development.").
323. Sukanya Pillay, *Absence of Justice: Lessons from the Bhopal Union Carbide Disaster for Latin America*, 14 Mich. St. J. Int'l L 479, 506–07 (2006) (noting a failure of the MDGs to impose accountability on transnational corporations); *compare* Robinson, *supra* note 103, at 39 (arguing that "the most defining attribute of human rights in development is its focus on accountability").
324. WHO, Human Rights, Health & Poverty, *supra* note 198, at 2.
325. *See* Yamin, *Not Just a Tragedy*, *supra* note 304, 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."); Braveman & Gruskin, *supra* note 169, at 541 ("A human rights perspective removes actions to relieve poverty and ensure equity from the voluntary realms of charity, ethics and solidarity to the domain of law.").
326. ICESCR, *supra* note 194, art. 2; *supra* Part III.B.2 (discussing application of the principle of progressive realization).

third generation collective (or solidarity) right,[327] views development itself as a right. As compared with an individual rights-based approach to development,[328] the collective right to development can enable both states and international actors to realize underlying determinants of health. In the case of advancing health rights, this involves assigning the obligations to realize rights on public health systems,[329] operationalizing principles of social medicine[330] through collective analysis rather than individual rights.[331] With neoliberal development policies impacting entire societies, collective rights and their corollary implementation mechanisms become necessary to assure the policies required to provide for the tools and shared benefits of public health systems, addressing the public goods that can only be achieved at the collective level.[332] This can be done most logically and effectively through a human right to development—a collective right that has come to the fore of human rights discourse in responding to the harmful ramifications of

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327. Alston, *Conjuring up New Human Rights*, *supra* note 303, at 610 ("[P]roposals for a third international human rights covenant featuring a range of 'third generation solidarity rights' have been strongly advocated. This group of rights has been said to include: The right to development, the right to peace, the right to a healthy environment."); Stephen P. Marks, *Emerging Human Rights: A New Generation for the 1980's?*, 33 Rutgers L. Rev. 435 (1981).

328. In distinguishing a rights-based approach to development from the right to development, Stephen Marks has noted:

> Expressed simply, the right to development is broader that the human rights-based approach, encompassing a critical examination of the overall development process, including planning, participation, allocation of resources, and priorities in international development cooperation. The human rights-based approach to development is part of the right to development, but it may also involve isolating a particular issue, such as health, and applying to that issue a clear understanding of the state's obligations under the relevant international human rights instruments and the insights applicable to project implementation derived from authorized interpretations of those obligations, such as General Comment 14. Thus, the right to development implies both a critical review of the development process in a given country and a program of action to integrate a human rights approach within all aspects of that process.

Marks, *The Human Rights Framework*, *supra* note 167, at 16. For a further explanation of this distinction, *see infra* note 367 and accompanying text.

329. Dan Beauchamp, *Community: The Neglected Tradition of Public Health*, Hastings Ctr. Rep., Dec. 1985, at 28, 29; *see also supra* Part II.B.

330. For a discussion of social medicine and its connections to development discourse, *see supra* notes 20–29 and accompanying text.

331. Waitzkin et al., *Social Medicine*, *supra* note 25, at 1594 ("Social medicine therefore defines problems and seeks solutions with social rather than individual units of analysis."). *See supra* notes 20–29 and accompanying text.

332. *See* Jennifer Prah Ruger, *Health and Social Justice*, 364 Lancet 1075, 1076 (2004) ("Collective agency is more important at the policy level, where open discussion and collective decision-making influence policy and resource allocation."). Under this logic, social justice requires distributive justice and distributive justice cannot occur in the absence of a collective unit of analysis. *Cf.* Friedrich A. von Hayek, *The Atavism of Social Justice*, *in* New Studies in Philosophy, Politics, Economics and the History of Ideas (1978), *reprinted in* Group Rights: Perspectives since 1900, at 168, 169 (Julia Stapleton ed., 1995) (arguing that individual freedoms are incompatible with social justice).

economic globalization and which can be applied internationally through development processes. The right to development, as a collective right, acknowledges an obligation to provide for these public goods—"assigning rights and obligations to the principal agents able to advance global public goods in the late twentieth century"[333]—and thereby addresses the provision of public goods at the societal level.

A. Origins: Collective Rights as a Response to Neocolonization

Human rights were initially conceived following the Second World War solely as individual rights.[334] While rights had previously been accorded to discrete groups to protect them in the aftermath of the First World War, it was felt by leaders of the victorious Allied Powers that this elevation of collective rights had led to many of the ethnic tensions that culminated in the Second World War.[335] Through the War, it had become clear that elevating group identity over individual inviolability had given rhetorical force to many of the Nazi crimes against humanity.[336] Following the War, the rights-bearer, with the exception of the collective right of self-determination,[337] would be framed as the singular individual.[338]

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333. Stephen Marks, *The Human Right to Development: Between Rhetoric and Reality*, 17 Harv. Hum. Rts. J. 137, 138 (2004).
334. *See* Micheline R. Ishay, The History of Human Rights: From Ancient Times to the Globalization Era 221 (2004). For an in-depth historical analysis of the dichotomy between individual and collective rights, *see* Peter R. Baehr & Koo VanderWal, Introduction Item: *Human Rights as Individual and as Collective Rights, in* Human Rights in a Pluralist World, *supra* note 182, at 33.
335. In particular, it was felt that Nazi Germany had misappropriated minority rights as a justification for the invasion of Czechoslovakia, an invasion ostensibly premised on protecting the German minority in that state. *See* Ernest Barker, Reflections on Government (1942), *reprinted in* Group Rights: Perspectives since 1900, *supra* note 332, at 123, 124 (noting that the elevation of group identity was responsible for the rise of Italian Fascism and German National Socialism, where "the mysticism of the group is a welcome ally to the personalism of the leader. It consecrates him, and it consecrates his party—no party in the ordinary sense of a section of the electorate, but a body of chosen believers in the unity, the reality, and the transcendency of the group").
336. Ishay, *supra* note 334, at 240–42.
337. UDHR, *supra* note 193; *see also* ICCPR, *supra* note 239; ICESCR, *supra* note 194; Declaration on Principles of International Law Concerning Friendly Relations and Cooperation Among States in Accordance with the Charter of the United Nations, *adopted* 24 Oct. 1970, G.A. Res. 2625, U.N. GAOR, 25th Sess., Supp. (No. 28), U.N. Doc. A/RES/2625 (XXV) (1970) (implementing the exercise of the right to self-determination through "the establishment of a sovereign and independent state, the free association or integration with an independent state, or the emergence into any other political status freely determined by a people"). For a discussion of the right to self-determination, see William F. Felice, Taking Suffering Seriously: The Importance of Collective Human Rights 57–68 (1996).
338. 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

However, as decolonization rapidly progressed throughout the world and the United Nations expanded several-fold, nascent member states (those that did not take part in the original drafting of the UDHR and subsequent covenants) forced a reexamination of this individualistic conception of human rights.[339] With the ascendance of these "developing" states, a renewed proclamation of collective human rights was first advanced in the late 1960s and early 1970s by the Non-Aligned Movement, a loose grouping of states in Africa, Asia, and the Middle East that banded together to advance their interests against those of the two major superpowers.[340] To these states, it had become clear that the state itself could be the holder of moral and legal rights, aggregated rights that are distinct from the sum of the individual rights of their peoples.[341] Viewing traditional human rights frameworks as an extension of colonial domination, these developing states advanced so-called "solidarity rights" as a means of freeing states from the societal binds of neocolonization.[342]

Often referred to in Western scholarly circles as "third generation" rights,[343] a pejorative remnant of Cold War discourses, collective rights operate in ways similar to individual rights, often seeking the same goals. However, rather than seeking the empowerment of the individual, collective rights operate at a societal level to assure uniquely public benefits that can only be enjoyed in common with similarly-situated peoples and

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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"); *see* Vernon Van Dyke, *Collective Entities and Moral Rights: Problems in Liberal-Democratic Thought*, 44 J. Pol. 21 (1982), *reprinted in* Group Rights: Perspectives since 1900, *supra* note 332, at 180, 180 (noting that "in various international documents such as the covenants on human rights, they [liberals] have secured the spelling out of rights for individuals and are making the promotion of these rights (or some of them) a major issue in the world"); Donnelly, Universal Human Rights, *supra* note 121, at 23 ("Even where one might expect groups to appear as right-holders, they do not.").

339. Raul Prebisch, The Economic Development of Latin America and Its Principal Problems (1962) (noting the comparative disadvantages of developing states in engaging in international discourse).

340. Ishay, *supra* note 334, at 221–22.

341. Ellen Messer, *Anthropology and Human Rights*, 22 Ann. Rev. Anthro. 221, 223 (1993) (explaining relativistic understandings of human rights frameworks and advocating the cross-cultural study of human rights norms).

342. *See* Rhoda Howard, *Evaluating Human Rights in Africa: Some Problems of Implicit Comparisons*, 6 Hum. Rts. Q. 160, 163–64 (1984).

343. While other scholars have referred to collective rights as "third generation rights"—including them within a tripartite framework of first (civil and political), second (economic and cultural), and third (solidarity) generation rights—the 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.

cannot be realized through individual rights mechanisms.[344] Because these rights inhere in the collective, rather than each individual member of the collective, they apply more readily to situations in which there is a group interest (or solidarity) in the substance of the right, as there is in, *inter alia*, self-determination, environmental protection, humanitarian assistance, peace, common heritage, and development.

As developing states broke free from their colonial past and joined the world community, they have attempted to enshrine a collective vision of rights into international law as a means of shielding themselves from what are perceived to be imperialist global economic policies.[345] 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 1976 Universal Declaration of the Rights of Peoples.[346] Emboldened by the success of the ICESCR, viewed by many as a path to global economic justice, developing states' rising influence and redistributive demands set the stage for the international invocation of collective rights.[347] While lacking the humanizing quality of individual rights,[348] these collective rights have nevertheless proven effective in shifting the balance of power in international relations and creating widely recognized, if not always realized, entitlements in international law.

B. International Codification of a Right to Development

At the heart of this burgeoning codification of collective rights, the United Nations has repeatedly given its imprimatur to a collective right to devel-

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344. Felice, Taking Suffering Seriously, *supra* note 337, at 17; *see also* Van Dyke, *supra* note 338, at 183 ("[A]ssuming that the object is to satisfy the interests and needs of individuals, it does not necessarily follow that the associated rights should go to individuals. Where the right should be located is a matter of practicality; and in some instances it is best, if not essential, to locate it in a collective unit.").

345. *See, e.g.*, Vienna Declaration and Programme of Action, U.N. GAOR, World Conf. on Hum. Rts., art. 1, § 10, U.N. Doc. A/CONF.157/23 (1993) [hereinafter Vienna Declaration] (recognizing a collective right to development as a human right).

346. Universal Declaration of the Rights of Peoples, Algiers, 4 July 1976, *reprinted in* Issa G. Shivji, The Concept of Human Rights in Africa 111–15 (1989).

347. Marks, *The Human Rights Framework*, *supra* note 165, at 138; *see also* Marks, *Emerging Human Rights*, *supra* note 327; Uvin, *supra* note 77, at 41 (noting the rise of the developing world though "well-known nationalist third-world statesmen, who were emboldened by the success of the OPEC embargo"); Cornwall & Nyamu-Musembi, *supra* note 164, at 1422 ("The 1966 International Covenant on Economic, Social and Cultural Rights provided an important starting point for a host of Third World-led initiatives one of whose outcomes was the Declaration on the Right to Development in 1986.").

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

opment—reaffirming it through a 1986 General Assembly Declaration,[349] recognizing it as a universal and inalienable right in the Vienna Declaration and Programme of Action,[350] establishing a Sub-Commission under the Commission on Human Rights to create concept documents and guidelines for adoption, and appointing an Independent Expert, to oversee its progress and implementation.[351] Although a meteoric rise in scholarship has accompanied the advent of the right to development, the right has nevertheless faced many obstacles to its realization. Because the right to development is often described as a "vector" of rights,[352] encompassing all economic and social rights (in addition to civil and political rights) under a single collective rights banner,[353] it is often thought to be unenforceable because of a state's inability ever to realize all of its components.[354] Because of this overbreadth, Western states—the United States most vocally—have opposed a right to development in any form more binding than aspirational platitudes and have abjured all national or international obligations deriving therefrom.[355] Despite this reflexive opposition, the right to development has yielded rhetorical and programmatic gains for public health systems.

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349. Declaration on the Right to Development, G.A. Res. 41/128, *adopted* 4 Dec. 1986, U.N. GAOR, 41 Sess., Annex, U.N. Doc. A/RES/41/128 (1986) (defining development as a "comprehensive economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals" (emphasis added)).
350. Vienna Declaration, *supra* note 345, art. 1, § 10.
351. Stephen Marks, *Obstacles to the Right to Development* 1 (François-Xavier Bagnoud Ctr. for Health & Human Rights, Harvard Sch. of Pub. Health, Working Paper No. 17, 2003), *available at* http://www.hsph.harvard.edu/fxbcenter/FXBC_WP17—Marks.pdf; Reflections on the Right To Development (Arjun Sengupta et al. eds., 2005); Marks, *The Human Right to Development*, *supra* note 333, at 139; Arjun Sengupta, *On the Theory and Practice of the Right to Development*, 24 Hum. Rts. Q. 837 (2002).
352. Arjun Sengupta, *Development Cooperation and the Right to Development* (François-Xavier Bagnoud Ctr. for Health & Human Rights, Harvard Sch. of Pub. Health, Working Paper No. 12, 2003), *available at* http://www.hsph.harvard.edu/fxbcenter/FXBC_WP12—Sengupta.pdf. For a discussion of the "vector" conceptualization of the right to development, see *infra* notes 371–74 and accompanying text.
353. Arjun Sengupta, *Realizing the Right to Development*, 31 Dev. & Change 553, 555 (2000).
354. Franz Nuscheler, *The "Right to Development": Advance or Greek Gift in the Development of Human Rights?*, *in* The International Debate on Human Rights and the Right to Development 54, 59 (Franz Nuscheler ed., 1998) (arguing that separate emphasis should be placed on each individual economic and social right).
355. For a description of early US objections to the right to development, see Philip Alston, *Making Space for New Human Rights: The Case of the Right to Development*, 1 Harv. Hum. Rts. Y.B. 3, 22 (1988); Marks, *The Human Right to Development*, *supra* note 333. Among other reasons, skeptics of the right to development fear frameworks similar to those that surrounded the New International Economic Order, which aimed (and failed) to fundamentally restructure trade, transnational corporations, aid and international institutions to the detriment of international financial institutions. *Infra* note 358.

1. Normative Development

The Declaration on the Right to Development, which states plainly and unequivocally that the right to development is a human right, was adopted by the United Nations in 1986 by an overwhelming majority, with the United States casting the sole dissenting vote.[356] The first article of the Declaration on the Right to Development succinctly proclaims the substance of and justification for a right to development:

> The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in and contribute to and enjoy economic, social, cultural, and political development, in which all human rights and fundamental freedoms can be fully realized.[357]

Although this recognition of a right to development in international "soft law" became the legal basis for global calls of "international resource distribution"—the final death spasm of the New International Economic Order movement[358]—the rise of the right to development was quickly subdued by the hegemony of neoliberal theory and then crushed by the "Third World debt crisis," theory and fact which came together in IMF discourses to create the neoliberal development regime.[359] In spite of this setback in its implementation, the rhetorical basis for a right to development had been set into law, laying the foundation for its resurrection at the 1993 Vienna World Conference on Human Rights, wherein a post-Cold War political consensus was reached (with the participation of the United States)[360] to reestablish the right to development as a universal and inalienable right:

> The World Conference on Human Rights reaffirms the right to development, as established in the Declaration on the Right to Development, as a universal and inalienable right and an integral part of fundamental human rights. . . . Lasting

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356. Marks, *The Human Rights Framework*, *supra* note 167, at 12.
357. Declaration on the Right to Development, *supra* note 349, art. 1.
358. Ruth E. Gordon & Jon H. Sylvester, *Deconstructing Development*, 22 Wis. Int'l L.J. 1, 60 (2004) (noting that "many of the principles found in the New International Economic Order were soon reformulated and reintroduced as the Right to Development"). The New International Economic Order (NIEO) aimed to fundamentally restructure trade, transnational corporations, aid, and international institutions, including provisions to: reduce trade barriers against exports from developing countries; support stabilization of commodity prices and indexation of these prices to tie them to the cost of manufactured products produced by developed countries; regulate transnational corporations, technology transfers, and nationalization of foreign property; increase overseas development assistance, including the development of a food-aid program; democratically reform the IMF and World Bank; and renegotiate the debts of developing countries. Cornwall & Nyamu-Musembi, *supra* note 164, at 1422.
359. Uvin, *supra* note 77, at 40–42.
360. The Vienna Declaration only became possible by the temporary reprieve of US resistance to positive (economic, social, and cultural) rights in the immediate aftermath of the Cold War. Cornwall & Nyamu-Musembi, *supra* note 164, at 1422.

> progress towards the implementation of the right to development requires effective development policies at the national level, as well as equitable economic relations and a favourable economic environment at the international level.[361]

With the Vienna Declaration proclaiming the universality, indivisibility, and interdependence of all human rights through the unanimous declaration of the 171 participating member states, the right to development held allure for those states seeking to move beyond Cold War divisions between positive and negative rights and establish collectivist international claims for social justice.

Yet even this second life for the right to development was not enough to move discourse on the right to development to programmatic ends, and by 1995, the right had yet to be invoked as a mechanism for political implementation.[362] All that changed in 1998. That year, the Commission on Human Rights (since reinvented as the Human Rights Council) established a Sub-Commission with the continuing task of developing concept documents and guidelines on implementation for the right to development. Under the Sub-Commission, an Open Ended Working Group was established on the right to development, and Arjun Sengupta, a prominent Indian economist, was appointed Independent Expert to oversee the state of progress and implementation of the right to development.[363] Pursuant to this mandate, the Open Ended Working Group has met four times, with Sengupta producing six background reports[364] on the scope and content of the right in order to:

> (I) monitor and review progress made in the promotion and implementation of the right to development . . . ; (II) review reports and any other information submitted by States, United Nations agencies, other relevant international organizations and non-governmental organizations . . . ; and (III) present for the consideration of the Commission on Human Rights . . . with regard to the implementation of the right to development, and suggest possible programmes of technical assistance . . . with the aim of promoting the implementation of the right to development.[365]

With the end of the mandate of the Independent Expert in 2004, the Working Group moved forward to advance its efforts through a high-level task

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361. Vienna Declaration, *supra* note 345, art. 1, § 10.
362. Uvin, *supra* note 77, at 43 (citing Claude E. Welch, Protecting Human Rights in Africa: Roles and Strategies of Non-Governmental Organizations 275 (1995)).
363. *Commission on Human Rights, Report on the Fifty-Fourth Session*, E.S.C. Res. 72, U.N. ESCOR, Comm'n on Hum. Rts., 54th Sess., Supp. No. 3, at 229, U.N. Doc. E/CN.4/1998/177 (1998) (establishing first Working Group). For more on the Independent Expert, see http://www.unhchr.ch/development/right-03.html.
364. These reports have been compiled online, *available at* http://www.unhchr.ch/html/menu2/7/b/mdev.htm.
365. *The Right to Development*, C.H.R. Res. 1998/72, U.N. ESCOR, Comm'n on Hum. Rts., 54th Sess., 58th mtg., ¶ 10a, U.N. Doc. E/CN.4/1998/72 (1998).

force on the right to development, which has held three meetings on the right to development as of the time of this writing and derived further the key principles that underlie the right to development.[366]

In distinguishing the normative content of the right to development from a "rights-based approach" to development,[367] the right to development posits both the process and substance of development as a human right, taking a holistic approach that attempts to mend the artificial divisions between different "generations" of rights and recognizing explicitly the indivisibility and interdependence of civil and political as well as economic, social, and cultural rights.[368] This holistic approach to rights recognizes that an easing of resource constraints through economic development can contribute to the increased enjoyment of economic, social, and cultural rights and also generate the conditions necessary for the enjoyment of civil and political rights.[369] That is, this approach views the political development that generally accompanies economic development to create conditions conducive to the rule of law, democratization, and enhanced transparency, generating a virtuous cycle for the improvement of positive and negative rights.[370]

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366. For a summary of the proceedings of the first two meetings of the high-level task force, see Felix Kirchmeier, *The Right to Development—Where Do We Stand?*, Dialogue on Globalization, at 19–23 (July 2006), *available at* http://library.fes.de/pdf-files/iez/global/50288.pdf.

367. *Marks, The Human Rights Framework*, *supra* note 167. The distinction between a right to development and a rights-based approach to development remains fraught with confusion in the normative elaboration of the right to development, although the Independent Expert has several times clarified that "a *rights-based process of development* is not the same thing as *the right to development*." Arjun Sengupta, *The Human Right to Development*, *in* Development as a Human Right: Legal, Political, and Economic Dimensions 9, 11 (Bård A. Andreassen & Stephen P. Marks eds., 2006) (emphasis in original).

368. Declaration on the Right to Development, *supra* note 349, art. 6(2) ("All human rights and fundamental freedoms are indivisible and interdependent and that, in order to promote development, equal attention and urgent consideration should be given to the implementation, promotion and protection of civil, political, economic, social and cultural rights . . . ."); *id.* art. 6(3) ("States should take steps to eliminate obstacles to development resulting from failure to observe civil and political rights, as well as economic social and cultural rights."); *see* Marks, *The Human Rights Framework*, *supra* note 167 (noting that the holistic approach avoids misleading categorizations of human rights and that the Universal Declaration and several more recent formal texts support this holistic approach).

369. *See, e.g.*, David Beetham, *The Right to Development and its Corresponding Obligations*, *in* Development as a Human Right, *supra* note 367, at 79, 80 ("Without economic development, the resource constraints that limit the realization of human rights for a country's people cannot be overcome. This proposition applies as much to civil and political rights (provision of police forces, courts, legal aid, and so forth) as to economic, social and cultural rights.").

370. This holistic interpretation of development accords with broader modernist thinking about development as not solely an economic transformation, but also one that involves a total restructuring of social and political systems. For more information on modernization theory, see Seymour Martin Lipset, *Some Social Requisites of Democracy*, 53 Am. Pol. Sci. Rev. 69–85, 102–03 (1959).

Considering the right to development as a "vector" of rights,[371] "each element of the vector is a human right, just as the vector itself is a human right, since the right to development is an integral whole of those rights."[372] As a composite right, the right to development includes many, if not all, of the civil, political, economic, social, and cultural rights from the International Bill of Rights (UDHR, ICCPR, and ICESCR) under a single, anti-essentialist banner. For Sengupta,

> It is convenient to describe [the right to development] in terms of an improvement of a "vector" of human rights, which is composed of various elements that represent the different economic, social, and cultural rights as well as the civil and political rights. The improvement of this vector, or in the realization of the right to development, would be defined as the improvement of some—or at least one—of those rights without the violation of any other rights. All these rights, in turn, are dependent on each other.[373]

Thus, the right to development encompasses a range of individual rights, including health, education, information, participation, freedom from discrimination, and decent living and working conditions. Because the fulfillment process for component rights is not a "zero sum" game, however, the fulfillment of one right need not necessarily come at the expense of others.[374]

As the realization of these interdependent rights of the right to development remains resource dependent, this process of development necessarily includes the growth of GDP as an element in easing a state's resource constraints.[375] Although it is clear that economic growth (measured by increase in GDP and industrialization) is necessary for a sustainable an increase in several component rights of the right to development, it is equally clear that this is not sufficient, whereupon growth in GDP must be carried out in a way that does not deteriorate or violate any of the other component rights. Only a growth measure that incorporates human rights can show progress in the implementation of the right to development.[376] While the neoliberal

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371. Sengupta, *Development Cooperation*, *supra* note 352, at 3 ("Right to development, however, cannot just be an 'umbrella right' or the sum of a set of rights but rather a composite right when all these rights are realized together in an integrated manner.").
372. Arjun Sengupta, *Implementing the Right to Development*, *in* International Law and Sustainable Development: Principles and Practice 341 (Nico Schrijver & Friedl Weiss eds. 2004).
373. Sengupta, *Realizing the Right to Development*, *supra* note 353, at 3.
374. *See* Kirchmeier, *supra* note 366, at 11 (noting that the right to development "calls for an environment conducive to the realization of all these rights").
375. Sengupta, *Development Cooperation*, *supra* note 352, at 3–4 ("A process of development where all these rights are to be realized together would, therefore, include growth of GDP as an element that eases the country's resource constraints. The right to development as a process represented by a vector of human rights would, therefore, be composed of elements representing the improvement of different rights as well as the growth of gross domestic product carried out in a rights-based manner.").
376. Sengupta, *On the Theory and Practice of the Right to Development*, *supra* note 351, at 869.

economic model measures economic development in terms of GDP and national economic growth rates above all else, the preamble of the Declaration on the Right to Development defines the subject matter of the right to development as a "comprehensive, economic, social, cultural and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting there from."[377] Consequently, the right to development is best conceptualized as examining both the outcome and the process of achieving development goals.[378]

In deriving enforceable obligations based on this right, the right to development finds the rights-holder to be both the individual and the collective, in this case, the peoples of the state. The Declaration on the Right to Development uses the language of both "individuals" and "peoples," noting the individual and collective dimensions to the right to development. Whereas the Declaration on the Right to Development states that "the human person is the central subject of development and should be the active participant and beneficiary of the right to development,"[379] both the Declaration and interpretations thereafter have noted aspects of the right to development that are collective in nature, focusing on the two levels, individual and collective, at which the right to development can be applied.[380] Correspondingly, the duty-bearer of those rights is seen as both the state (for individual rights) and the international community (for collective rights), with the latter obligator, as discussed in greater detail below, necessitating international coordination, as well as strategic programs of cooperation.[381]

2. Criticism of the Right to Development

Despite its long and established history, the very existence of such a right to development (as with the entire collective rights framework) remains at

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377. Declaration on the Right to Development, *supra* note 349, Preamble. Of note is the language of well-being, which is closely related to the concept of human development discussed previously. *Supra* note 42 and accompanying text. Without the qualifier "human," the term "development" often is used exclusively to mean economic growth. However, as UNDP pointed out in launching the Human Development Report, the human development "way of looking at development differs from the conventional approach to economic growth, human capital formation, human resource development, human welfare or basic human needs." United Nations Development Programme, *Human Development Report* 11 (1990); *see also* Marks, *The Human Rights Framework*, *supra* note 167, at 1.

378. By contrast, a rights-based approach to development is concerned with the modalities through which the process of development is carried out, rather than focused on any particular end product or outcome. Marks, *The Human Rights Framework*, *supra* note 167, at 5.

379. Declaration on the Right to Development, *supra* note 349, Preamble.

380. Kirchmeier, *supra* note 366, at 12–13.

381. *Infra* Part IV.B.3.

a crossroads of seemingly irreconcilable conflict.[382] While almost all states have acknowledged the existence of the right to development, divergent interpretations of that right have served to vitiate the right of much of its normative content.[383] The turbulent political history underlying discourse on the right to development has left even "rights-based development" activists reticent to discuss the right to development directly in confronting global inequalities.[384] In light of this subsidiary status in the discourse of human rights, should solidarity rights, rights belonging to entire peoples, be viewed equivalent to other human rights? If so, should they be considered as merely "aspirational" or as creating legally binding obligations?

Criticisms of the right to development are often a proxy debate for the weaknesses in collective rights discourse. Many liberals, who "tend to think of a nation or people not as a collective entity but as an aggregation of individuals,"[385] have under appreciated the degree to which harm can occur at a structural level beyond the individual. Decried by Western scholars, collective rights arguments are often reduced to communitarian (often Occidental) appeals to cultural relativism.[386] A North-South divide in acceptance of collective rights has only widened as governmental and nongovernmental groups have rushed to apply the right to development.[387]

Beyond ideological abstraction, several scholars have criticized the right to development specifically, finding it to be devoid of meaning and impractical for implementation.[388] These scholars have argued that the right to development under law "has been a milestone, but politically and

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382. For early criticisms of collective rights, see Philip Alston, *A Third Generation of Solidarity Rights: Progressive Development or Obfuscation of International Human Rights Law?*, 29 Neth. Int'l L. Rev. 307 (1982).
383. For a survey of country positions on the right to development, see Kirchmeier, *supra* note 366, at 13–15 (noting that developed Western states have often construed the right to development solely as an individual right and have denied that it creates any legal obligations among states).
384. Cornwall & Nyamu-Musembi, *supra* note 164, at 1423 ("The absence of the right to development from the rights vocabulary of international development actors is explained partly by a deliberate effort to steer clear of the controversies raised by its reference to global inequalities.").
385. Van Dyke, *supra* note 338, at 180.
386. Donnelly, Universal Human Rights, *supra* note 123, at 114 (decrying communitarian criticisms of individual human rights as "utopian or shortsighted"); Ann Kent, Between Freedom and Subsistence: China and Human Rights 30–31 (1993).
387. *See* Felice, *The Viability of the United Nations Approach*, *supra* note 96, at 563–64.
388. *See generally* Jack Donnelly, *In Search of the Unicorn: The Jurisprudence and Politics of the Right to Development*, 15 Ca. W. Int'l L.J. 473 (1985) (viewing the right to development as little more than exhortations or recommendations without established authority in international law). *But see* Wade Mansell & Joanne Scott, *Why Bother About a Right to Development*, 21 J. L. & Soc. 143, 173 (1994) (arguing that the right to development is not in fact a "new" right per se, but rather a "rearticulation in the language of rights of long standing claims which had been evident both throughout much of the period of colonialism and years immediately following liberation").

practically, it has been a total failure."[389] Consequently, these scholars have alternately ignored, mocked, and trivialized the elaboration of the right in various UN reports.[390]

In rebuffing attempts to operationalize its legal obligations, many developed states have continuously criticized the extraterritorial duties under the right to development.[391] The 1986 Declaration on the Right to Development places obligations on all states, but by "effectively pointing an accusing finger at industrial countries,"[392] it has led to a near universal rejection by industrial states in subsequent efforts to lay out a plan of action for implementing the right to development through specific obligations on developed states.[393] To these states, the right to development has been invoked to create binding legal obligations on what has traditionally been viewed as discretionary foreign aid.

These ongoing debates notwithstanding, scholars and advocates have pressed forward in developing the right to development, seeking to create a legally binding instrument that would obligate developed states and the international community to respect, protect, and fulfill the rights of developing states during developmental transitions.

3. Enforcement of the Right: The Role of International Assistance and Cooperation

As discussed above, interpretations of the right to development have focused on the two levels—individual and collective—at which the right to development can be realized. Although the Declaration on the Right to Development states that "the human person is the central subject of the development process and that development policy should therefore make the human being the main participant and beneficiary of the right to development,"[394] the language of the declaration gives credence to a collective rights-holder, using the language of both "individuals" and "peoples" in describing the bearers of the right.[395] In applying the right to development on behalf of

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389. Uvin, *supra* note 77, at 42.
390. *E.g. id.* ("Given that essentially nobody cares what [Sengupta] writes and that he is a smart and nuanced man, he has been able to put together a set of very interesting reports over the years."). For example, in a book of 240 pages on "Human Rights and Development," Uvin devotes just over three pages to the right to development, summarily dismissing it as irrelevant to his analysis.
391. Skeptics of the right to development have been most resistant to accepting the role of international assistance and cooperation in the right to development. For these skeptics, the memory of the attempt at building a NIEO looms large. Cornwall & Nyamu-Musembi, *supra* note 164, at 1422.
392. *Id.*
393. Kirchmeier, *supra* note 366, at 13–15.
394. Declaration on the Right to Development, *supra* note 349, Preamble.
395. Sengupta, *The Human Right to Development, supra* note 367, at 29.

these peoples, scholars have argued, based on the right to self-determination,[396] for the right of peoples to enforce the right to development against the international community (through international organizations) to protect the state during development policy implementation, when the state is unable to realize this right itself.[397] To exercise these rights of peoples, scholars view governments as representatives for their respective constituencies; at the international level, only the national government is seen to serve as a valid rights-holder for all its peoples.[398]

With regard to this obligation beyond the state, the Declaration on the Right to Development emphasizes the crucial importance of international cooperation. Pursuant to this, states have a duty under Article 2 of the Declaration "to co-operate with each other in ensuring development and eliminating obstacles to development . . . and fulfill their duties in such a manner as to promote a new international economic order based on sovereign equality, interdependence, [and] mutual interest . . . ."[399] This obligation is reiterated in article 6, holding that "all states should co-operate with a view to promoting, encouraging and strengthening universal respect for and observance of all human rights and fundamental freedoms."[400] The obligation of states to cooperate to achieve rights is not limited to the wording of the right to development, but derives from the UDHR and subsequently the ICESCR, which finds in Article 2 that states must take steps "individually and through international assistance and co-operation" to progressively realize all economic, social, and cultural rights.[401] This clause has been interpreted to codify the right of states to make claims of reciprocal obligation against other states, as duty-bearers of the right to development.[402]

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396. Mohammed Bedjaoui, *The Right to Development, in* International Human Rights in Context: Law, Politics, Morals 1118 (Henry J. Steiner & Philip Alston eds., 1996) ("The 'right to development' flows from this right to self-determination and has the same nature.").
397. Anne Orford, *Globalization and the Right to Development, in* People's Rights 127 (Philip Alston, ed., 2001).
398. Kirchmeier, *supra* note 366, at 12 ("If the RtD is to be seen as a right of peoples (as groups of individual right holders), states, and their governments in their capacity as representatives of the people, could figure as right-holders.").
399. Declaration on the Right to Development, *supra* note 349, art. 3(3).
400. *Id.* art. 6.
401. ICESCR, *supra* note 194, art. 2(1). Likewise, Article 12 of the UDHR—its clause on international assistance and cooperation—has been interpreted to implicate the right of states to make claims against other states and the international community. UDHR, *supra* note 193, art. 12.
402. Stephen P. Marks, *Obligations to Implement the Right to Development, in* Development as a Human Right, *supra* note 367, at 57, 72 (noting that the duty in Article 2 of the ICESCR, also stipulated in Articles 55 & 56 of the UN Charter, provides a legal basis for the reciprocal obligations of states to act jointly for the realization of human rights); *see also* Declaration on the Right to Development, *supra* note 349, art. 2(3) (providing that "states have the right and the duty to formulate appropriate national development policies").

Extending this argument, scholars and advocates have taken up this obligation in calling for states to exercise the right to development against the international community.[403] While it is clear that it is the "primary responsibility" of individual states to ensure the right to development, there is a critical duty of international cooperation in the realization of the right where it is beyond the state to create an environment conducive to the fulfillment of rights, either because the international community has blunted the state's reach or the causes of harm are international in scope.[404] In examining the factual circumstances giving rise to this international obligation, scholars have looked to a range of global institutional barriers, which, by virtue of "significant and avoidable" international economic arrangements, stand as structural constraints on the ability of developing states to develop economically. Based upon these institutional barriers, scholars have argued that governments bear duties not to "initiate or support policies or institutional arrangements, whether domestic or international, which systematically damage any country's economic development, or encourage a markedly uneven form of that development."[405]

As a result, scholars have found collective duties on the international community, with obligations on the international community (both within the jurisdiction of states and extraterritorially) to act in a way that alters unjust institutional structures.[406] These unjust institutional structures include, *inter alia*: trade regimes that encourage developing states to open their markets to goods while the developed world maintains tariffs and subsidies that damage developing countries' producers; patents that constrain access to needed technologies in the developing world; IMF policies for countries in financial crisis that burden developing world states with long term payments at inflated interest rates; and capital market liberalization that make developing states vulnerable to speculative flows and financial crises.[407] Combined with additional neoliberal development policies that deteriorate national public health systems,[408] these global institutions have prevented states from realizing the rights of their peoples, infringing the health rights of entire societies.

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403. Orford, *supra* note 397, at 127.
404. Sengupta, *The Human Right to Development*, *supra* note 367, at 30–31; Kirchmeier, *supra* note 366, at 11–12 ("Wherever the creation of this environment lies beyond the possibilities of a given nation state, the duty of international community becomes relevant.").
405. Beetham, *supra* note 369, at 84.
406. Margot E. Salomon, *International Human Rights Obligations in Context: Structural Obstacles and the Demands of Global Justice*, *in* Development as a Human Right, *supra* note 367, at 96, 99–101.
407. Beetham, *supra* note 369.
408. *See supra* Part II.C.3 (discussing the ways in which neoliberal development policy deteriorates public health systems).

V. APPLYING THE RIGHT TO DEVELOPMENT TO THE REALIZATION OF PUBLIC HEALTH

Human rights—and the advocacy that promotes them—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."[409] Where appropriate, it is possible to reenvision human rights in light of shifting paradigms,[410] reformulating rights to "reflect changing needs and perspectives and respond to the emergence of new threats to human dignity and well-being."[411] The social transformations inherent in globalization engage an evolving framework for human rights.[412] General Comment 14 is an initial, though incomplete, part of this evolving notion of health rights.[413] Despite this evolution, the right to health cannot, as an individual right to health services, be effective in responding to the societal harms of neoliberal development processes,[414] fostering "a need to promote and protect socio-economic rights by designing and creating new institutions where rights as 'trumps,' trump economic interests."[415]

The right to development offers a collective means by which to serve the goals of the individual right to health in responding to globalized economic forces.[416] As argued by Amartya Sen, "[h]ealth equity cannot be

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409. Alston, *Conjuring up New Human Rights*, *supra* note 303, at 607; *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").
410. Jürgen Habermas, Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy 88 (William Rehg trans., 1996). Within the negative rights regime, this evolution of human rights norms has been seen most dramatically in the expansion of human rights to protect against discrimination on the basis of gender, race, and sexual orientation.
411. Alston, *Conjuring up New Human Rights*, *supra* note 303, at 609; *see also* Kirby, *supra* note 205, at 12 ("[T]he voyage of discovery that the Universal Declaration initiated is far from complete. With each new decade, new insights are gained and shared.").
412. *See* J. Herman Burgers & Rob Kroes, *Social Transformation and Human Rights, in* Human Rights in a Pluralist World, *supra* note 182, at 167, 167 (assuming that "major processes of social transformation exert significant influences on approaches toward human rights and on compliance with them").
413. For a discussion of the flaws stymieing General Comment 14's ability to create rights for public health, see *supra* notes 302–308 and accompanying text.
414. *See supra* Part III.A.
415. Evans, *supra* note 135, at 211 (citing Henry Shue, Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy (1996)).
416. In this sense, the present article does not seek to challenge globalization but rather to employ globalization's beneficial effects while ameliorating its harmful sequelae, existing within the stream of scholarship addressing the contentious dialectic between "globalization-from-above" (capital formation) and "globalization-from-below" (human rights). *See* Falk, *supra* note 137, at 61, 63. Within the globalization-from-below framework, this article advances a broader conception of human rights that encompasses economic,

concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom."[417] In considering the economic allocations that underlie health, the individual right to health is ill-suited to respond to these collective development transitions.[418] As recognized by Vernon Van Dyke, "[s]ometimes an interest of individuals can be best served, or only served, by allocating the related right to a group."[419] This is the case with the public's health.

It is incumbent on scholars of health and human rights[420] 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."[421] Through globalization, underlying determinants of health "transcend spatial boundaries to signify respective degrees of overlaps and commonalities in experiences,"[422] affecting entire societies.[423] 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

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social, and cultural rights at both an individual and collective level through the right to development. Cognizant of concerns around new rights claims, however, this article veers from the contentious path of laying out novel treaty language. *Compare* Alston, *Conjuring up New Human Rights*, *supra* note 303 (warning against the proliferation of new rights in international law) *with* Alice M. Miller, *Human Rights and Sexuality: First Steps Toward Articulating a Rights Framework for Claims to Sexual Rights and Freedoms*, 93 Am. Soc'y Int'l L. Proc 288, 292 (1999) (creating a framework for sexual rights without advancing new treaty language).

417. Amartya Sen, *Why Health Equity?*, 11 Health Econ. 659, 659 (2002).
418. *Supra* Part III; *see also* Evans, *supra* note 135, at 200–01 (noting the liberal criticism of positive claims in that "rights are claimed by the individual, whereas government social policy is concerned with achieving an overall increase in social welfare" (citations omitted)).
419. Van Dyke, *supra* note 338, at 186.
420. The François-Xavier Bagnoud Center for Health and Human Rights, the first academic center to focus exclusively on the intersection of health and human rights, has begun to take up the challenge of employing the right to development through its Program on Human Rights in Development. François-Xavier Bagnoud Center for Health and Human Rights, Right to Development Project, *available at* http://www.hsph.harvard.edu/fxbcenter/rtd.htm.
421. Meyer & Schwartz, *supra* note 33, at 1191.
422. L. Amede Obiora, *Feminism, Globalization, and Culture: After Beijing*, 4 Ind. J. Global Legal Stud. 355, 402 (1997).
423. Ronald Labonte & Ted Schrecker, *Globalization and Social Determinants of Health: Introduction and Methodological Background*, 3 Globalization & Health 16 (2007) (conceptualizing globalized economic forces as an underlying determinant of health).

> must be considered dynamic. An attempt to deal with one, the disease, without the other, the society, would be inherently inadequate.[424]

Neoliberal development policy's societal impacts on health implicate collective responses to health dilemmas.[425] In fulfilling obligations during development processes to provide for underlying determinants of health through public health systems, the right to development can provide a human rights framework within this collective discourse, marshaling for the individual and state both a vector of substantive rights and a process for rights-based development.

A. Theoretical Justifications—What Can the Right to Development Do for Public Health?

Development promotes the health of nations. The right to development, as a collective right, can create a utilitarian framework for health through state public health systems, yielding overall maximum social utility in providing for underlying determinants of health. Conceptualizing development programs as a mechanism for disease prevention and health promotion, public health scholars and activists, working through the ecological model of public health,[426] can use human rights to build a broader social justice movement for shaping and improving underlying social determinants of health through public heath systems. By emphasizing competition and marketization under the aegis of "individual freedom," neoliberal development policy's autonomy-diminishing effects impair the realization of the right to health by curtailing the individual's ability to realize healthy conditions.[427] Public health systems must respond by addressing underlying determinants of health through equitable development at the national level.

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424. Jonathan M. Mann, *Human Rights and AIDS: The Future of the Pandemic*, *in* Health and Human Rights: A Reader, *supra* note 248, at 216, 222. In the case of distinguishing a right to health from a right to development approach to HIV, for example, it is clear that while donations of HIV medications under the right to health may be an immediate solution to the problem of premature death from HIV, this may not be as sustainable a solution as the right to development in improving the systemic lack of access to life-saving medications or the prevention of HIV through public health systems.
425. *See* VanderWal, *Collective Human Rights*, *supra* note 182, 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.").
426. *Supra* Part II.A.1 (discussing the ecological model of public health as a means through which to buttress underlying determinants of health).
427. *Supra* notes 74–76, 170–75 and accompanying text (recognizing considerations of autonomy at the heart of the right to health); *see also* Willard Gaylin & Bruce Jennings, The Perversion of Autonomy: The Proper Uses of Coercion and Constraints in a Liberal Society 106–26 (1996) (discussing the limits of autonomy for individual health).

The tools of public health systems—including medical knowledge, disease surveillance, environmental health, and treatment options—are themselves public goods that, by their very nature, have meaning only in the context of societies.[428] Like many environmental protections,[429] a public health system, 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.[430] As a public good, public health systems lead to shared positive externalities—in this case, health for all. Neoliberal economic policy has served to undermine the determinants that underlie the health of nations.[431] While it is intuitive that communicable disease surveillance and treatment be included among global public goods,[432] there is a growing awareness that development processes have served to transmute noncommunicable disease prevention and health promotion from private goods into global public goods.[433] In this context, even public

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428. *Supra* Part II.B (discussing the role of public health systems as public goods); *see* Dyna Arhin-Tenkorang & Pedro Conceição, *Beyond Communicable Disease Control: Health in the Age of Globalization*, *in* Providing Global Public Goods: Managing Globalization 484, 489 (Inge Kaul et al. eds., 2003); Beauchamp, *supra* note 179, 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"); Rosalind Pollack Petchesky, *From Population Control to Reproductive Rights: Feminist Fault Lines*, 3 Reproductive Health Matters 152, 160 (1995) ("Such enabling conditions [for achieving social rights] entail correlative obligations on the part of governments and international organizations to treat basic human needs, not as market commodities but as human rights.").
429. For an analysis of the environment as a global public good, see Anthony J. McMichael et al., *Global Environment*, *in* Global Public Goods for Health: Health, Economic, and Public Health Perspectives supra note 52, at 94, 95–101.
430. *See* VanderWal, *Collective Human Rights*, *supra* note 182, at 83, 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.").
431. *See* Nick Drager & David P. Fidler, *Foreign Policy, Trade and Health: At the Cutting Edge of Global Health Diplomacy*, 85 Bull. World Health Org. 162, 162 (2007).
432. In the context of infectious disease, the elimination of the disease (in addition to the vaccination programs of public health) can be considered a public good, where disease eradication serves to prevent transmission even to the unvaccinated. Arhin-Tenkorang & Conceição, *supra* note 428, at 491. As a public good, the benefit of vaccination to even the unvaccinated is known in public health as "herd immunity," the state acquired when enough of a population has been vaccinated that a disease cannot spread, even if every individual has not been vaccinated. Leon Gordis, Epidemiology 19–20 (2d ed. 2000). As such, herd immunity highlights that there is a collective element to public health—without collective action, good population health cannot be achieved.
433. *See* Chen et al., *supra* note 52, 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"); Lawrence O. Gostin, *Why Rich Countries Should Care About the World's Least Healthy People*, 298 J. Am. Med. Ass'n 89, 90 (2007) (arguing that it is in the interest of the international community to improve public health in the developing world).

health knowledge can be seen as a public good, a determinant of health realized only through global efforts and beneficial to all.[434]

To apply these public goods in promoting the public's health, it is necessary to consider the wide-ranging determinants impacted through development processes under the "vector of rights" approach of the right to development.[435] In doing so, the right to development takes a "holistic approach" to rights,[436] where the fulfillment of one right is seen to affect the realization of others and create a net effect that is greater than the sum of its individual parts.[437] Because this holistic approach accounts for the direct and indirect ways in which human rights interact intersectionally,[438] it provides a more comprehensive, and thereby accurate, framework for addressing interconnected underlying conditions that limit human flourishing.[439] Acknowledging this complex reality of development, the right to development advances an intersectional rights-based public health paradigm that would view the composite oppressions and benefits of development programs as interacting and mutually reinforcing under a vector of rights. Only through this holistic approach can states and international actors address the multifaceted pathways that link development and health through underlying determinants of health, providing a normative foundation for considering poverty reduction, public goods, and public health systems together through the lens of public health.

But assessing these multifaceted determinants requires a collective, rather than individual, analysis. Development policy operates at the level of the state, and international coordination is not influenced by individual rights perspectives.[440] If the socio-economic environment determines social inequalities in health[441] and this socio-economic environment operates at a collective level, then a collective right is essential to provide for the public goods necessary to alleviate these collective harms through public

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434. *See* Stiglitz, Globalization and Its Discontents, *supra* note 90, at 224 ("Knowledge itself is an important global public good: the fruits of research can be of benefit to anyone, anywhere, at essentially no additional cost.").
435. *See supra* notes 371–74 and accompanying text (describing the "vector of rights" approach to the right to development).
436. Robinson, *supra* note 103, at 27.
437. Lisa A. Crooms, *Indivisible Rights and Intersectional Identities Or, "What Do Women's Human Rights Have to Do with the Race Convention?,"* 40 Howard L.J. 619 (1997).
438. The idea of intersectionality was first introduced by North American "critical race theory" scholars to relate feminist analysis to the experience of race. Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics and Violence against Women of Color*, 43 Stanford L. Rev. 1241 (1991).
439. *See* Sengupta, *Development Cooperation*, *supra* note 352, at 3.
440. *Supra* Part III.A.
441. For a description of the causal pathways through which a lack of development impacts underlying determinants of health, see *supra* Part II.A.1.

health systems. Only through the public goods of public health systems will individuals have the capability to realize health. In the wake of neoliberal economic reforms and the spread of neoliberal ideology, the broad definition of primary health systems laid out in the Declaration of Alma-Ata[442] has been replaced with one that focuses on narrow, vertical, curative interventions in the context of national health system retrenchment and decentralization.[443] Through the right to development, there can be a revitalized call to reconceptualize health systems as "core social institutions" that define the very experience of poverty and development, using this reconceptualization to scale up the provision of underlying determinants of health to realize the highest attainable standard of health. Because no individual can rightly make a claim against the state under the individual right to health for a specific public health program,[444] collective rights become necessary to give meaning to public goods and provide for their realization through national health systems. As recognized by Dan Beauchamp, "public 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."[445] Collective human rights can elevate human rights discourse in addressing these group interests through international law, operating *ex ante* in structuring development programs to preserve national public health systems.

Working in concert with the individual right to health,[446] the right to development can combine, under the same framework, the prevention of poverty and inequality with the fulfillment of public health systems. For many in public health, "a commitment to health necessarily implies a commitment to reducing poverty."[447] By protecting public goods in the context of economic growth, a right to development would secure the public health systems necessary to promote health through the poverty reduction process. Yet it is clear that economic growth is necessary but not sufficient to alleviate inequity.[448] Development through free markets is often justified by arguments for collective good and aggregate benefit, with growth distributed without regard for individual economic and social rights.[449] Social justice

442. *Supra* notes 265–74 and accompanying text (discussing the rise and fall of the Declaration of Alma-Ata as a source of health rights).
443. *Supra* notes 271–74 and accompanying text.
444. *Supra* notes 181–93 and accompanying text.
445. Beauchamp, *supra* note 329, at 29; *see also* Gaylin & Jennings, *supra* note 427, at 228–46.
446. For a discussion of means through which the right to development and the right to health can act in concert, see *infra* Part V.B.3.
447. Braveman & Gruskin, *supra* note 169, at 540 ("Human rights perspectives can contribute concretely to health institutions' efforts to tackle poverty and health, and focusing on poverty is essential to operationalizing those commitments.").
448. Nankani et al., *supra* note 98, at 481; *see also supra* notes 112–116 and accompanying text.
449. *See* Donnelly, Universal Human Rights, *supra* note 123, at 200–202 (noting that markets foster efficiency but not social equity or the enjoyment of individual rights).

requires both economic growth and distributive justice. Incorporating these health principles into development discourses explicity can promote the fair distribution of the benefits of development and equal opportunities in access to resources for the public's health.[450] Thus, the collective right to development can bring equity in the distribution of underlying determinants of heath by facilitating the type of growth that is necessary to achieve social justice through development.[451] Focusing attention on the distribution of resources that drive socially unjust health disparities[452]—examining the whole structure and process of development—the right to development provides an approach more likely to lead to sustainable health systems than the approach reflected in the current neoliberal economic policies.[453] By assessing health equity through social impact analyses (comparisons between more and less advantaged social and economic groups), the right to development's synoptic lens can provide a national human rights analysis for alleviating insalubrious inequality.[454]

In maximizing resources for health under this framework, if the realization of health rights in development is inherently conditioned by the principle of progressive realization, then the realization of those rights can be assured only through their prioritization during the development project. The progressive realization of multiple individual rights consecutively is unhelpful to coordinated national decision-making.[455] Through holistic analysis, however, the right to development provides a systemic perspective, considering development's impact on the entire vector of rights concurrently and creating a unified framework for negotiating tradeoffs among rights in the development process.[456] This collective rights structure therefore can create country-specific frameworks to address collective-specific determinants of health, rather than vertical, disease-specific individual health interventions.[457]

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450. *See* Sengupta, R*ealizing the Right to Development*, *supra* note 353, at 565.
451. *See id.*, at 568.
452. Paula Braveman, *Defining Equity in Health*, 2 Health Pol'y & Dev. 180, 180–81 (2004).
453. The United Nations Development Programme's vision of "sustainable human development" is a reflection of this approach, highlighting empowerment, cooperation, equity, sustainability, and security in the development process. Donnelly, Universal Human Rights, *supra* note 123, at 194–95.
454. *See* Braveman, *supra* note 452, at 184.
455. Robinson, *supra* note 103, at 34.
456. Sengupta, *Development Cooperation*, *supra* note 352, at 3 ("The integrity of these rights implies that if any one of these rights is violated, the whole composite right to development is also violated.").
457. In this country-specific analysis, local knowledge is relevant in understanding what underlying determinants of health exist in a state, what health behaviors mean to individuals, and how behaviors are facilitated or constrained by various contexts. Thus, when creating a public health national plan pursuant to the right to development, *infra* Part V.B, it is necessary to identify the specific health needs of the state, with priorities set on the basis of economic and epidemiological evidence and governed by frameworks for efficiency and cost-effectiveness. *See* Nankani et al., *supra* note 98, at 482.

As a vector of rights, the right to health would be a component right of the development vector, as would be investments in other component rights such as education, water, and housing, that—as underlying determinants of health—can be expected to have positive externalities that will improve public health while advancing the overall vector.[458] For this virtuous cycle to be attained, the realization of the component rights to health, water, education, housing, and others must be carried out in a manner that prioritizes them under a singular framework to achieve sustainable development.[459] Such a development framework would encourage the alignment of programs in a "horizontal" rather than a "vertical" manner, moving beyond traditional "silos" to work collaboratively across disciplines and sectors to address underlying determinants of health.[460] This would position health professionals to incorporate themselves in the activities of sectors already involved in development, building strategic, sector-transcending national plans protective of public health systems.[461]

With globalization limiting the ability of the state to respect, protect, and fulfill human rights in this health system development, it is necessary to work within a rights framework that incorporates international duties and acknowledges the wide range of global actors that affect the public's health. Obligations on the international community are rarely discussed—and never operationalized—in relation to the right to health.[462] For example, although General Comment 14 "emphasize[s] that it is particularly incumbent on States parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical,'"[463]

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458. For example, improved maternal literacy has been shown conclusively to reduce infant mortality, presumably through the improved knowledge that the mothers gain about proper sanitary and nutrition practices. Robert A. LeVine et al., *Maternal Literacy and Health Care in Three Countries: A Preliminary Report,* 4 Health Transition Rev. 186 (1994). Similarly, improved housing conditions appear to reduce the spread of tuberculosis. Per Gustafson et al., *Tuberculosis in Bissau: Incidence and Risk Factors in an Urban Community in Sub-Saharan Africa,* 33 Int'l J. Epidemiology 163 (2004).

459. *See* Sengupta, *Implementing the Right to Development*, *supra* note 372, at 344 ("[A]ll the elements [of human rights] are interdependent, both at any point in time and over a period of time. They are interdependent in the sense that the realization of one right, for example the right to health, depends on the level of realization of other rights, such as the right to food, or to housing, or to liberty and security of the person, or to freedom of information, both at the present time and in the future.").

460. United Nations, Dep't Econ. & Soc. Aff., The Inequality Predicament: Report on the World Social Situation 2005, at 18 (2005).

461. For more on sector-wide approaches see Mick Foster, Center for Aid and Public Expenditure, *New Approaches to Development Co-operation: What Can We Learn from Experience with Implementing Sector Wide Approaches?* (Overseas Dev. Inst., Working Paper No. 140, 2000), *available at* http://www.odi.org.uk/publications/working_papers/wp140.pdf.

462. *See supra* notes 192–197 and accompanying text (discussing weaknesses of individual rights in creating international obligations).

463. General Comment 14, *supra* note 207, ¶ 45 (quoting ICESCR, *supra* note 194, art. 2).

this hortatory language has gone largely unheeded.[464] To the extent that health scholars have sought an international development order under the right to health, as they have attempted to do through the MDGs,[465] this global framework has been cast in the discretionary language of foreign aid, with states failing to press other states or international institutions with legal obligations to provide this aid.[466] Without any binding commitments, the official United Nations target of raising total official development aid to 0.70 percent of the gross national income remains woefully deficient, with developed states contributing on average a mere 0.22 percent, the United States a paltry 0.10 percent.[467]

The right to development offers legal obligations that can alter this paradigm of charitability. The Declaration on the Right to Development emphasizes the instrumentality of international cooperation, commiting states through a legal duty "to cooperate with each other in ensuring development and eliminating obstacles to development" and "promoting, encouraging and strengthening universal respect for and observance of all human rights and fundamental freedoms."[468] While individual states have the "primary responsibility" to ensure the right to development, international cooperation is critically important in the realization of this right where the state alone is unable to realize the rights of its peoples.[469] Thus, the Vienna Declaration disaggregates obligations under the right to development, finding that "implementation of the right to development requires effective development policies at the national level, as well as equitable economic relations and a favourable economic environment at the international level."[470] Pursuant to this framework, whereas the right to heath can continue to empower individuals to press health services claims against the state,[471] the right to development can empower states in their negotiations with international development actors, placing duties on the "international community" of states to *respect* (through an easing of trade disparities, structural adjustment, and inequitable development), *protect* (from transnational corporations), and *fulfill* (by increased support for national public health systems) the right to

464. *Supra* notes 298–308 and accompanying text.
465. *Report of the Special Rapporteur of the Commission on Human Rights, Paul Hunt, on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Submitted in Accordance with Commission Resolution 2004/27*, U.N. GAOR, 59th Sess., Agenda Item 105(b), ¶ ¶ 32–35, U.N. Doc. A/59/422 (2004).
466. *Supra* Part III.C (discussing the effectiveness of the MDGs as a non-legal approach to global public health)
467. Sengupta, *Development Cooperation*, *supra* note 352, at 23–24 (chart).
468. Declaration on the Right to Development, *supra* note 349, arts. 3(3), 6(1).
469. *Supra* Part IV.B.3 (reviewing international obligations pursuant to the right to development).
470. Vienna Declaration, *supra* note 345, art. 1, § 10.
471. *See infra* Part V.B.3 (laying out a programmatic framework for harmonizing obligations under the right to health and right to development).

development.[472] By permitting states to raise collective rights obligations against this wider range of global duty-bearers, the right to development would impose obligations on the global community of states, and in so doing, help to bring public health considerations into international development discourses.

As a result, the right to development provides public health actors with access to discourses that would allow for the discussion of public health indicators at the development table. As Mary Robinson cautions, "we are far from arriving at a position where those working in the human rights tradition and those working in the development tradition feel they speak the same language."[473] The advancement of a collective right to development can provide greater utility in a debate taking place at the level of the state, wherein public health actors are provided a language through which to speak to the harms of development, in the language of development, during the course of development.

B. Programmatic Considerations—How Can Public Health Use the Right to Development

Employing the right to development to address public health issues unaddressed by current rights-based frameworks would allow public health scholars and activists to enter development debates in advocating for the distribution of and access to development's resources through national health systems. Such a framework would provide a legal basis for incorporating public health actors in development discourses and would guide these actors in advancing the design, implementation, and evaluation of national development programs.

1. Determining Fulfillment and Violation of the Right to Development

Under the right to development, concrete and measurable public health indicators can be identified and tracked to monitor progress at the national and sub-national level. The collection of national and disaggregated data and the monitoring of human development outcomes, especially public health indicators and health systems capacity, can be employed to determine whether states are realizing health rights in an equitable and participatory

472. *See* Kirchmeier, *supra* note 366, at 10 (recognizing that obligations under the right to development are "not imposed on one individual state, i.e. as regards its internal structures, but on the international community, which is obliged 'to promote fair development policies and effective international cooperation'"). For the programmatic implications of this rights framework, see *infra* notes 519–33 and accompanying text.

473. Robinson, *supra* note 103, at 31.

manner and to the maximum of available resources. By focusing on the health outcomes, in addition to the processes of realizing specific development goals, states and international actors can be obligated legally to refocus their resources toward the improvement of public health systems rather than viewing economic growth at the national level as the sole outcome of development.

In order to gauge whether states are meeting their public health obligations under the right to development, states can be required to develop national health strategies and plans of action, including in these plans indicators and benchmarks as a means of framing public health standards to which states can be held accountable. Scholars have argued that the "most important feature of the RTD [right to development] approach is its emphasis on an operational program with specific policies of national actions and international cooperation within an operational model of realizing the rights." As part of these policies, scholars have outlined the use of poverty reduction and social indicator targets as basic "operational elements" by which to adjudge the realization of each of the component rights of the right to development.[474] By conceiving the right to development as a vector of rights, public health actors can look to specific public health indicators representing underlying determinants of health, which would allow these indicators (and interactions among indicators) to serve as a measure of improvement in each of the component rights of the right to development vector.[475]

In creating a framework for public health indicators under the right to development, it is necessary to differentiate among structural indicators, process indicators, and outcome indicators:

- Structural Indicators—Structural indicators refer to the adoption of requisite legal frameworks and institutions to oversee the implementation of rights, including policy and regulatory frameworks.
- Process Indicators—Process indicators are best thought of in terms of a government's effort toward achieving development goals, such as the amount of resources budgeted toward certain issues or the strategy for poverty alleviation and progressive actions toward achieving national targets.
- Outcome Indicators—Outcome indicators measure the degree to which the process of development has resulted in actual improvements in the substance of the right to development.[476]

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474. Sengupta, *Development Cooperation*, *supra* note 352, at 6–9.
475. *Cf.* Sengupta, *The Human Right to Development*, *supra* note 367, at 31 ("It may not be easy to build up an overall indicator for the right to development. This is because to convert a vector comprising a number of distinct elements into a scalar or an index would require a process of averaging or weighting the various elements that would be open to fundamental objections.").
476. Rajeev Malhotra, *Towards Implementing the Right to Development: A Framework for Indicators and Monitoring Methods*, *in* Development as a Human Right, *supra* note 367, at

Under this framework, a right to development can be seen to apply structural and process indicators to assess collective obligations of conduct *ex ante* and apply outcome indicators to assess collective obligations of result *ex post*.

Examining indicators *ex ante* (at the stage during which states work with international actors to create development programs), structural indicators for public health would assess a state's enabling legislation for its public health system (including codification of the right to health, as a signatory to the ICESCR or by way of national legislation) and the authority of the department or ministry of health responsible for addressing underlying determinants of health through its public health system.[477] In addressing such indicators, states would be pressed to create and maintain sustainable national public health bureaucracies—which in many states either are nonexistent or have been eviscerated in adherence with development conditionalities[478]—to coordinate national disease prevention responses and health promotion efforts.[479] To do so, process indicators would substantiate claims to prioritize systemic public health interventions during negotiations over development reforms. Given the "progressivity" inherent in realizing economic, social, and cultural rights,[480] a state's efforts can be examined as a function of the "maximization" of its resources in prioritizing the fulfillment of rights underlying the public's health.[481] For example, a state may need to demonstrate that it has allocated adequate resources through its public health system to suppress specific epidemics, as well as supported the underlying conditions that prevent the outbreak of these health crises, including education, housing, and gender rights. Because of the trade-offs necessary in allocating finite resources to underlying determinants of health, states could prioritize funds by taking into account the pathways through which these underlying determinants affect health, pushing for improvement in the overall vector

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196, 213–15. In addition to these indicators, Malhotra advocates distinguishing indicators for procedural and substantive human rights. *Id.* at 210.

477. *See id.* at 213 (noting that "structural indicators in the context of the right to food would include information on the legal status of the right; legal status of related rights (rights of women to agricultural land); the existence of institutional mechanisms, including the policy and regulatory frameworks; and agencies mandated to address and monitor the issue of food availability and accessibility").

478. *See supra* Part II.B.

479. *See* Gostin et al., *The Law and the Public's Health*, *supra* note 19, at 64 ("The essential job of public health agencies is to identify what makes us healthy and what makes us sick, and then to take the steps necessary to make sure we encounter a maximum of the former and a minimum of the latter.").

480. *Supra* Part III.B.2.

481. *See* David L. Cingranelli & David L. Richards, Measuring Economic and Social Human Rights: Government Effort and Achievement 3–4 (10 Oct. 2005) *available at* http://www.humanrights.uconn.edu/conf_2005.htm (noting the unfairness involved in utilizing resource-dependent outcome indicators as measures of states' fulfillment of their human-rights obligations under the ICESCR and the inability of these measures to capture variations in levels of effort across countries).

of rights as long as relative allotments among priorities are not thought to weaken public health systems. Thus, under this framework for applying structural and process indicators, interventions that address the underlying causes of disease through a synergy of rights (by, for example, the sustainable scaling up of health systems) would be favored over narrow, vertical interventions with limited time horizons.[482]

In considering *ex post* outcome indicators, the inclusion of public health measures in a right to development would facilitate state obligations of result, with these results quantified easily through minimum national and sub-national public health indicators—such as life expectancy and infant mortality[483]—and amenable to examination through national and international adjudicative bodies. While the individual right to health (like other economic, social, and cultural rights) has long been held to obligations of conduct more so than obligations of result,[484] public health indicators provide a demonstrable measure of the efficiency of a state's progressive realization of economic, social, and cultural rights at the collective level. By expanding the population under consideration through aggregate data measures, public health practitioners could appreciate the significance of anomalies in average and median health status and correlate these anomalies with underlying determinants of health engendered by development processes.[485] This application of outcome indicators is in keeping with the "human development approach" to development (itself an extension of the "capabilities approach" to human rights[486]) and would take into account the

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482. Further, as the quality of data for the generation of indicators also depends on the resources available for research, indicators will improve with economic development. Indeed, part of the logic of building health systems to realize the health rights is to improve countries' disease surveillance capacity. Improving surveillance capacity allows the state to detect disease outbreaks and track trends in health burden to determine how to allocate resources. Thus, surveillance is also resource-dependent. *See* Malhotra, *supra* note 476, at 215.

483. *See* Tom J. Farer, *Toward a Humanitarian Diplomacy: A Primer for Policy*, *in* Toward a Humanitarian Diplomacy: A Primer for Policy 22 (Tom J. Farer ed., 1980) ("Development experts generally agree that life expectancy, infant mortality, and literacy are the most appropriate indicators for measuring the physical well-being of any country's population and for the measurement of progress towards higher levels of economic and social well-being for the general population.").

484. *Supra* note 231 and accompanying text. Whereas the individual right to health may create inequitable obligations of conduct, a right to development could place quantifiable obligations of result on states.

485. Leon Gordis, *From Association to Causation: Deriving Inferences from Epidemiologic Studies*, *in* Epidemiology 184, 185 (2d ed. 2000).

486. *See* Sengupta, *The Human Right to Development*, *supra* note 367, at 12 ("The Human Development Approach could be regarded as an extension of the 'basic needs' approach [to development] by moving from the indicators of basic needs in terms of commodities to the indicators of human development in terms of achievements, such as life expectancy, infant survival, and adult literacy, supplementing the indicators of per capita real income.").

myriad underlying mechanisms through which health systems can improve the public's health.[487] As economic deprivation has a profound impact on health outcomes,[488] public health indicators (such as disease-related disability-adjusted life years (DALYs))[489] are sensitive to measures of poverty incidence; whereas poverty is difficult to measure,[490] certain public health manifestations of poverty (such as sanitation-related infectious diseases) may actually be more accurate and useful measures of economic deprivation than measurement of the incidence of poverty itself.[491] By incorporating such public health outcomes in national PRSPs,[492] a framework that has not been employed successfully through the right to health,[493] these PRSPs can encourage monitoring of outcomes and thereby provide accountability in development for the public's health.[494] As PRSPs contain a component that is outcome-oriented and focused on the process of development, embedding the right to development directly into PRSPs could press development actors to integrate human development alongside poverty reduction, elevating health systems as core institutions to be protected and promoted through the development transition.

While economists often cite the relationship between development and health as running largely in the direction of health leading to improved potential for economic development,[495] the utilization of public health outcomes as core social indicators reverses this causal arrow and provides a

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487. *See* Malhotra, *supra* note 476 (noting that there may be a number of processes that contribute to a single outcome and it is therefore important to distinguish between process and outcome indicators).
488. *Supra* Part II.A.
489. Disability-adjusted life years (DALYs) are a comparative measure of disease burden that includes both mortality and morbidity. For more on DALYs and how they are calculated, see generally Christopher J. L. Murray & Alan D. Lopez, *Mortality by Cause for Eight Regions of the World: Global Burden of Disease Study*, 349 Lancet 1269 (1997).
490. The challenge of measuring poverty, particularly quantifying poverty in econometric terms, is partially what led the World Bank to engage in an uncharacteristic use of qualitative and ethnographic methods to gain insight into what poverty means to the poor themselves. *See* World Bank, Voices of the Poor: Study Purpose and Design, *available at* http://go.worldbank.org/6G6JIRJ100; World Bank, World Development Report (WDR) 2000/2001: Attacking Poverty, *available at* http://siteresources.worldbank.org/INTPOVERTY/Resources/WDR/overview.pdf.
491. *See* Robertson, *supra* note 136, at 703 (noting "serious deficiencies" in using resource utilization to measure state compliance with economic, social, and cultural rights).
492. For a discussion of the role of PRSPs generally in development discourses, see *supra* notes 98–102 and accompanying text.
493. The World Health Organization already has begun to consider ways of incorporating health indicators into PRSPs. World Health Organization, PRSPs: Their Significance for Health: Second Synthesis Report (2004). However, this approach has met with mixed success. Mohindra, *supra* note 102, at 167.
494. *See* Nankani et al., *supra* note 98, at 492 (noting that "while the MDGs present a set of extremely useful targets for low-income countries and their development partners, the PRSP provides a vital accountability mechanism that would otherwise be lacking").
495. *Supra* note 1.

human rights basis for refocusing development on the improvement of health. Through this, public health indicators can be used in place of traditional development indicators (e.g., GDP, inflation, and growth rates) to assess a country's level of human development. Under the application of such a right to development framework, improved and equitable public health outcomes would become a central goal of the process of development rather than a means to an economic end, reconceptualizing economic development as *human development*.

2. National and International Obligations

While the collection and dissemination of indicators is essential to determining whether a country is fulfilling its international obligations, indicators ultimately can contribute little beyond "blaming and shaming" mechanisms to ensure the enforcement of the right to development.[496] To operationalize these principles in legally enforceable ways during development processes, the right to development may be brought to bear for public health systems at two procedural levels:

- Intra-national level—Collectives invoke the right to development against their governments.
- International level—States or peoples invoke the right to development against the international community to embed human rights norms in the foundational texts and practices of global institutions.

At the national level, collectives may invoke the right to development to press the state to employ a rights-based approach to development that furthers the realization of public health outcomes. Through this, the peoples within the state could bring claims against their government in national judicial forums should the government adopt neoliberal economic reform packages that diminish public goods or public health systems and thereby undermine underlying determinants of health. Under the right to health, this mode of enforcement has been utilized, with several successes, to require governments to provide essential medicines to their citizens, demonstrating that skillful litigation can compel governments to fulfill their human-rights obligations.[497] However, there are significant limitations to an approach

496. *See supra* note 262 and accompanying text (discussing the role of shaming mechanisms in enforcing the right to health).

497. A review of litigation in low- and middle-income countries has identified seventy-one court cases from twelve countries in which individuals or groups had claimed access to essential medicines with reference to the right to health or specific human rights treaties ratified by governments. In fifty-nine cases, access to essential medicines was upheld through the courts under the right to health, with most of these cases occurring in Central and Latin America. However, because most of these cases were adjudicated through constitutional provisions on the right to health (supported by human-rights treaties), courts did not deem resource constraints to be a valid defense for shirking obligations under the right to health. Hans V. Hogerzeil et al., *Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable Through the Courts?*, 368 Lancet 305 (2006).

that invokes an individual right to health to procure essential medicines,[498] limitations that may be overcome through the right to development. In the absence of systems to distribute medications and ensure the appropriate conditions for adherence to regimens, the procurement of medicines at reasonable prices still may not guarantee public health improvements without a state first codifying enabling legislation for its health ministry and scaling up its health system capacity. Further, there are myriad health conditions not amenable to treatment with medical therapies alone, as both the prevention and ultimate eradication of the vast majority of diseases in the developing world can be achieved only through the creation of sustainable health systems necessary to provide for underlying determinants of health: sanitation, nutrition, health surveillance, and improved living standards.[499]

Working through the right to development for the public's health offers a legal basis by which to ensure the scaling up of public health systems for the improvement of underlying determinants of health. As with direct adjudication of the right to health, peoples may invoke a collective right to development to challenge state economic policies that are damaging to national or regional public health systems and that are likely to lead to rising health inequalities within the country.[500] Through this, state signatories to the Declaration on the Right to Development and Vienna Declaration, while not bound as if through treaty ratification, nevertheless can face international legal obligations to develop in a rights-based manner. This method of enforcing rights against the government has already been adopted in several states on the basis of individual rights,[501] often accomplished by reference to the incorporation of rights in state constitutions.[502] Under the right to development, this could be expanded, with groups within the state petitioning to hold both the government and non-state actors, including transnational

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498. *Supra* notes 261–264 and accompanying text.
499. *See supra* Part II.B (noting the comparative importance of underlying determinants of health for improving the public's health).
500. *See* Meier, *supra* note 155 (arguing for state duties pursuant to a collective human right to public health).
501. *Supra* note 263 and accompanying text. Sandra Liebenberg argues that South Africa's constitutional protection of fully justiciable socio-economic rights in facilitating the redress of economic deprivation and inequality within the process of development constitutes the partial fulfillment of the right to development. *See* Sandra Liebenberg, *Making a Difference: Human Rights and Development—Reflecting on the South African Experience*, *in* Development as a Human Right, *supra* note 367, at 167, 167–195.
502. Dine, *supra* note 164, at 188. *But see* Yash Ghai, *Redesigning the State for "Right Development," in* Development as a Human Right, *supra* note 367, at 141–66 (noting the case of Kenya, which engaged in a participatory process to involve citizens and stakeholders in the redesigning of their constitution to comply with a right to development, but finding the rights-based, participatory process to lead to mixed results where sectional politicians hijacked the process to seek political power).

corporations and international organizations, accountable for violations of the right to development.[503]

However, intranational enforcement of human rights alone may be limited in changing the global institutional arrangements that affect the opportunity of states to enter the international economic arena on an equal footing, impeding their ability to realize human rights obligations. As noted by Joseph Stiglitz:

> Today . . . we have a system that might be called *global governance without global government*, one in which a few [international] institutions—the World Bank, the IMF, the WTO—and a few players—the finance, commerce, and trade ministries, closely linked to certain financial and commercial interests—dominate the scene, but in which many of those affected by their decisions are left almost voiceless.[504]

Stiglitz's commentary highlights the utility of international obligations under the right to development, a right of states and peoples that can reform international institutions to allow for greater development cooperation among states in accordance with human-rights standards. As a collective right possessing international obligations, the right to development can be invoked to alter the international institutional structures that obstruct the national developmental and distributive policies necessary for the public's health.[505]

At the international level, representatives of states could utilize the collective rights of the right to development to raise international duties when negotiating with international organizations over lending conditionalities, ensuring that development policies will promote—rather than harm—health rights through the protection of public health systems (as core social institutions) during economic reform. Since the ability of states to develop and to fulfill their human rights obligations domestically is often constrained by the actions and institutional arrangements of the international community, the realization of the right to development may require a restructuring of international institutions and foreign-aid programs, allowing states to enter

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503. As the state is the principal duty bearer under international law, it is incumbent upon states to ensure that third parties operating within their borders do not violate human rights. *See* Dine, *supra* note 164, at 180 ("Indirect liability of companies would be imposed by holding states responsible for the behavior of corporations. This requires states to ensure that proper national laws are in place to control corporations, in this way states fulfil their duty to protect human rights.").

504. Stiglitz, Globalization and Its Discontents, *supra* note 90, at 21–22; *see also* Susan Strange, The Retreat of the State: The Diffusion of Power in the World Economy 4 (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").

505. For more on the role of international institutional structures in shaping health, see Salomon, *supra* note 406, at 96.

development debates with a legal right to cooperation from other states in public health, not simply a plea for charity.

In moving toward this goal, the right to development may be implemented through both direct and indirect means. The right to development may be imposed directly on international institutions where human rights clauses are explicitly written into international law, binding International Financial Institutions (IFIs) by embedding norms directly in the foundational documents and jurisprudence of these organizations.[506] The current institutional rules embedded in the constitutions of international organizations give preference to wealthier states over those that are economically "weak."[507] Through the right to development, states can use international law to reform these rules to make voting and membership structures more egalitarian and thus more responsive to the public health needs of developing states.[508] Alternatively, the right to development may be implemented indirectly through the obligations of states to abide by human rights norms when voting or participating within these organizations.[509] When states parties support IMF and World Bank policies, in particular when they make financial contributions to them, they collectively uphold policies that result in human rights violations in developing countries (i.e., where macroeconomic prescriptions violate states' core obligations for realizing underlying determinants of health).[510] Through this indirect mechanism, states that are both signatories to the right to development and members of the World Bank or IMF can be pressed to use their bargaining power to bring development programs in line with their obligations to respect, protect, and fulfill health rights.[511] As seen in the example of the

506. For an initial discussion of this approach, see Sigrun I. Skogly, The Human Rights Obligations of the World Bank and the International Monetary Fund (2001).
507. *See, e.g.*, Ariel Buira, *The Governance of the IMF in A Global Economy*, *in* Challenges to the World Bank and IMF: Developing Country Perspectives 13 (Ariel Buira ed., 2003) (discussing the rules regarding voting, quotas, and qualified majorities that constitute the power structure of the IMF and the ways in which small economies are systematically disadvantaged).
508. Dine, *supra* note 164. *But cf.* Marks, O*bligations to Implement*, *supra* note 402, at 72 (noting that what is prescribed in international law and what is politically feasible are separate issues, with binding norms on international financial institutions proving politically infeasible).
509. Dine, *supra* note 164.
510. Rachel Hammonds & Gorik Ooms, *World Bank Policies and the Obligation of Its Members to Respect, Protect and Fulfill the Right to Health*, 8 Health & Hum. Rts., 28 (2004).
511. *Id.* As Paul Hunt has argued, "if they wish, relevant state parties, such as Least Developed Countries (LDCs) may argue that it is impermissible for any international or other policy maker to push the most vulnerable members of their societies below the basic international threshold represented by the Covenant's provision." Jennifer Tooze, *Aligning States' Economic Policies with Human Rights Obligations: The CESCR's Quest for Consistency*, 2 Hum. Rts. L. Rev. 229 (2002).

WTO—a forum for member state negotiation of free-trade principles, often to the disadvantage of public health[512]—the right to development could be employed to insert human rights norms into either trade negotiations or the jurisprudence of dispute resolution mechanisms.

Outside of these organizational mechanisms, the right to development could be employed to institute a "development compact," a "mechanism for ensuring the recognition among all stakeholders of the 'mutuality of the obligations' so that the obligations of developing countries to carry out these rights-based programs are matched with reciprocal obligations of the international community to cooperate in order to enable the implementation of those programs."[513] To accomplish this compact, scholars have argued for the establishment of a financial facility, the Fund for Financing Development Compacts, with contribution commitments from all the members of the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD),[514] to promote development cooperation for poverty reduction and social development through PRSPs.[515] Applying the right to development internationally, such a development compact with callable commitments would assure developing states that they, if they fulfill their obligations under the right to development, would not have their development programs disrupted due to their lack of financing.[516]

Apart from these direct and indirect obligations, an additional way of conceptualizing international obligations under the right to development is to extend the rubric of state obligations to "respect, protect, and fulfill" human rights from the domestic to the global sphere. Under this analogous tripartite system, IFIs (e.g., World Bank and IMF) have an obligation to *respect* the rights of states by refraining from infringing the rights of states to have capable, appropriate public systems and equitable welfare states. In this sense, the right to development can be viewed as restoring sovereignty to states in economic policymaking, thereby creating an enabling environment

512. *See supra* notes 149–154 and accompanying text (noting the harms of intellectual property regimes to the public's health). WTO decisions have tended to favor corporations and free trade at the expense of national standards, including national health standards. Exemptions recognizing the need to protect health put a high evidentiary burden on member states to provide scientific justification for deviations from general obligations. Health Policy in a Globalising World 35 (Kelley Lee et al. eds., 2002).
513. Sengupta, *Development Cooperation*, *supra* note 352, at 8.
514. *See id.* ("As all of them [states] have recognized the right to development, especially after the Vienna Declaration of 1993, they are expected to make at least some provisional Callable Commitment of additional ODA for this fund, which may be invoked only in the event of the need to bridge the resource gaps of countries implementing an RTD program fully in accordance with the obligations agreed upon.").
515. *See supra* notes 98–102 and accompanying text.
516. *Id.*

necessary for states to meet their domestic obligations to realize economic, social, and cultural rights, including the right to health.[517]

Similarly, the international community has an obligation under the right to development to *protect* states from non-state actors, in particular TNCs, whose pursuit of increasingly flexible labor markets and deregulated policy environments has resulted in a "race to the bottom" as countries compete for scarce sources from foreign direct investment (FDI).[518] These TNC actions have raised insurmountable difficulties for state governance in support of the public's health.[519] To protect states from the deregulatory policies that harm the health of workers and society at large,[520] the international community can protect states through the enactment of international labor and environmental standards that companies may be held to, regardless of their country of operation.

Lastly, as the realization of collective rights in a globalized world will require international cooperation,[521] the WHO can be viewed as an institutional mechanism for *fulfilling* the obligations of the international community for public health under the right to development. The WHO, as "the only organization with the political credibility to compel cooperative thinking" around global health policy,[522] can serve a dual role of promoting cooperation in international responses to global public goods (such as preventing the transnational spread of infectious illness) and coordinating efforts to provide assistance to national health systems. Just as the underlying conditions that give rise to public health at the domestic level are considered to be public goods, at the international level, global public goods are those which "benefit

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517. *See* Mazur, *supra* note 74, at 64 ("International human rights law, caught within its framework of state responsibility for human rights violations, is unable to deal fully with the changes to state sovereignty accelerated by the process of globalization. Where the violator of human rights law is not a state or its agent but a globalized economic institution or a transnational corporation, international human rights law finds it difficult to provide any redress to the victim.").
518. 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 43, 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").
519. *See* Scott Burris, *SARS, Public Health and Global Governance*, 77 Temple L. Rev. 143 (2004) ("In the case of a good traditionally seen as public, such as public health, the new descriptions of governance raise important practical and normative questions about the responsibilities and accountability of non-state actors.").
520. *See* Jack Donnelly, *Human Rights, Globalizing Flows, and State Power, in* Globalization and Human Rights, *supra* note 137, at 226, 232 ("[F]irms are increasingly free to move "offshore" to escape the costs imposed by welfare state guarantees of economic and social goals. The resulting market pressures to constrain national social welfare policies are increasingly supplemented by pressures from international financial institutions.").
521. Mazur, *supra* note 74, at 63.
522. Garrett, *supra* note 272, at 22.

all of mankind" and are the "collective responsibility of all nations."[523] The UDHR provides that "[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."[524] While rarely recognized by scholars of the UDHR, this international order is particularly relevant for facilitating the UDHR's promise of health rights: "*a standard of living adequate for the health* and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services."[525] Health rights necessitate international cooperation. Creating the "social and international order" necessary to uphold a right to development for health will require international structures for facilitating cooperation among public health systems.[526]

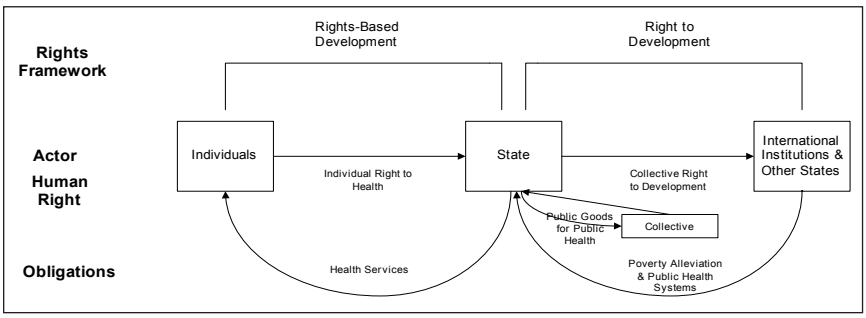
As the leading global health organization, the responsibility for policy coordination around these emerging disease threats falls naturally to the WHO. In addition, the WHO also can fulfill international health obligations under the right to development by acting as an arbiter of international health aid. As Laurie Garrett has articulated, the recent glut of public and private funds toward global health has the potential to generate either "spectacular improvements in the health of billions of people, driven by a grand public and private effort comparable to the Marshall Plan—or they could see poor societies pushed into even deeper trouble, in yet another tale of well-intended foreign meddling gone awry."[527] With the massive influx of funds going toward health and health-related development projects, the WHO has a central role to play in ensuring that health aid is channeled into projects that strengthen health systems rather than siloed into vertical, disease-specific programs.[528] Where such leadership necessitates collective public health obligations through treaty law, the WHO has an opportunity to codify such obligations by integrating the work of the WHO Commission on Social Determinants of Health[529] through the recently-proposed Framework

523. Stiglitz, *The Theory of International Public Goods*, *supra* note 54, at 2.
524. UDHR, *supra* note 193, art. 28.
525. *Id.* art. 25 (emphasis added).
526. *See* Cees Flinterman, *Three Generations of Human Rights*, *in* Human Rights in a Pluralist World, *supra* note 182, 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).").
527. Garrett, *supra* note 272.
528. *See* David Fidler, *Constitutional Outlines of Public Health's "New World Order,"* 77 Temple L. Rev. 247 (2004) (noting that the WHO can contribute to the realization of health without challenging state sovereignty).
529. WHO, Commission on Social Determinants of Health, *available at* http://www.who.int/social_determinants/en (bringing together scholars across country and discipline to examine social determinants of health as causes of inequitable health between and within countries).

Convention on Global Health,[530] creating a lasting legacy of public health in international law.

3. Harmonizing the Individual Right to Health and Collective Right to Development

While the right to development poses great public health advantages in examining inequalities among states, it is necessary to look beyond average national health indicators to examine disease inequality within states. With rights-based development frameworks complementing the right to development in addressing distributional concerns, these rights can act in concert to maximize and to allocate available resources—in absolute and relative terms—for the public's health. As explained in the analysis above and illustrated in the figure below, the collective right to development can work alongside the individual right to health, constructing claims for which the right to health cannot respond through a rights-based development framework alone.



This symbiotic framework can be employed as a normative guide to provide public health scholars and activists with a powerful series of instruments to prevent disease and promote health through development, with the right to development examining systemic problems engendered by development processes and the right to health mobilizing national resources equitably for specific health issues and services. Applying the right to development to existing procedures under the right to health, treaty bodies could examine disaggregated data for vulnerable and marginalized groups to identify the effects of economic inequality on health outcomes.[531] Such indicators would

530. Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 G'TOWN L. REV. 331 (2008).
531. Malhotra, *supra* note 476, at 215.

provide assessment of the process of rights-based implementation of the right to development. In the rights-based approach to implementing the right to development, the study of health disparities may serve not only to identify areas where the right to health has been violated, but disparities in health status also may be used to identify inequitable power relations resulting from development processes.[532] Using the example of health to demonstrate how the rights-based approach to development can address the issue of inequitable distribution of the benefits of development that is often masked by aggregate indicators, Julia Häusermann argues:

> Economic and social inequalities and inequities are observable through differential health status. Poor health frequently reflects poverty and social marginalization. In turn, poor health exacerbates impoverishment and disadvantage. Health status indicators . . . are thus frequently an indication of the denial of the human rights that are so vital for survival and development in dignity.[533]

Development at a national level is vital to the realization of the vector of rights under the right to development; in order for development to proceed in a rights-based manner, it must not leave behind significant portions of the population.[534] Measuring the degree of health disparities under the right to health constitutes a critical means of determining whether the development process has occurred in a rights-based manner and has moved toward complete fulfillment of the right to development.

VI. CONCLUSION: FROM RIGHTS-BASED DEVELOPMENT TO A RIGHT TO DEVELOPMENT

Public health scholars and activists have long employed an individual right to health in development discourses, unsuccessfully promoting an atomistic vision of health care against the collective processes of neoliberal economic policy. In confronting the unhealthy ramifications of development—both from

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532. *See* Sengupta, *Realizing the Right to Development*, *supra* note 353, at 561 (arguing that "[o]ne of the benefits of using a rights-based approach to development is that it focuses attention on those who lag behind others in enjoying their rights, and requires that positive action be taken on their behalf"); Mary Robinson, *The Value of a Human Rights Perspective in Health and Foreign Policy*, 85 Bull. World Health Org. 241, 241 (2007) ("The human rights framework—by focusing attention on vulnerable populations, minorities, the rural poor and women especially, who are most often neglected and marginalized—forces those in authority to ask hard questions about whose needs are not being met, and whose voices are not being heard.").

533. Julia Häusermann, A Human Rights Approach to Development 32 (1998).

534. Rajeev Malhotra adds that a rights-based approach to development permits the use of positive discrimination, or affirmative action, to address the vulnerabilities and inequities of marginalized groups. Malhotra, *supra* note 476, at 204.

a lack of development and lack of equitable development—it is incumbent on public health scholars to examine human rights at a collective level, employing the panoply of rights available for improving health systems. The right to development provides a framework through which the collective harms of development can be scrutinized through a public health lens. Only through access to development discourse—armed with the collective obligations of the right to development—can public health systems be preserved in a way that will protect underlying determinants of health, ameliorating the harms of development policy for the public's health.