
Advancing Health Rights in a Globalized World: Responding to Globalization through a Collective Human Right to Public Health

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In confronting the insalubrious ramifications of globalization, human rights scholars and activists have argued for greater national and international responsibility pursuant to the human right to health.¹ Codified seminally in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to health proclaims that states bear an obligation to realize the “highest attainable standard” of health for all.² However, in pressing for the highest attainable standard for each individual, the right to health has been ineffective in compelling states to address burgeoning inequalities in underlying determinants of health, focusing on individual medical treatments at the expense of public health systems. This article contends that the paradigm of individual health, focused on a right to individual medical care, is incapable of responding to health inequities in a globalized world and thereby hampers efforts to operationalize health rights through public health systems. While the right to health has evolved in international discourse over time, this evolution of the individual right to health cannot address the harmful societal ramifications of economic globalization. Rather than relying solely upon an individual right to medical care, envisioning a collective right to public health – a right applied at the societal level to address underlying determinants of health – would alleviate many of the injurious health inequities of globalization.

I. Globalization Reframes Health Debates

Economic globalization, conceptualized as the increasing global interconnectedness of economic affairs, has harmed the public’s health through myriad, overlapping causal pathways. Although national economic growth has led to select improvements in health,³ the application of neoliberal economic policy to achieve that growth – through global processes of marketization, liberalization, privatization, and decentralization – has served to exacerbate disparities in health between rich and poor.⁴ Despite neoliberal economic policy’s rhetorical homage to individualism, globalization, in tragic irony, has taken responsibility for health out of the control of the individual, predetermining harm at the societal level.⁵ Thus, while globalization has resulted in

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improvements in technology and health services for a chosen few in the developed world, various globalized economic processes (as explained in the causal mechanisms outlined in Table 1) have robbed individuals of the autonomy to exercise health rights and stripped governments of the strength to fulfill them.⁶

II. Public Health Responds to Globalization: Understanding Underlying Determinants of Health

As globalization's effects began to impact morbidity and mortality rates, it became clear to public health theorists that socio-economic changes were influenc-

Table 1

Globalization's Impacts on Health

Process	Mechanism
Shared Health Dilemmas	<p><i>Double Disease Burden</i> Infectious diseases (among them AIDS, SARS, and drug-resistant tuberculosis) have spread rapidly throughout the world – as a result of global trade and travel – disregarding national and regional boundaries</p> <p>Noncommunicable diseases (from harmful food, water, and housing) and also chronic diseases (such as cardiovascular disease, cancer, and diabetes) have resulted from inequitable development</p>
Poverty and Inequitable Development	<p>Neoliberal development policies are correlated with widening financial inequalities – and correspondingly, health gaps – within states and among states in the developed and developing world</p> <p>Even where 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</p> <p>For the billions living on less than \$2/day, extreme poverty has led to dire consequences for poverty-related disease – stemming from, for example, undernourishment and a lack of access to safe drinking water and basic sanitation – and a “high death/high birth” population dynamic</p>
Deterioration of the Built Environment	<p><i>Changes in the Built Environment</i> Migration – insalubrious migration harms health where individuals from rural areas, seeking employment or escape, have migrated at unprecedented rates to urban centers that lack the infrastructure to support such influxes</p> <p>Employment – the rapid introduction of market-oriented policies has led to a bifurcation of employment opportunities and forced many to seek employment in informal economies</p> <p>Housing – slum housing is plagued by inadequate sanitation and infrastructures, creating conditions associated with significant decreases in healthy outcomes</p>
Weakening of Public Health Systems	<p><i>Structural Adjustment Programs</i> Crippling of state health systems – structural adjustment programs have left many developing welfare states without the health systems and technologies necessary to respond to the majority of the world's disease burden</p> <p>Weakening of regulations that protect health – developing governments, already under pressure to privatize, face enormous obstacles in making the long-term budgetary commitments necessary for improvements in public health and health care systems</p>
Increasing Influence of Transnational Corporations	<p>Exploiting new markets – through the threat and practice of relocation, transnational corporations have stymied national efforts to regulate their behavior, pushing states toward creating regulatory safe-havens for their operations</p> <p>Damaging environments/Creating dangerous products – the rise in inequitable trade and unregulated industrialization of the developing world, processes driven by transnational corporations, has led to local and global environmental health problems while creating products damaging to the public's health</p>

Adapted from B. M. Meier, “Employing Health Rights for Global Justice: The Promise of Public Health in Response to the Insalubrious Ramifications of Globalization,” *Cornell International Law Journal* 39 (2006): 711-77.

ing underlying determinants of health in ways that could not be accounted for by the medical model of health. Rather than being affected by medicine and clinical care, there is growing acceptance that the vast majority of health conditions derive primarily from underlying determinants of health.⁷ These underlying determinants of health – including, *inter alia*, financial resources, employment, access to potable water and sanitation services, adequate supply of safe and nutritious food, shelter, healthy environmental conditions, social stability, freedom from violence and discrimination, and health-related information and services – are addressed most effectively not through individual medical or behavioral interventions but through changes in national and international public health and social welfare systems.⁸

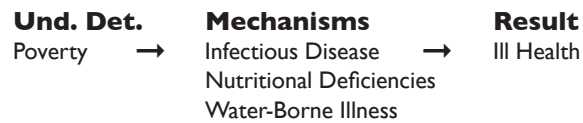
Whereas a biomedical or behavioral approach to public health focuses primarily on individual curative treatments in clinical settings, a social medicine vision of public health⁹ protects and promotes the health of entire societies¹⁰ by employing multi-disciplinary, multi-agency interventions to address the collective causes of health and disease.¹¹ Through this expanded conception of health, public health seeks not just the highest attainable standard of health for each individual, but the widest distribution of health benefits throughout society. Thus, in meeting the challenges of globalization and alleviating harm to societies, public health approaches aim “to achieve the greatest good for the greatest number”¹² and to narrow inequities in health while improving the health status of the most vulnerable.

To do so, the rise of an “ecological model” in public health has led researchers to examine structural underlying determinants of health.¹³ Drawing on a history of scholarship in social medicine,¹⁴ public health scholars focus on social suffering, often referred to as “structural violence,”¹⁵ based on the premise that “public health cannot be separated from its larger socioeconomic context.”¹⁶ Figure 1 illustrates how poverty can operate as an underlying determinant of ill health, wherein resources account for disparities in health behaviors and communicable disease, with these mechanisms in turn affecting health status. Thus, absolute poverty is seen as a fundamental underlying cause of ill health, operating at a societal level to harm the public’s health through a multitude of diseases and mechanisms.

It is in these evolving discourses on underlying determinants of health that public health is being “pushed 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,

Figure 1

Underlying Determinants of Health



* Absolute poverty is a fundamental underlying cause of disease, operating at a societal level and having effects on health status, no matter the disease or the mechanism.

Adapted from B. G. Link and J. Phelan, “Social Conditions as Fundamental Causes of Disease,” *Journal of Health and Social Behavior* 35 (1995): 80-94.

maintained, and organized.”¹⁷ Through this appreciation of the impact of societal underlying determinants on individual capabilities for health,¹⁸ the ecological model “implicates our collective responsibility for unhealthy behavior,” with public health practitioners examining underlying determinants of health “in the way society organizes itself, produces and distributes wealth, and interacts with the natural environment.”¹⁹

From these discourses, there has grown an awareness of public health as a public good. Among the public goods making up public health, scholars and practitioners have emphasized a variety of shared social, environmental, and structural factors – the underlying determinants of health discussed above – finding these public goods potentially more important than the private goods of medicine and health services in preventing disease and promoting health.²⁰ Under this broader construction of health, public health systems, the infrastructures for the public’s health,²¹ can be seen to alleviate harmful societal determinants of health and assure provision of the public goods necessary to create underlying conditions through which people can be healthy.²² While public health practitioners continue to develop varied proximal interventions to influence individual health (seeking to improve, for example, individual knowledge, resources, and decision-making power) almost all agree that overarching improvements in public health goals could best be achieved through public health systems.

Despite this recognized importance, the neoliberal economic paradigm undermines the supply of public goods, crippling public health systems and diminishing their ability to prevent disease and promote health. With this economic model determining the structure of globalization, “tension persists between the philosophy of neoliberalism, emphasizing the self-interest of market-based economics, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal.”²³ Although scholars and

activists have attempted to employ international legal obligations to structure globalization in a manner that does not violate the human right to health,²⁴ “[t]he grip of the liberal consensus remains powerful and may not yield readily to the suggestion that the institutions and organizations that support globalization need reorientation towards supporting socioeconomic [rights] claims,”²⁵ thereby limiting public health actors in responding to globalization’s societal health harms through individual human rights discourses.

III. The Incomplete Success of the Human Right to Health

While public health scholarship has come to appreciate the role of structural forces in determining health status through underlying determinants of health, the human right to health has remained mired in largely ineffective individualistic discourses.²⁶ Human rights scholars, employing an individual right to health – a right drafted during “the golden age of medicine,” a time when advances in medicine and curative technology led physicians to believe that a state of “complete” health was possible²⁷ – have been normatively incapable of responding to globalization’s harms to underlying determinants of health. As noted by Audrey Chapman,

Historically, health systems were developed on a curative or clinical model of health. More recently, advances in epidemiological research have sensitized policymakers to the importance of public health interventions and preventive strategies of health promotion. Social science research has also underscored the importance of social, economic, gender, and racial factors in determining health status. Nevertheless, governments have often failed to develop a comprehensive approach to health reflecting these insights.²⁸

Despite the lofty language of “health for all,”²⁹ the right to health has been advanced in the ICESCR as an individual right, focusing on individual access to health services at the expense of collective health promotion and disease-prevention programs through public health systems.³⁰ These dichotomized medicine-public health discourses have contributed to ambiguity in implementing the right to health,³¹ stymieing efforts to operationalize health rights through public health systems and enabling globalization’s legacy of deteriorating national systems that have abandoned vulnerable populations and left governments impotent to address an expanding set of societal health claims.³²

Founded upon the non-derogable right to life, the Universal Declaration of 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.”³³ 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 to include “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,”³⁴ laying out the formulation of the right to health that has since been widely replicated in various international treaties and national constitutions.³⁵

However, since the enumerated obligations of Article 12 “constitute goals as opposed to actions that member nations must take,”³⁶ this treaty language provides little guidance as to the specific scope of states’ legal responsibilities,³⁷ creating, at best, an “imperfect obligation” on states in implementing the right to health.³⁸ While states and treaty bodies have come to different interpretations as to which health services should be included within the core content of the right to health, the right has been hindered in its ability to influence underlying determinants of health because of (1) a path-dependent focus on medical services; (2) the contingent nature of obligations pursuant to the principle of progressive realization; and (3) the individual rights framework for the realization of health. These factors limit the ability of the right to health to affect the public health systems determinative of health.

The right to health was codified during a unique and unrepresentative moment in the history of ideas surrounding health, leaving it inapplicable to current public health dilemmas. By the end of the Second World War, discourses on health had veered away from the social medicine focus of public health during the course of the “golden age of medicine,” a time of perceived unlimited possibility for the advancement of medical science.³⁹ It was felt that infectious diseases could be controlled and would soon run their course within developed countries.⁴⁰ With medical therapies cutting into the spread of infectious disease, public health programs began to lose relevance and were displaced by the medical profession’s individual treatments, which sought to bring about the “end of disease”⁴¹ through the hand of the knowing physician, operating with medical tools, one patient at a time. In keeping with this medicalized conception of health, 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.⁴² Through processes of path dependence,⁴³ these formative events in the creation of the right to health have impacted contemporary institutions for health rights – a trend only exacerbated by

the advent of globalization – with the right to health’s focus on medicine neglecting the systems required for public health and social justice.

Compounding national impediments to implementing the right to health through health care, responsibility to realize the right to health is viewed as resource dependent.⁴⁴ In accordance with the principle of progressive realization, promulgated 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.”⁴⁵ Accordingly, through the linkages between the “available resources” standard and “achieving progressively” provision, the universality of human rights loses its rigidity in the context of health.⁴⁶ Under the ICESCR’s framing of the right to health, states may justifiably differ in their actions based upon their respective political will, disease prevalence, and economic resources,⁴⁷ so long as their compliance efforts “move as expeditiously and effectively as possible towards the full realization of Article 12.”⁴⁸ This contingent standard for state obligations has set the conditions for a “flawed enforcement mechanism,” through which no state can be held accountable for its failure to achieve healthy conditions.⁴⁹ Because of this shifting obligation for the realization of health, holding states to only a modicum of effort in health care, the principle of progressive realization has hobbled efforts to create standards, indicators, or benchmarks for operationalizing the right to health.⁵⁰

A belated attempt to reverse this neglect of public health was made in 2000 when the Committee on Economic, Social and Cultural Rights (CESCR) – the legal body charged in the ICESCR with drafting official interpretations of, and monitoring state compliance with, the ICESCR – took up these issues surrounding the right to health in drafting General Comment 14.⁵¹ Finding the right to health to be subject to evolution over time, the CESCR sought to interpret the individual right to health in light of expanding definitions of the concept of health, drawing together the interdependent positive and negative rights frameworks that impact a state’s ability to respect, protect, and fulfill the right to health.⁵² With the CESCR viewing the curative conception of health in Article 12 as anachronistic in light of modern understandings of health disparities,⁵³ the Committee implicitly acknowledges a correlation between individual and public health, finding within the right to health a responsibility to provide access to public health services and information.⁵⁴ This collective framework for examining individual health was consistent with the scholarly interpretation of the right as requiring national planning through a

population-wide view of public health.⁵⁵ The CESCR, through its previous review of country reports, 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.⁵⁶ General Comment 14 provided 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 ambiguous obligations not yet codified.

Even where the CESCR does not explicitly label its strategies as public health, it nevertheless solidifies the public health underpinnings of the right to health, holding that there exist governmental responsibilities to address “underlying determinants of health.” According to the text of Comment 14, the right to health extends

not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.⁵⁷

Furthermore, in expounding the obligations necessary to fulfill these constituent rights, General Comment 14 speaks not only to the individual as a bearer of rights, but also specifically to a state responsibility to assist “communities,” “groups,” and “populations.”⁵⁸ Addressing the subject of public health directly, even if not explicitly naming it a right, General Comment 14 observes, almost as an afterthought in its penultimate footnote, that

States parties are bound by both the collective and individual dimensions of Article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.⁵⁹

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.

Although the CESCR has found the individual right to health to include collective rights to an expansive public health system through these implicit and explicit formulations of international law, General Comment 14 is legally insufficient to establish a col-

lective 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 preponderance of its normative weight behind aspects of health services (availability, acceptability, accessibility, and quality)⁶⁰ and thereby continuing to advance individual medical/technological solutions to problems requiring societal reforms. Like much contemporary human rights scholarship, it supports an individual right while acknowledging that human rights are necessarily embedded in their social context, and thus that “individual human rights are characteristically exercised, and can only be enjoyed, through collective action.”⁶¹ As a result of its promulgation of such expansive obligations, General Comment 14’s conception of the right to health 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,”⁶² reinforcing admonitions that the proclamation of new human rights through interpretation trivializes the human rights regime and delegitimizes more firmly established rights.⁶³ By virtue of the individual nature of the right it interprets, General Comment 14 cannot adequately obligate states 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,”⁶⁴ its interpretations of the ICESCR lack the self-executing authority and detailed, explanatory reasoning integral to the development of national and international policies.⁶⁵ General Comment 14 is necessary but not sufficient to obligate states to realize underlying determinants of health through public health systems. For rights scholars to advance disease protection and health promotion, they must look beyond individual rights frameworks to codify collective international legal obligations commensurate to a public health-centered response to globalization.

IV. A Collective Right to Public Health

Many scholars and activists have looked to human rights in responding to the harms of globalization. Despite years of human rights scholarship and advocacy, however, there remain debates surrounding even the recognition and applicability of existing social and economic human rights in addressing the consequences of globalization.⁶⁶ These lingering questions, impeding human rights in addressing globalization, stem in part from an individualistic conception of human rights that is incapable of speaking to the societal ramifications of globalization. It is at the societal level – the level at which globalization operates – that human rights must respond. By transmuted discourse from individual to collective rights, human rights can

combat globalization’s societal harms, giving states the legal tools necessary to fulfill the public’s right to health through public health systems.

Achieving the highest attainable standard of health in a globalized world will require states to meet health promotion and disease prevention goals through public health systems, thereby fulfilling the collective rights of its peoples to the “conditions in which people can be healthy.”⁶⁷ With globalization impacting entire societies, collective rights and their corollary implementation mechanisms become essential to assuring the collective action required to provide for underlying determinants of health through the tools and shared benefits of public health.⁶⁸ While it has long been held that promoting the general welfare is inherent in state sovereignty, it has not heretofore been presented in the lexicon of human rights as an obligation of the state or international community. Collective rights acknowledge this obligation by “assigning rights and obligations to the principal agents able to advance global public goods in the late twentieth century,”⁶⁹ thus creating legal responsibilities to address the provision of public goods at the societal level. In the case of advancing health rights, this involves assigning rights at the societal level for state public health systems.

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

Human rights were initially conceived following the Second World War solely as individual rights. Whereas rights had previously been accorded to minority groups in the aftermath of the First World War, it was felt by leaders of the victorious Allied Powers that this elevation of collective minority rights had facilitated many of the ethnic tensions that culminated in the Second World War.⁷⁰ Following this War, the rights-bearer would be conceptualized as the sovereign individual.⁷¹

However, as decolonization rapidly progressed and the United Nations expanded several-fold, nascent member states, those that had not taken part in the original drafting of the UDHR and subsequent Covenants, forced a reexamination of this individualistic conception of human rights. Collective human rights were first advanced in the late 1960s by the Non-Aligned Movement, a loose grouping of developing states in Africa, Asia, and the Middle East that had banded together to advance their interests against the two major superpowers. Viewing traditional human rights frameworks as an extension of neo-colonial domination, these developing states attempted to advance so-called “solidarity rights” in international law as a means of freeing states from the societal binds of international relations.⁷² Relegated by the supremacy of individual rights in early treaties, col-

lective rights received their first imprimatur in the African human rights system,⁷³ and following several successful attempts to imprint collective rights in international declarations,⁷⁴ scholars have put forth arguments to recognize collective rights to, *inter alia*, development, environmental protection, humanitarian assistance, peace, and common heritage.⁷⁵

Often referred to now as “third generation” rights, a discursive remnant of the Cold War, collective rights operate in ways similar to individual rights, often seeking the same goals. Rather than operating through the empowerment of the individual, however, collective rights operate at a societal level to assure public benefits that can only be enjoyed in common with similarly situated individuals but that cannot be fulfilled solely through individual rights mechanisms.⁷⁶ While lacking the humanization of suffering addressed through individual rights,⁷⁷ and often decried by Western scholars as mere communitarian appeals to cultural relativism,⁷⁸ collective rights have nevertheless proven effective in shifting the balance of power in international relations – creating widely recognized, if not always realized, entitlements in international law – and responding to the societal effects of globalization.

B. Public Health as a Human Right

International legal scholars have long promoted the evolutionary nature of human rights, re-envisioning human rights to “reflect...changing needs and perspectives and respond...to the emergence of new threats to human dignity and well-being.”⁷⁹ General Comment 14 is an initial, though incomplete, part of this evolving rights framework. Despite its evolution, the right to health cannot, as an individual right, be effective in responding to the societal harms of globalization, giving rise to a need to prevent disease and promote health through collective rights mechanisms.

Moving beyond an analysis of General Comment 14 in operationalizing collective interpretations of health, it is incumbent on rights proponents 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.”⁸⁰ Globalization’s societal impacts to public health implicate collective responses to health dilemmas. Generalizing from the HIV/AIDS pandemic to modern health crises, Jonathan Mann argued that “it ought to be clear that since society is an essential part of the problem, a societal-level analysis and action will be required.”⁸¹ Such a societal framework for health necessitates a collective right to public health, obligating states to address the systematic and social conditions that underlie disease.

I. THEORETICAL CONCEPTUALIZATION

In responding to globalized processes through disease prevention and health promotion systems, a collective right to public health offers a framework for addressing societal inequities that result from globalization, altering the atomistic egoism that plagues the fulfillment of an individual right to health and pressing national governments to be responsive to all their peoples rather than bowing to the rampant individualism bred by the neoliberal engines of globalization.⁸² The market-based global economy, in directing state policy and international relations, has proven itself incompetent to speak to individual health rights and detrimental to states seeking to fulfill these rights through social justice programs.⁸³ Applying only a curative health model to societies under the individual right to health has denigrated state responsibility for the common good, relegating obligations for healthy conditions to the individual alone.⁸⁴ Yet, to the degree that the right to health, like all individual rights, is premised on the autonomy of the individual,⁸⁵ globalization’s autonomy-diminishing effects impair the ability of the informed individual to affect his or her health, thereby denying the freedom of choice pivotal to a “capability approach” to the right to health⁸⁶ and necessitating a collective approach to health rights. (For example, as seen in the cases of obesity and tobacco-related disease, globalization’s impact on underlying determinants of health – through, *inter alia*, poverty, educational opportunities, and advertising – has impinged upon the right of the informed individual to make healthy choices.⁸⁷) To combat the health disparities of a globalized world, human rights must speak to the collective social factors that underlie the onset and spread of disease, requiring states to impose societal interventions through broad public health systems that move well beyond the individual model of medicine.

If the tools of public health systems – including medical knowledge, disease surveillance, and treatment options – are public goods that, by their very nature, have meaning only in the context of societies,⁸⁸ then a collective human right to public health becomes necessary to give meaning to these public goods and to provide for their realization under international law. Like many environmental protections,⁸⁹ public health systems, based upon their non-divisible and non-excludable externalities,⁹⁰ cannot easily be divided among individuals but can only be enjoyed in common with similarly situated peoples.⁹¹ While it is intuitive for infectious disease prevention to be included among public goods, globalization processes have served to join societies in the bonds of collective suffering, converting noncommunicable disease prevention and health promotion from private goods into

global public goods.⁹² Thus, with a broad conception of public health viewed as a collective public good, no individual can rightly make a claim against the state under the individual right to health for a specific component of a public health system. Overcoming obstacles to collective action, a right to public health provides a means for coordinating the realization of public goods, alleviating underlying determinants of ill health through action taken at a societal level.

2. PROGRAMMATIC COMPONENTS

In considering the programmatic policies necessary to operationalize this theoretical construct, a collective right to public health would buttress the sustainable

public health systems necessary to address underlying societal determinants of health. This would be in accordance with the preamble to the WHO Constitution, which declares that governments have a responsibility to provide both adequate health and social measures.⁹³ These social measures, as noted by Aart Hendriks,

entail...a duty for States to undertake measures aimed at the creation of conditions favourable to the achievement and maintenance of the highest attainable level of health, notably by gradually improving the socio-economic conditions which may hamper the realization of this right, and is not

Table 2

Substantive and Procedural Components of a Collective Right to Public Health

Substantive	Procedural
<p><i>Core content</i> Comprehensive public health law modernization and bureaucratic reorganization</p> <p>States could implement cost-neutral structural, regulatory, and bureaucratic facets of disease prevention that can be considered essential for protecting public health because of either a particular disease's or a particular program's societal effect on morbidity and mortality</p> <p><i>Funding-dependent obligations</i> Bounded inherently by the logic of progressive realization, states and the international community would be obligated to scale-up public health systems and other infrastructures necessary for the provision of public goods</p> <p>States could prioritize resources toward those health promotion programs scientifically proven to provide the greatest good to the greatest number of persons, a utilitarian hallmark of public health administration</p> <p><i>Equity</i> In speaking to underlying determinants of health, a collective right to public health would create equality in realizing its minimum core standard and peripheral obligations</p> <p>Compared with individual medical services, which states provide preferentially rather than universally, public health systems could provide equitably for minimum societal-level health standards for all persons, giving states the authority to employ their limited means to prevent disease and promote health at the collective level through public health systems</p>	<p><i>Standards</i> Benchmarks to national and international bodies in uncovering insalubrious societal conditions and guiding states in their allocation of health resources</p> <p>A right to public health could frame concrete, measurable, and readily available national indicators by which states could accurately report the state of health in their respective territories, and international treaty bodies could better gauge and adjudge these states' reports on the realization of health rights, assuring state accountability</p> <p><i>Justiciability</i> As compared with obligations of conduct (measured through resource allocations), a right to public health would permit international bodies to hold states to obligations of result, with these results quantified easily through minimum national public health indicators (e.g., life expectancy, infant mortality)</p> <p>By expanding the population under consideration, public health practitioners could appreciate the causal significance of anomalies in health status at the national level and correlate these anomalies with underlying determinants of health</p> <p><i>Policy remedy</i> Collective claims to systemic public health interventions and sustainable national public health systems</p> <p>In development discourses, a right to public health would provide the state with a normative framework for debating the lending policies of the IMF and World Bank and trade policies of the WTO, protecting health infrastructures during structural adjustment and trade negotiations and shaping national public health systems to address those most vulnerable to the ramifications of globalization</p>

confined to ensuring adequate health promotion measures or guaranteeing a comprehensive health care insurance and delivery system.⁹⁴

By emphasizing the social measures necessary for health, a right to public health would underscore the indivisibility of all human rights as underlying determinants of health, fulfilling these interconnected rights through public health systems. Table 2 outlines this programmatic framework by enumerating the practicalities that would be necessary at substantive and procedural levels to develop enforceable state obligations under a right to public health.

C. Harmonizing Individual and Collective Health Rights

Although Western scholars have often presupposed an opposition between individual and collective human rights,⁹⁵ this distinction appears inappropriate to the modern era of globalization, particularly in the field of health, where the goals of individual and collective rights frequently overlap. Collective rights operate in ways similar to individual rights, often seeking the same goals as individual rights while acting at a societal level to ensure public benefits that cannot be fulfilled through individual rights mechanisms. Thus, in situating and operationalizing health rights, a collective right to public health can be seen to complement, not deny, the individual right to health.

Despite this complementarity, Western libertarian theorists continue to give reflexive preeminence to individual rights, subordinating the state's collective obligations for public health where even a slight abridgement of individual liberties exists.⁹⁶ This zero-sum view of individual and collective health rights has led to a largely false dichotomy in state obligations for health, encouraging states to apply individual curative interventions for health harms best confronted through public health systems. Through globalization, this Western model has been transplanted to developing states, limiting rights scholars in developing a global public health ethic.⁹⁷ As a consequence, global public health, and the individuals who comprise the public, have suffered.

By harmonizing individual and collective human rights, it becomes apparent that there need not always be a tradeoff between advancing individual human rights and promoting public health. Consequently, the individual and public components of health rights should not be seen as mutually exclusive but rather as interdependent means necessary for a life with dignity.⁹⁸ In a globalized world, the collective enjoyment of public health is a precondition for an individual human right to health, with public health systems

addressing the collective determinants of health outside the control of the individual. Through a right to public health, the discourse of collective rights can be used to supplement individual rights in realizing the highest attainable standard of health for all.

V. Conclusion

While health is a fundamental human right, without which other rights would not be possible, those committed to health rights cannot move forward solely on the inertia of an established individual right to health. The social transformations inherent in globalization engage an evolving framework for health rights. With globalization transforming health risks from the individual to collective level, responding to changes in underlying determinants of health demands the evolution of health rights to encompass a collective right to public health.

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