

The Highest Attainable Standard: The Implications of an Evolving Human Right to Health for Global Public Health and International Health Systems

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This dissertation attempts to uncover the discourses that have led to the evolution of legal norms encompassing the right to health, examining how such norms have evolved in international law since their proclamation in the 1948 Universal Declaration of Human Rights (UDHR) and codification in the 1966 International Covenant of Economic, Social and Cultural Rights (ICESCR) as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Despite a burgeoning stream of analysis on the scope and content of the right to health,¹ there has been little reexamination of the foundations of this right. While others have laid out the course of events that led to the drafting of the right to health in article 12 of the ICESCR, no scholar has yet attempted to uncover the ideas that led to the development and evolution of this right. For example, Brigit Toebes—whose text, “The Right to Health as a Human Right in International Law,” remains the leading scholarly exposition of the right to health—notes that “[i]n the absence of a record of the reasons of the drafters” of the right to health, the reasons underlying the language of the right to health “remains largely a matter of guesswork” (Toebes 1999, p. 32). This lack of debate concerning the historical construction of health rights, a discussion no international body has addressed in any detail,² has limited efforts to provide guidance as to the specific scope of states’ obligations under the right to health and left states with little appreciation of the

¹ Where once U.S. legal scholarship shunned the right to health (with only one major article in a U.S. law journal focused on the right to health under the ICESCR between the advent of the right to health in the ICESCR in 1966 and the end of the Cold War in 1990 (Leary 1988)), contemporary events—including the end of the Cold War, the HIV/AIDS pandemic, and the harms of the neoliberal economic model—have engendered revitalized interest on the right to health within a growing interdisciplinary community at the intersection of public health and human rights (e.g., Hendriks 1998; Nielsen 1999; Chapman 2002; Yamin 2003; Gostin & Gable 2004; Ruger 2006).

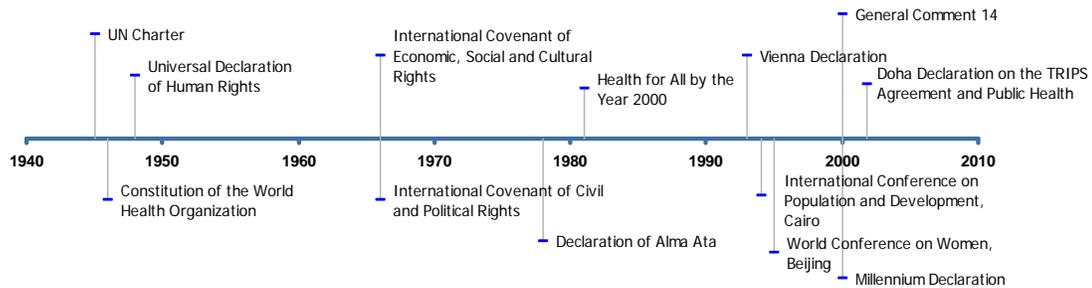
² Although the Committee on Economic, Social, and Cultural Rights (CESCR) has recently found the right to health in the ICESCR to have evolved over time (CESCR 2000)—finding within it ascertainable state obligations for disease prevention and health promotion—the CESCR’s General Comment on the right to health has become subject to criticism for “find[ing] no support in the text of the Covenant or in its negotiating history” (Gorove 2004).

reasoning upon which they are to accept obligations to provide governmental interventions that were not considered at the time of the ICESCR's original drafting and promulgation. To inform this debate in a way that will give credence to state obligations to respect, protect, and fulfill the right to health, it is necessary that scholars, policymakers, and advocates understand the disparate underlying discourses and reasoning that culminate in changing the meaning of 'health' and the scope of the human right that upholds it.

The proposed study—researching the history of political, legal, and medical thought underlying the various conceptions of the human right to health—analyzes the grounds upon which the right to health has evolved in international law since the end of the Second World War. The analysis proceeds in four parts. The first part of this study investigates the history of ideas that led to the codification of a right to health in the ICESCR, seeking to uncover the underlying normative discourses that led to the development of the right to health and the corresponding state obligations deriving from that right. Tracing the evolution of the right to health in response to changing health threats, theories, and technologies, the second part of this study charts the expanding scope of the right to health through its interpretations in scholarly discourse and manifestations in international documents subsequent to the ICESCR, including, *inter alia*, the Declaration of Alma Ata, Health for All by the Year 2000, the International Conference on Population and Development, the World Conference on Women, and General Comment 14 to the ICESCR (highlighted in Figure 1, Documents Framing a Human Right to Health).

While the right to health can be shown to have evolved in international legal discourse, such an evolution of the right to health—intrinsically bound as an individual human right—does not address underlying determinants of health through public health systems, a necessary public health imperative in combating the insalubrious effects of global economic policy. While the first two parts of this study would be sufficient to justify a doctoral dissertation based upon social scientific study, the traditions of legal scholarship demand that research not exist in a scholarly vacuum but go beyond findings of fact to contribute, through policy proposal, to the active progression of law. Undertaking such a proposal to close the identified gap between existing human rights obligations and current understandings of health threats, theories, and technologies, the third part of this study proposes the codification of a collective right to public health in international law as a means of responding—at the national and international level—to societal underlying determinants of health. In translating this right to public health from theoretic conceptualization to programmatic reality, this study offers in its fourth part a means for the World Health Organization to employ international treaty law in realizing a right to public health, using coordinated legal mechanisms to revitalize the national and global public health systems necessary to assure the highest attainable standard of health for all.

Figure 1: Documents Framing a Human Right to Health



I. Methodological Considerations

This proposed dissertation research examines how health discourses have been translated into international legal norms through the human right to health. Under the hypothesis that *the right to health has evolved over time and in relation to developments in health threats, theories, and technologies*, this study looks historically at the association between legal norms of the right to health and health discourses of underlying medical and public health literatures, researching the processes that led to the internationalization of health discourses in human rights law and the subsequent shifts in international health jurisprudence based on changes in these health discourses. To do so, this study defines the scope of the right to health based on state international legal obligations, looking not solely to international law as the foundation of such a right but also to the debates that preceded each codification in international legal discourse. Such a model implicates the study of law not simply as the content of adopted treaties or jurisprudence, but the study of the underlying processes and interactive dynamics of adopting or implementing norms, examining the social environment for legal reform of the right to health through the discourses of medicine and public health.

This research is grounded in the methodological understanding that (1) the language of human rights is a means by which states support their shared norms and (2) the language of health and medicine is a means by which scholars, practitioners, and advocates advance explanations for health causes and solutions. The relationship between these two dialectics will form the basis of this dissertation research, examining the effect of changing *health threats, theories, and technologies* on the codified norms that compose the human right to health. To complete this examination, the present study will employ legal research methods to analyze changes in the language of the human right to health, assessing underlying health discourse through discourse analysis of associated health literatures.

A. Legal Analysis

The study of legal norms, beginning as early as Aristotle's questioning of the meaning of justice, has long been a focus of study in political science. In concretizing these norms, the end of the Second World War brought with it an understanding that

international human rights norms must be codified, enforcing morality through power under international law (Carr 1946). Given the law's role in memorializing and reifying these norms (Mill 1881), legal analysis is well suited to studying changes in ideas as they are manifested in international law, providing insight into the socially-constructed 'evolution' of human rights over time (Donnelly 1994).³ Within this methodological framework, the proposed research charts the meaning of these historically contingent and changing norms composing the 'right to health' under international law.

While it is generally accepted that human rights evolve in response to 'standard threats' (Shue 1980), few before have attempted to study this normative evolution of a human right.⁴ This dearth of research is pronounced in the right to health, where no previous scholar has attempted to trace the ideational development of international health rights. Viewing rights as state-constructed legal principles rather than divinely-endowed panacea (Slaughter et al. 1998),⁵ it becomes possible to chronicle the ideational development through which human rights come into being and 'evolve' over time, employing social scientific research to provide causal theories for the law's association with social norms (Riles 1994). From this positivist framework has arisen a burgeoning stream of interdisciplinary research (Slaughter 1993), with international legal researchers employing theories of international relations to explain, *inter alia*, the social construction of shared global norms under constructivist human rights theory (Koh 1997). Pursuant to constructivist theory, norms, collective understandings of appropriate behavior, have explanatory force independent of state situational constraints, and thus, international law relies on ideas, values, and norms that exist separate from the distribution of state power (Finnemore 1996; Finnemore & Sikkink 1998). Emphasizing an interaction between state interests and social structures, constructivism finds that state goals are endogenous to state interactions with institutions, with norms determining state preferences in both goals and the means to achieve those goals (Kratowill & Ruggie 1986).

³ The human rights regime presents itself as the final, unchanging stage of human development. Whereas rights may evolve along a progressive trajectory, there is no room in the lexical supremacy of human rights for the possibility of cyclical retrogression. This lexical primacy presents particular difficulties for a human right drafted during a unique period in time not representative of current thought on an issue, a difficulty this research takes up in the study of the right to health.

⁴ While other have studied international norm convergence in issue areas ranging from women's suffrage (Ramirez et al. 1997) and apartheid (Klotz 1995) to nuclear weaponry (Risse-Kappen 1994) and humanitarian intervention (Finnemore 2003), no scholar has examined the extent to which norm convergence for a human right is encapsulated in international law.

⁵ Within legal discourses, human rights, based on natural law discourses of the Enlightenment and extended through Western liberalism, were originally thought to have theistic or rationalist foundations, with inalienable principles derived from a 'Supreme Being.' A secular counter to the theistic rights foundation has been found in positivist foundations, wherein human rights exist as entitlements granted by the authority of the state, with these state-derived rights holding neither universal nor inalienable authority over the sovereign. Based in a mixture of these foundations, many legal scholars have looked to "human dignity" as the "moral theory of human nature" on which human rights can be based (Donnelly 1985). Extending Rawls's theory of justice internationally, equal liberty is seen to reinforce theories of natural law, with human rights providing the norms for what is just and good in order to create a shared social purpose (Kratowill 1989) and capabilities for human functioning (Nussbaum 1992).

Under a societal approach to constructivism, this study situates ‘regulative norms’—norms ordering state behavior—in the formalistic language of human rights jurisprudence,⁶ viewing the development of each international human right as an iterative process indicative of a global set of norms (Ruggie 1998). These international norms are encapsulated in treaties and then elaborated through treaty enforcement bodies, international conferences and declarations, state practice, and judicial enforcement (Slaughter et al. 1998). In this sense, international law reflects the negotiated codification of global norms already in existence and reifies those norms until revised through normative evolution and subsequent legislative or jurisprudential amendment (Alston 1984). During this process of normative change, individual state and nongovernmental representatives harmonize individual state norms (negotiating potentially conflicting norms), advancing these ideas about collective morality into international legal obligations (Müller 2001), which are then incorporated into national law and internalized by states (Koh 1997).⁷

Rather than looking at the right to health as a singular idea or state obligation, this analysis will delineate the right to health into component norms—each of which can independently emerge, evolve, and spread over time (Wiener 2003)—in order to examine the evolving meanings of health rights through the health discourses that presaged them. By disaggregating the right to health into discrete ideas, this study will document the independent evolution of these ideas and analyze their individual contribution to an evolving right to health, using these ideas to describe how international texts construct norms for the state’s distribution of social goods. The specific ideas examined in this study, while not precisely designated, fall under two major headings of state duties under the right to health, (1) health services and (2) health systems, with each of these government obligations divided into three substantive areas: (a) Communicable Disease Control, (b) Non-Communicable Disease

⁶ In determining the content of human rights law, while these norms governing state behavior need not be codified through treaties—as judgments of appropriate behavior clearly are made even in the absence of legal proscriptions—international law has become the predominant way of memorializing global regulatory norms (Finnemore 2000).

⁷ Applying a “tipping point” model (Sunstein 1997) to global norm development in international relations, norms are seen to reach a ‘tipping’ point, followed thereafter by “norm internalization,” broad international acceptance through which states bundle together and incorporate the newly accepted values into the language of human rights and subsequently incorporate those rights into national law (Finnemore & Sikkink 1998). While others have studied this last stage of the tipping point process, norm internalization, to describe how treaty law “generates a legal rule which will guide future transnational interactions between the parties [and]. . . help[s] to reconstitute the interests and even the identities of the participants in the process” (Koh 1997, p. 2646; Hathaway 2002), an understanding that norms influence state behavior says little for the origin of these norms or how they change over time, questions addressed only through a societal approach to constructivism. Recognizing the dearth of scholarship on the origin of rights, this study focuses on the development and change of those norms at the international level rather than compliance with international norms at the domestic level. By looking solely at the development of the right to health in international legal discourse, this study avoids any behavioral research on the influence of the norms within the right to health on the actions of states, which would require state-specific research examining how norms are implemented through their recognition by national governments and exercise by individuals (Donnelly 1986). While the right to health can only find meaning through its codification in national constitutions and incorporation in the social value systems of individuals, such an examination of the internalization of the right to health by states is beyond the scope of the present study.

Control/Health Promotion, and (c) Underlying Structural Determinants of Health. This framework—depicted in Table 1 below and described in the paragraphs that follow—will allow for a more nuanced description of the progression of legal thought within the right to health, allowing comparisons of the individual legal norms that have been altered incrementally within international legal standards.

Table 1: Examples of Component Norms of the Right to Health

	Health Services	Health Systems
Communicable Disease Control	Vaccination/Treatment	Quarantine/Isolation Laws
Non-Communicable Disease Control/Health Promotion	Curative Health Care	National Health Service
Underlying Structural Determinants of Health	N/A ⁸	Clean Water Infrastructures

First, communicable disease control is the cornerstone of international legal obligations under the right to health. With state obligations long predating the codification of a right to health, communicable disease prevention is relevant as a matter of international concern separate and apart from the human rights regime (Barkhuus 1943). Grounded in the work of epidemiology, communicable disease control had long been a foundational principle of international health agencies, with these responsibilities passed to the World Health Organization (WHO) at the conclusion of the Second World War (Fidler 1999). Because communicable disease prevention necessitates state action (Pannenberg 1979), there is practical global demand for international norms to control the actions of states at the national level, a demand that was addressed in WHO’s expansive constitutional mandate of facilitating the cooperation of all countries in attaining the highest possible level of health (Alary 1995). Flowing from this international obligation, state duties for disease prevention were codified in article 12 of the ICESCR, which recognizes a right to “the prevention, treatment and control of epidemic, endemic, occupational and other diseases” (ICESCR 1966, art. 12(2)(c)).

Second, non-communicable disease control has gained emphasis through the right to health’s turn toward primary health care, a process for health promotion derived from the definition of ‘health’ in the WHO Constitution: “health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO 1948). Despite an early emphasis on health promotion systems, the right to health has come to be characterized as a right to health care services (Chapman 1994). In 1978, as the ICESCR was entering into force, representatives from 134 state governments adopted the Declaration on Primary Health Care, a document that has come to be known as the Declaration of Alma Ata (WHO 1979). The Declaration of Alma Ata focuses on the equitable provision of primary health care, outlining obligations on states to provide

⁸ As is the premise of the third part of this dissertation study, an improved understanding of underlying determinants of health has clarified the importance of health systems in disease prevention and health promotion and highlighted inherent limitations in the evolution of the individual right to health.

“essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford” (Ibid.). In this emphasis on care, health promotion soon moved away from equity-based pronouncements and, driven by a ‘medical-industrial’ complex, toward a curative model of health services through medicine (Cueto 2004). This medicalization of the right to health was incorporated into WHO guidelines the following year under WHO’s strategy document, *Health for All by the Year 2000* (WHO 1981) and continues into the present day through global emphasis on access to medicines (Hogerzeil et al. 2006).

Lastly, the concern of international law with underlying determinants of health is of both antiquated and recent origin. Social medicine—a movement arising out the industrial revolution in pre-1848⁹ Prussia and France and revitalized in Great Britain during the Second World War—has long viewed medicine as an interdisciplinary social science necessary to examine how social inequalities shape the experience of disease (Virchow 1848). Finding that illness has multiple social causes, social medicine scholars have long looked to social and political reform (i.e., health systems), rather than medicine, as a means of health promotion (Ryle 1948; Sand 1934). This understanding of social medicine has been rediscovered through increased study of underlying determinants of health, finding contemporary focus in the ‘multi-causal’ determinants of health model and the examination of health on the basis of social class (Marmot et al. 1987). Through the underlying determinants of health laid bare through neoliberal global economic policies (Kim et al. 2000) and the rise of the “ecological model” in public health (Susser & Susser 1996), health rights have returned to their social medicine foundations (Oppenheimer et al. 2002). In 2000, the Committee on Economic, Social and Cultural Rights (CESCR), the legal body charged with drafting official interpretations of and monitoring state compliance with the ICESCR,¹⁰ took up these issues surrounding the right to health in drafting General Comment 14, holding that there exist governmental responsibilities for addressing these “underlying determinants of health” (CESCR 2000, ¶ 11). 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.

To determine the content of these legal norms, this study will employ international legal research and legal analysis to understand components of the normative content of the right to health under international law. Expressions of health rights are found in accepted written sources of international law: formal international law (international treaties and conventions, international custom, general principles of

⁹ The year 1848 marks the wave of leftist revolutions that swept across European states, which, while largely failing to overthrow regimes, resulted in vast changes in national social policies. With physicians taking a large part in the revolutionary discourses, the public’s health would play a prominent part in post-1848 health policies despite the failure of the revolutions (Rosen 1974).

¹⁰ In 1985, the United Nations Economic and Social Council (ECOSOC), the body charged with this enforcement 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 1966, art. 16).

law, and judicial decisions and the writings of scholars), “soft law” (non-binding declarations), and scholarship (Henkin 1990), with each passing codification generating increased specificity and complexity in governmental human rights obligations. In uncovering these legal obligations, this study will look to: (1) published treaty language and official preparatory documents (*travaux preparatoire*) (formally indexed by the United Nations); (2) official conference proceedings and programs of action (available electronically); (3) treaty and official committee archives (collected by professional archivists and stored by the United Nations or one of its ancillary organizations); and (4) legal scholarship from multiple country contexts (collected and enumerated by the CESCR). Where there are gaps in the documentary record, these sources will be clarified, complemented, and supplemented by interviews with key informants, identified through a snowball sample of individual policy actors who had key roles in developing health rights in international law. These semi-structured interviews—beginning with leading human rights analysts at international and non-governmental organizations—will assist in identifying the norms developed through the right to health and in framing themes for discourse analysis of the health literatures.

B. Discourse Analysis

Flowing from this understanding of the changing legal norms inherent in the right to health, the purpose of this study is to examine how these disaggregated norms evolve in response to the discourses that underlie the substance of the right, in this case, semantic content shifts in the discourses of medicine and public health. In understanding the evolution of the human right to health, this study views the international legal language of the right to health to be defined both by historically prior legal language (intertextuality constraints) and by health discourses exterior to the law (interdiscursive relations) (Foucault 1972). To examine the ideational underlying mechanisms¹¹ at each stage of norm advancement, it is necessary to examine the microfoundations of these normative turns through historical research and discourse analysis (Cook, Dickens & Fathalla 2003). This historical research of health discourse will examine how health scholarship and activism support efforts to bring social facts to the development of the human right to health. To trace the history of the ideas composing the right to health in international legal texts, the proposed research will study the manner in which health discourses are translated into the language of human rights, elucidating the complex and coordinating interactions of these discourses in changing the meaning and application of a human right to health. To do so, this study will look to official United Nations clarificatory documents, preparatory documents, and secondary texts—those scientific, medical, and public health writings preceding and immediately following each respective international legal standard on the right to health. Drawing on the medical and public health literatures surrounding these facets of health discourse, this study will employ

¹¹ This study refers to these mechanisms as ‘underlying’ rather than ‘causal.’ Like many studies within law and international relations, the broad nature of the study, causal imprecision, and the substantial likelihood of reciprocal causality limit the verifiability of results, and while these ideational mechanisms are correlated with normative development in the right to health, methodological limitations prevent any attribution of causality to this study’s conclusions.

discourse analysis to analyze the ways in which such literatures alter the meaning of the ‘highest attainable standard of health’ over time.

Discourse analysis examines language in search of meaning, providing an understanding of how and why the language in question was formed and operates (Gee 2005). Eschewing essentialism (the persistence of meaning over time), discourse analysis allows for the exploration of the changing meaning of a concept, looking to the social construction of that concept. Through an analysis of the conceptual language underlying international law, it is possible to construct the authors’ perspectives on reality and social construction of that reality, situating international legal texts in the historical context of, for example, their legal, political science, or medical/public health literatures (Wiener 2003). It is these types of literatures that make up discourses, “[a] group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures” (Lupton 1992, p. 145). As such, discourses can provide for the investigation and analysis of social theories and, correspondingly, the development of norms in international law (Milliken 1999).

This study will examine how constituent norms of the right to health evolve in international law in response to underlying health discourses, particularly those changing discourses in social medicine, public health, and health systems and services. Secondary texts in medicine and public health have particular relevance in uncovering the discourses underlying international law for health. The language of human rights has meaning only through social practices, and it is ancillary texts—legal and non-legal alike—that both identify state practice with regard to rights and provide historically-situated evidence of the development and evolution of those norms.¹² With specific regard to the content of the right to health, scientific, medical, and public health developments have identified threats to health, framed the theories by which health is defined, and shaped what states can do by applying technologies to assure healthy conditions. Through an analysis of these health discourses, this research will study the manner in which underlying discourses are transmuted into the norms of human rights, elucidating the complex and coordinating interactions of these discourses in changing the meaning and application of a human right to health.

The types of underlying discourses examined in this study fall under three major headings—Health Threats, Health Theories, and Health Technologies—the discursive underpinnings of which are discussed in greater detail in Table 2 below and the paragraphs that follow. Through dramatic paradigm shifts in these discourses, new or ill-considered health threats have led to revolutionary new perspectives in health theories,

¹² In the study of the language of secondary texts, language must be analyzed as a reflection of its national, cultural, and linguistic origin. Within this framework of multiple discourses culminating in international law, it is vital that the present study identify documents written in all accessible languages and consider those documents based upon the national perspective of the respective authors and the linguistic differences through which those perspectives are related. To accomplish this, all efforts will be made through collaborative relationships to locate relevant foreign language documents, have these documents translated into English, and consult with native legal scholars to verify an accurate reading of the text.

which in turn have led to breakthroughs in the development of health technologies. It is these discursive pathways that will form the basis of the present discourse analysis.

Table 2: Typology of Health Discourses

	Health Discourses Underpinning the Evolution of a Human Right to Health
Health Threats	<ol style="list-style-type: none"> 1. Structural determinants (e.g., war, famine, environmental harms/natural disasters) 2. Communicable diseases (e.g., smallpox, tuberculosis, malaria) 3. Non-communicable diseases (e.g., cancer, occupational health) 4. Global interconnectedness (e.g., neoliberal development policy)
Health Theories	<ol style="list-style-type: none"> 1. Social medicine 2. Public health model for communicable disease 3. Chronic Disease Model/Curative health care 4. Structural violence/Underlying determinants of health
Health Technologies	<ol style="list-style-type: none"> 1. Sanitation 2. Medication 3. Vaccination 4. Trade

First, health threats—whether man-made, as in the cases of war and poverty, or natural, in the form of existing infectious diseases, emerging infectious diseases, and non-communicable diseases—have led to the recognition, depiction, and categorization of risks to health within the public health and medical communities. Second, in responding to these changing health threats, public health and medical practitioners, scholars, and advocates have developed a succession of prominent theories to conceptualize determinants of health (e.g., microbial, eugenic, behavioral, and ecological models), with each model serving to create unique policy approaches to disease prevention and health promotion. Third, in applying health theories to health threats, technological advancements—including diagnostics and treatments—have structured these policy responses in the form of specific health services and health systems. Taken together, these evolving discourses surrounding health threats, theories, and technologies have altered understandings of the meaning and limits of ‘health’ and consequently the government obligations for fulfilling these healthy states of being.

In applying discourse analysis to assess how these health discourses shape the scope and content of the right to health, this research examines the shared language of health threats, theories, and technologies in medicine and public health at specific moments in time surrounding codifications of the right to health. Guided by various “building tasks” of language—significance, relationships, politics, connections, knowledge, and sign systems (Gee 2005)—this analysis will trace the historical evolution of language in the medicine and public health literatures and how such mutually agreed-upon language reflects and constructs evolving states of health knowledge (Schiffren,

Tannen & Hamilton 2001). Sampling documents throughout major medicine and public health publications, this discourse collection will continue until theoretical saturation, when a complete range of themes is represented by the data (Starks & Trinidad 2007). In analyzing this discursive data, interpretation of the identified themes through an ordering of the building tasks will identify and isolate central themes of the literatures (Gee 2005).

II. Summary of the Research

This research is based on the hypothesis that punctuated shifts in thinking about health threats, theories, and technologies have led to associated (if not always corresponding) changes in the scope and content of the human right to health. By elucidating the effects of these factors in changing the conception of health rights, this study will provide scholars with valuable frameworks to form the basis of future quantitative and qualitative research on the right to health and provide human rights jurists and advocates with an improved understanding of evolving state obligations for public health.

As discussed above, this dissertation study shall proceed in four distinct parts, which shall take their form in the development of four separate sections on the evolution of the right to health. The initial study proceeds in the first two parts in accordance with the methods outlined above: first, examining the meaning of the norms inherent in the right to health at the time of its codification in the ICESCR, and second, describing the changes in health threats, theories, and technologies that have forced reexaminations and expansions of these norms making up the right to health. In many respects, this conceptualization of a right to health finds article 12 of the ICESCR as both the culmination and codification of all prior discourse on health rights and the foundation of a steady progression of scholarship defining article 12's obligation to provide for the "highest attainable standard" of health.

Preliminary research finds that the right to health was borne of a unique and unrepresentative moment in the history of ideas surrounding state obligations for health. Health advocates had long considered the obligations of governments for respecting, protecting, and fulfilling the conditions necessary for their peoples to be healthy. However, these discourses changed 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. This was a time of great uncertainty in the meaning of health – with the UDHR emphasizing medical care in declaring only that "everyone has the right to 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," while simultaneously, the WHO Constitution taking a far more synoptic view of health in declaring that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." As momentum for international law developed from the late-1940s to mid-1960s, the former, narrow vision of medical care as preeminently necessary for health would take hold of international legal discourse. Heightened by a belief in the unlimited possibilities of science during the 'golden age of medicine'—a sense that all the world's ills could be solved one person

(i.e., patient) at a time by the hand of the knowing physician and his medical tools—the right to health came to be exercised as a right to health care, with state obligations structurally reinforced through the political development and subsequent contraction of the welfare state. From this medicalized conception of health, rooted in the post-War era’s faith in science, the right to health was limited to the individual medical treatments then thought to be sufficient for health.

It is the expansion upon article 12’s obligations and concomitant sources of international law that will be the subject of the second part of this dissertation research. By examining evolving discourse on the right to health, the second part disaggregates the changing health threats, theoretical paradigms, and technological advancements that have driven scholars and international bodies’ expanding interpretations of the right to health in accordance with changing health discourses. Despite several expansions, however, formative events in creating the right to health impact the contemporary language of health rights, constraining the evolution of the right to health in addressing the harmful societal ramifications of global economic policy on underlying determinants of health. Economic globalization in the 1980s, with neoliberal development policy leading to the retrenchment of welfare states, highlights a break in the link between the right to health and its correlative health threats, theories, and technologies, with this decoupling limiting the effectiveness of the right to individual medical care in addressing the societal harms of globalization.

Based upon weaknesses of the individual human right to health in responding to harmful underlying determinants of health exacerbated by globalization, the third part of this study proposes a collective right to public health to complement the individual right to health in responding to these global changes. Rather than relying solely upon an individual right to medical care, envisioning a collective right to public health—employing the language of human rights at the societal level to address underlying determinants of health through obligations on the global community of states—would alleviate many injurious societal health inequities brought about by neoliberal economic policy. By emphasizing both individual and collective rights in international law, human rights can combat collective harms to the public’s health, giving states the legal tools necessary to fulfill the public’s right to health through public health systems.

Yet if globalization has presented challenges to health promotion and disease prevention, globalized institutions offer the promise of bridging national boundaries to alleviate societal health inequities under a collective right to public health. If determinants of health are outside the control of the state, global collective action through international law is essential to develop the governance structures for dealing with public health determinants and harms that take on international dimensions. This fourth part of the present study proposes that the global community of states coordinate and collaborate under WHO’s treaty-making mandate to develop a governance structure for global public health systems. International treaty-making offers states the opportunity to work cooperatively to uphold health rights, challenging the globalization of disease through the “globalization of public health.” With increasing issue complexity in the field of public health, necessitating rapid public health responses to emerging public health crises, the

need for centralized expertise and coordination from a single, autonomous organ will only increase. As seen through the experience of the Framework Convention on Tobacco Control in deriving multilateral public health obligations to combat global disease (FCTC 2000), WHO can play a vital role in developing global public health systems through international law, a role that could be augmented under the aegis of a human right to public health. Justifying international public health controls under a human rights framework would provide WHO action with the normative authority necessary to address globalization's harms to underlying determinants of health. By examining threats to global public health for what they are—violations of collective human rights—public health practitioners can build upon WHO's nascent international mechanisms to challenge global threats to public health.

III. References

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IV. Roadmap for Dissertation Chapters

- I. Birth of the Right to Health: Tracing the History of Ideas to Uncover the Meaning of the Human Right to Health
 - A. Contextualizing the Right to Health
 1. World War II
 - a. Ravages of War
 - b. Human Experimentation
 2. Nuremberg: Protecting Health by Prosecuting Physicians
 3. Aftermath of the War
 - a. Individual Human Rights as a Response to War
 - b. International Relations – Positive vs. Negative Rights
 4. “The Golden Age of Medicine”
 5. Creation and Contraction of the Post-War Welfare State
 - B. History of Ideas – Crafting a Right to Health
 1. Birth of an Idea – Health as a Right
 2. Codifying the Right to Health
 - a. UDHR
 - b. Constitution of the World Health Organization
 - c. ICESCR
 - C. Analysis – Historical Meaning of the Right to Health
 1. The Necessity of Having Health Among the Human Rights
 2. The Meaning of “Health”
 3. State Obligations Under the Right to Health
 - a. A Right to Health vs. A Right to Health Care
 - b. An Inclusive or Exclusive Right?
 - c. Equity in Health Care and Health
 4. Was the Right to Health ever intended to be enforceable?
 - a. Enforcement by Committee
 - b. Progressive Realization
 5. Transnational Obligations
 6. Collective Components of Health – Public Health Systems
 - D. Conclusion
- II. Tracing the History of Ideas to Examine the Prospect of Normative Evolution in the Right to Health
 - A. Evolution of the Right to Health in International Law
 1. Early Application of the Right to Health
 2. Alma Ata
 3. Health for All in the 21st Century
 4. Ottawa Charter
 5. Retrenchment of the Welfare State/WHO Efforts to Narrow Health
 6. UN Resurgence
 - a. Health & Human Rights Movement Redefines a Right to Health
 - b. Sustainable Development & Human Development

- c. Vienna Declaration
 - d. Women’s Groups Employ the Right to Health for Reproductive Health
 - e. Copenhagen Programme of Action
 - f. Millennium Development Goals
 - 7. HIV/AIDS Exceptionalism
 - 8. General Comment 14
 - a. Content – Defining the Normative Content of the Right to Health
 - b. Measurement – Gauging Adherence and Enforcing the Right to Health
 - i. Enforcing Progressive Realization
 - ii. Measurement Standards
 - iii. The Need for Continuing Elaboration
 - 9. Beyond General Comment 14: A Special Rapporteur on the Right to Health
 - B. The Current Content of the Human Right to Health
 - 1. An Evolving Meaning of ‘Health’
 - 2. “Core Obligations” Under the Right to Health?
 - 3. Positive vs. Negative Rights – Bridging the Divide
 - 4. Enforcement of the Right to Health
 - a. National Litigation
 - b. Shaming
 - 5. Transnational Obligations
 - C. Conclusion
- III. Rediscovering the Highest Attainable Standard: A Collective Right to Public Health
 - A. Globalization Reframes Health Debates
 - 1. Global Interconnectedness Highlights Shared Health Dilemmas
 - 2. Structural Adjustment Programs – Weakening National Health Infrastructures
 - 3. Impact of Globalization on the Built Environment
 - 4. The Rise of the Transnational Corporation
 - 5. Health vs. Trade
 - a. Intellectual Property
 - b. Trade Agreements
 - B. Public Health Responds to Globalization: Gaps Between Understanding of Public Health and Codification of the Right to Health
 - 1. Inadequacy of the Right to Health
 - 2. Medicine vs. Public Health
 - 3. Public Health as a Public Good: Understanding the Underlying Determinants of Health
 - C. A Collective Right to Public Health

1. Third Generation Human Rights – The Rise of Collective Human Rights
 - a. Collective Rights as a Response to Globalization
 - b. A Collective Right to Development
 2. Invoking Public Health in General Comment 14
 3. Declaring a New Human Right
 - a. Theoretical Conceptualization
 - b. Programmatic Components of a Right to Public Health
 - i. Substantive Elements
 - ii. Procedural Elements
 4. Harmonizing Individual and Collective Rights
 5. International Obligations
- D. Conclusion
- IV. The World Health Organization – A Global Response for a Collective Right
- A. Historical Origins of International Public Health Regulation
 - B. A Modern Basis for International Public Health Law
 1. International Health Regulations
 2. The WHO Framework Convention on Tobacco Control
 - C. Conclusion: Strengthening Global Health Governance Under a Right to Public Health
- V. Conclusion