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Global Health Disputes and Disparities

A critical appraisal of international law and population health

Dru Bhattacharya

Global Health Disputes and Disparities

Global Health Disputes and Disparities explores inequalities in health around the world, looking particularly at the opportunity for, and limitations of, international law to promote population health by examining its intersection with human rights, trade, and epidemiology, and the controversial issues of legal process, religion, access to care, and the social context of illness.

Using a theoretical framework rooted in international law, this volume draws on a wide range of rich empirical data to assess the challenges facing the field, including international legal treaty interpretation, and specific issues related to the application of law in resolving pressing issues in gender, access to care, and social determinants of health. In doing so, it illustrates the challenges for implementing rights-based approaches to address health disparities, with profound implications for future regulations and policymaking. It includes both interviews with leading scholars, as well as a variety of case studies from prominent international forums, including formal claims brought before the Human Rights Council and the Committee on the Elimination of All Forms of Discrimination Against Women, as well as regional and national experiences, drawn from disputes in India, Indonesia, South Africa, and the USA.

This volume is an innovative contribution to the burgeoning fields of global health and human rights, and will be of interest to students and researchers in public health, global health, law, and sociology interested in the social determinants of health and social justice from both theoretical and practical perspectives.

Dhrubajyoti (Dru) Bhattacharya is the Director of the Health Policy track in the Master of Public Health program at Loyola University Chicago, Assistant Professor of Health Policy at Loyola University Chicago Stritch School of Medicine, and Visiting Professor of Law at Loyola University Chicago School of Law, USA.

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and how critical engagement among individuals of different perspectives only improves our collective understanding.

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1 Introduction to international law and global health

"Wisdom sets bounds even to knowledge."
– Nietzsche, Maxims and Missiles, 5
Twilight of Idols (1888) tr. Anthony M. Ludovici

What is "global health"? The term, as Dr. Koplan once remarked, is "fashionable" and, as such, has garnered significant attention in the media and in universities worldwide.[1] The field is distinct, but encompasses "international health," which was historically focused on issues in low-income and developing countries. It is also distinguishable from, but encompassing, "public health," which concerns preventive measures to secure subnational population health. It embraces "medical care," which concerns the delivery of particular health services for the benefit of an individual patient. And if we break down the terms, some have argued that "global" includes transnational determinants (e.g., climate change, urbanization) that affect health within all countries; and others have argued that any negative "health" trends should be addressed by the international community, the cross-border threat notwithstanding.

The idea of an international body of law that could govern health-related affairs emerged from the recognition that intrastate health issues, fueled by globalization, may transcend national borders and require international efforts to mitigate the threats. But threats to what, exactly? National security? Values espoused in a myriad of international proclamations?

Ultimately, no matter what factor(s) may account for the heightened recognition of health on the international stage, we have seen a notable shift away from an exclusive biomedical paradigm that explains the onset of illness as the result of physiological changes in the body towards a broader framework that envisions health as a social construct. This is not an entirely novel proposition, as we found when the Constitution of the World Health Organization (WHO) was adopted by the International Health Conference held in 1946. The WHO Constitution states in its Preamble that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] Public health workers would welcome

these developments as an affirmation of their field, which looks at health beyond the experience of a single individual (and the walls of a healthcare system) and as a product of a social- or "population"-based phenomenon. It is unclear, however, whether the intentional omission of the term "social" is illustrative of an underlying tension in recognizing the linkages between social policies and health.

Is there a distinct body of international law that governs the practice of public health? Yes and no. Many human rights treaties are replete with health-related rights, duties, and privileges accorded the institutions and individuals responsible for securing the public's health. Numerous provisions regulate the collection and dissemination of data, the provision of services, and the disclosure of information to enhance individual decision-making and promote population health. In recent times, the year 2005 marked a landmark achievement for public health advocates with the entry into force of the Framework Convention on Tobacco Control (FCTC), which was ratified by 170 Member States of the WHO. It is undeniable that there is a burgeoning interest among countries worldwide in the role of law, and international law in particular, in shaping public health policy. This interest, in turn, has given rise to novel academic endeavors to outline the precise parameters of law on the international stage to secure population health. Professors Gostin and Taylor have conjured a term, "global health law," to elucidate this nascent field of inquiry. They define the term as follows:

> Global health law is a field that encompasses the legal norms, processes, and institutions needed to create the conditions for people throughout the world to attain the highest possible level of physical and mental health. The field seeks to facilitate health-promoting behavior among the key actors that significantly influence the public's health, including international organizations, governments, businesses, foundations, the media, and civil society. The mechanisms of global health law should stimulate investment in research and development, mobilize resources, set priorities, coordinate activities, monitor progress, create incentives, and enforce standards.[3]

Their definition draws from formal sources of public international law, for example treaties, and formal subjects of international law, for example state, international organizations; and has five distinctive features: (1) mission, that is ensure condition for public's health; (2) key participants, for example state/international organizations; (3) sources, that is public international law; (4) structure (methods for global health governance); and (5) moral foundation, that is social justice. Based on these elements, they identify four grand challenges facing the international health community, including: (i) State-centricity in the international legal system (inability to incorporate non-state actors into governance; state sovereignty results in weak treaty commitments); (ii) skewed-priority setting (limited legal framework for national action; limited international cooperation; poverty a principal obstacle to

disease prevention and health promotion); (iii) flawed implementation and compliance (no dispute settlement body for global health law issues, no incentives or options to encourage State compliance); and (iv) fragmentation, duplication, and lack of coordination (proliferation of actors and institutions with health agendas, recommend that the WHO take a stronger leadership role in this regard).

While I am intrigued by the breadth of this description, I do not find the term "global health law" or the four grand challenges, above, particularly persuasive. First, State-centricity is still necessary to address (1) the nature and context of health problems and (2) the political realities of international relations. Health problems may be described in the aggregate, but often have relative causality depending on numerous determinants of health. While poverty is an obstacle, it does not absolutely absolve States or individuals of the contribution of individual behaviors on societal outcomes, laws restricting educational and economic opportunities, and existent policies and practices allowing structural violence to sustain. For women, the combination of these behaviors, laws, and practices have been associated with enhanced risk for physical and mental abuse, sexual violence, and attendant health risks, including sexually transmissible infections and diseases and chronic reproductive health problems. State-centricity simply ought not to be regarded as a scapegoat for the threats posed by complacency as relates to these social and individual factors.

In fact, State-centricity is the reality of international relations, and health rarely trumps other equally (if not more) pressing prerogatives, such as trade and national security. The explicit purpose of the revised International Health Regulations is to prevent the spread of international disease and "avoid unnecessary interference with international traffic or trade"—not for members to ameliorate, and help others ameliorate, subnational disease threats that preclude everyone's enjoyment of the highest attainable standard of health. Also, consider the dismissal by the International Court of Justice of the 1996 World Health Organization's request for an advisory opinion to determine whether "in view of health and environmental effects, the use of nuclear weapons by a State in war or other armed conflict [would] be a breach of its obligations under international law including the WHO Constitution." The ICJ found the request to arise outside the scope of the WHO's activities, and tantamount to disregarding the principle of specialty.

Second, as far as dispute settlement is concerned, consultative and (quasi) adjudicative bodies exist, but they ought to be thoroughly scrutinized. Treaty monitoring bodies provide consultative services by reviewing country reports, but provide inadequate criteria for evaluation of progress and growth. Optional Protocols (ICCPR, CEDAW, and ICESCR) also create an avenue to reflect on the application of broader principles to actual disputes; inevitably shape the development of norms, practices, and international jurisprudence; and, upon taking steps based on the Committee's recommendations, also directly affect national legislation and policymaking as well as international

relations. Finally, incentives already exist but they may take different forms, which affect the degree of cooperation: political, economic, and social. Some States find being a Party an end in and of itself; others look to future bi- and multi-lateral agreements; some look to adoption to formulate national policy; while others to advocate for reform extraterritorially.

So while there is no consensus on what global health or global health law is, for that matter, it is clear that international law can affect health outcomes by providing normative standards (treaties) for specific State Party measures to reduce the perceived burden of health threats. At the very least, it provides oversight and review of efforts to promote population health vis-à-vis the reporting mechanisms, which facilitate monitoring and surveillance. More recently, international law has accommodated the role of non-traditional subjects, including individual victims and quasi-adjudicative bodies (treaty-monitoring Committees) vis-à-vis the Optional Protocols to evaluate State laws, policies, and interventions—although these avenues have not been adequately scrutinized.

Together, these developments suggest that the field of international law holds much promise for promoting population health worldwide, but there is much work to be done, and a critical appraisal of the field as relates to specific areas of inquiry is long overdue. This work does not add to the compendium of studies on international trade law, the general intersection of health and gender, or public health in particular. Rather, I adopt a critical approach that examines the challenges that are unique to each of these areas, and provide alternative frameworks to understand the potential and limitations of international law as it relates to (1) treaty interpretation and adjudication of health-related disputes, (2) human rights and religion, which often shapes prevalent social norms, (3) trade and access to preventive and therapeutics measures, and (4) epidemiology and social determinants of health.

These are controversial topics and a successful resolution of the issues that are involved stretch well beyond the scope of this book. It is my intent, however, that by engaging them in a manner that goes beyond the traditional legal analyses that are often employed, students and future health advocates will appreciate the complexity of the health burden as a function of legal processes, social norms shaped within a defined historical context, existent policies and priorities, and assumptions underlying our own scientific methodologies and characterization of public health problems.

Since I am the first to acknowledge the need to recognize different viewpoints, I am honored to include excerpts from personal interviews with renowned scholars and practitioners in the field, which the reader will find interspersed throughout. Among the participants include Professor George Annas (Boston University School of Public Health), Professor Benjamin Mason Meier (University of North Carolina), Professor Kayhan Parsi (Loyola University Chicago), and Professor John Kraemer (Georgetown University Law Center). I hope readers will find the diversity of opinions and insights helpful in their studies, research, and advocacy.

2 A critical assessment of treaty-monitoring bodies

A case study of CEDAW's Optional Protocol

"A decision which is the product of reasoned argument must be prepared itself to meet the test of reason."

– Lon L. Fuller[1]

Introduction

The thirtieth anniversary of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) should be met with ambivalence. Since its adoption in 1979, the treaty has engendered transnational dialogue for 185 States Parties to address discrimination against women. Its breadth is laudable and its depth evinced by provisions addressing discrimination in all walks of life, including employment, healthcare, family relations, and civic participation. CEDAW also occupies a unique position among other international instruments by recognizing an inextricable linkage between social determinants and health outcomes. In doing so, it bridges the ominous divide between economic, social, and cultural rights with civil and political rights. As the only treaty that specifically addresses women's health, however, CEDAW is a victim of its own success.

Despite mandatory State reports that account for progress made over the years, implementation of health-related measures has proven particularly troublesome. For example, mandating States to modify culture and ensure that families adopt a "proper" view of maternity raises legitimate questions about government interference with individual liberty interests.[2] Though discrimination may threaten the physical and social well-being of all women, inter-State disparities in health, wealth, and education may compel governments to adopt different policies for meeting the immediate needs of their populations. While socio-economic status undoubtedly affects health outcomes, there is simply no consensus on what model allocates resources in the most equitable fashion.

In some developing nations, prescribed notions of social inferiority and limited access to education and healthcare contribute to high rates of illiteracy and maternal mortality. Every year, over 500,000 women die because of pregnancy-related causes, even though the majority of these deaths are

preventable.[3] Discrimination contributes to these trends by precluding access to health information on family planning, and quality medical care. The latter is exemplified in patriarchal societies where access is predicated upon, inter alia, spousal consent, or the availability of a female physician. Less obvious (but equally detrimental) examples include expectations of motherhood whereby high rates of fertility heighten the risk of complications and, coupled with inadequate healthcare systems, result in increased maternal deaths.

In wealthier States, discrimination takes on even more subtle forms, and raises complex medicolegal issues. CEDAW requires, for example, that governments promote non-discriminatory policies that enable access to "services . . . related to" family planning or "in connection with" pregnancy. Is emergency contraception "related to" family planning? Are both abortion and fertility treatment "in connection with" pregnancy? Has an insurance provider who covers varicocele ligation for men but refuses to pay for surgical impregnation for women engaged in a *discriminatory* practice? Absent express directives, interpretation is the quintessential means of demarcating the nature and scope of the provision.

The CEDAW Committee ("Committee") is the only body authorized to provide guidance on how governments should translate their treaty obligations into precise policy directives. The Optional Protocol to CEDAW ("Protocol") empowers the Committee to review individual claims, assess their veracity, and issue recommendations in response thereto. To be sure, the Committee is not a tribunal, but submitting a claim to its independent review has a unique adjudicative flavor with far-reaching implications. Recognizing the Committee's jurisdiction to pass judgment on State acts (or omissions) has political consequences to the extent that governments are perceived as complying with their international treaty obligations. On the domestic front, requiring a formal response by the State Party delineating steps taken to remedy a violation may have significant economic and social effects. Governments may be asked to provide direct remuneration to a claimant, amend existing laws, and even develop new programs. Consequently, the claims procedure not only serves as a potential avenue of individual recourse, but also implicates inter- and intra-State relations.

To date, individuals have not been reluctant to use the Protocol to address health-related issues. In fact, half of the claims submitted thus far are unique to women's health, such as forced sterilization and incidents of domestic violence. Given the profound reach of each decision, the Committee's rationale will be scrutinized for the reasons employed. Professor Fuller's general admonition is worth remembering, for "[e]ven if there is no statement by the tribunal of the reasons for its decision, some reason will be perceived or guessed at and the parties will tend to govern their conduct accordingly."[4] In the universe of international relations, treaty interpretation simply cannot afford an unseemly presentation in form or substance.

Submitting to the Committee's judgment not only concedes a modicum of competence, but lends legitimacy to the heightened rationality that inheres