Beyond Lifestyle: Governing the Social Determinants of Health

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BEYOND LIFESTYLE: GOVERNING THE SOCIAL DETERMINANTS OF HEALTH

Wendy K. Mariner†

Non-communicable and chronic diseases have overtaken infectious diseases as the major causes of death and disability around the world. Despite recognition that reduction in the chronic disease burden will require governance systems to address the social determinants of health, most public health recommendations emphasize individual behavior as the primary cause of illness and the target of intervention. This Article argues that focusing on lifestyle can backfire, by increasing health inequities and inviting human rights violations. If States fail to take meaningful steps to alter the social and economic structures that create health risks and encourage unhealthy behavior, health at the population level is unlikely to improve significantly. Viewing the global health challenge from the perspective of human rights, however, reveals opportunities for positive change in all sectors of governance. Explicit recognition of human rights can help refocus attention on the fundamental causes of health and protect individuals from unnecessary harm.

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I. INTRODUCTION

Global systems of health governance were first developed to combat the spread of infectious diseases across national boundaries. Infectious diseases may always be with us, but they are no longer the predominant threat to public health that they were historically, neither in developed democracies, nor in developing countries. Successes in controlling and treating infectious diseases have resulted in non-communicable and chronic diseases becoming the leading causes of mortality for most of world’s population. Despite increasing recognition of the global burden of chronic disease, effective steps to prevent or mitigate this burden have been scattered and limited. Perceived dangers of pandemics, such as SARS, influenza, Ebola, and Zika, periodically capture international attention and distract attention from more persistent threats to population health.

To a noticeable extent, global recommendations to prevent non-communicable and chronic diseases have followed the global public health model for containing infectious disease by targeting individual behavior or lifestyle as a primary cause of illness and a locus for intervention. This Article argues that this approach is not well suited to the task. Rather, it often fails to alter the fundamental causes of behavior and also risks violating human rights. If the goal of global health governance is to improve health and human flourishing, as this Article believes it is, or should be, then more robust efforts are required to address the fundamental causes of chronic diseases; namely, policies and programs to improve the social determinants of health. The need for such efforts can be seen by viewing global health goals through the lens of human rights, which recognizes State responsibilities for protecting both public health and individual freedoms.

This Article begins with a brief description in Part II of how non-communicable and chronic diseases have overtaken infectious diseases as the major sources of death and disability around the world. Part III describes the social determinants of health—social, economic, educational, environmental, political, and cultural conditions in which people live and work—which are the fundamental causes of mortality and morbidity. Part IV argues that efforts to address social causes remain inadequate, in
part because they focus heavily on individual lifestyle and personal behaviors rather than the deeper fundamental causes. Part V argues that significant improvements in global population health are unlikely to materialize unless governance systems in all sectors recognize how their respective policies and activities affect the social determinants of health. Epidemics of communicable diseases, however, frequently disrupt sustained attention to fundamental causes of chronic disease, as discussed in Part VI. The Article concludes that because global health goals reflect human rights, national and international commitments to respect, protect, and fulfill human rights also have the potential to improve global health. Explicit recognition of human rights can help refocus attention on fundamental causes of health and protect individuals from unnecessary harm.

II. THE BURDEN OF DISEASE GLOBALLY AND IN THE UNITED STATES

Chronic diseases have surpassed communicable diseases as the leading causes of death, not only in high-income countries, but also around the world. Global Health Observatory data for 2012, shown in Table 1, report that the leading causes of death globally were ischemic heart disease, stroke, chronic obstructive pulmonary disease and lower respiratory infections. Chronic and non-communicable diseases accounted for an estimated thirty-eight million (about sixty-eight percent) of the total fifty-six million deaths worldwide in 2012. This represents an increase in the proportion of deaths attributable to chronic diseases since 2005, when the World Health Organization (WHO) estimated that thirty-five million (sixty percent) of the fifty-eight million deaths from all causes around the world resulted from chronic diseases. That was “double the number of deaths from all infectious diseases (including HIV/AIDS, tuberculosis and malaria), maternal and perinatal conditions, and nutritional deficiencies combined.” This trend is likely to continue, even if the estimates are based on highly imperfect data. WHO projects that deaths from chronic diseases may increase to fifty-two million by 2030.

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10 Number of Global Deaths from Various Causes, Global Health Observatory Data Repository, WORLD HEALTH ORG., http://apps.who.int/gho/data/node.main.CODWORLD?lang=en [hereinafter WHO GHO].

11 Id.


13 Id. at 2.

14 WHO GLOBAL STATUS REPORT, supra note 9, at 8; see Colin D. Mathers & Dejan Loncar, Projections of Global Mortality and Burden of Disease from 2002 to 2030, 3 PLOS MED. 2011, 2016 (2006), http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0030442 (estimating 73.2 million total deaths globally in 2030, along with a more optimistic estimate of 64.9 million deaths and a more pessimistic estimate of 80.7 million deaths).
TABLE 1. LEADING CAUSES OF DEATH, GLOBAL, 2012

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th># (in millions)</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>7.4</td>
<td>13.2</td>
</tr>
<tr>
<td>Stroke</td>
<td>6.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>3.1</td>
<td>5.6</td>
</tr>
<tr>
<td>Lower respiratory infections</td>
<td>3.1</td>
<td>5.5</td>
</tr>
<tr>
<td>Trachea &amp; Bronchial cancers</td>
<td>1.6</td>
<td>2.9</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Diarrheal diseases</td>
<td>1.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Road injury</td>
<td>1.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Hypertensive heart disease</td>
<td>1.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Preterm birth complications</td>
<td>1.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Liver Cirrhosis</td>
<td>1.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>0.9</td>
<td>1.8</td>
</tr>
</tbody>
</table>

In 2012, the top three causes of death in low-income countries were lower respiratory infections, HIV/AIDS, and diarrheal diseases. In the rest of the world, however, heart disease and stroke were the top two causes. About seventy-five percent of deaths from chronic diseases were in low-middle income countries, affecting men and women about equally.

In one sense, the rising proportion of deaths from chronic diseases might be good news. The data suggest that as countries improve their economies, deaths from infectious diseases may decline. This could also indicate that people are living long enough to acquire a non-communicable disease. Life expectancy is increasing, and scientific advances have converted some formerly fatal infectious diseases, like HIV, into manageable chronic conditions, at least for more affluent populations. But, in some circumstances, a quick death from a heart attack or stroke may be preferable to years of pain or inability to function. Chronic diseases often come with disabilities that make life difficult, undermining the value of longevity.

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15 WHO GHO, supra note 10.
17 WHO GHO, supra note 10.
20 Id. at 10.
21 WHO GHO, supra note 10 (Ischemic heart disease and stroke accounted for 3 in 10 deaths in 2012). But see DANIEL CALLAHAN, THE ROOTS OF BIOETHICS: HEALTH, PROGRESS, TECHNOLOGY, DEATH 76 (2012) (“With chronic disease you will most likely have a much longer life, but spend a significant portion of your old age in poor health, inexorably declining. Is that a good bargain? Most of us seem to think so. We prefer to die old rather than young . . . and to take our chances with chronic disease.”) (discussing increased health care costs with chronic diseases).
22 Christopher J.L. Murray et al., Global, Regional, and National Disability-Adjusted Life Years (DALYs) for 306 Diseases and Injuries and Healthy Life Expectancy (HALE) for 188 Countries, 1990-2013: Quantifying the Epidemiologic Transition, 386 LANCET 2145, 2145 (2015).
causes, including health conditions, injuries, and genetics. Between 110 and 190 million people over fifteen years of age have difficulty functioning, especially those with chronic diseases, and this number is expected to grow. Moreover, disabilities affect family members, who often experience stress as well as loss of income. Rapid aging of the population, currently increasing at 3.26% per year, will intensify these problems and likely dampen economic growth. Europe currently has the largest percentage of elderly at twenty-four percent of the population, and it is estimated that by 2050, about one quarter of the populations in all areas of the world except Africa will be age sixty or older.

All this is to suggest, as international organizations and commentators recognize, that efforts to improve global health should pay more attention to the causes of chronic conditions. The global burden of disease has not only shifted from communicable to chronic, but population health concerns have also shifted from premature deaths to increased years of life lived with disabilities. Because chronic diseases both cause poverty and stifle economic development, which in turn cause illness, disability, and death, improving health can create a positive feedback loop with improving economic development.

III. FUNDAMENTAL CAUSES OF DISEASE

What causes all this illness, injury and disability? In the field of global health and public health generally, there is widespread recognition of the social determinants of health—the social, economic, educational, environmental, political and cultural conditions that influence the health of populations. When Canadian Minister of National Health and Welfare, Marc LaLonde, introduced the Health Field Concept in 1974, he identified four main influences on health: human biology; environment;...
lifestyle; and healthcare organization. The 1978 Declaration of Alma Ata stated, “Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures.” In the decades since, countries have paid increasing attention to healthcare services emphasized by Alma Ata, including primary care. But healthcare services alone cannot remove all the causes of disease or injury. Both the Millennial Development Goals and the more recent Sustainable Development Goals call for action on a variety of social determinants of health. The United Nations Conference on Sustainable Development, known as Rio+20, concluded that “health is a precondition for and an outcome and indicator of all three [economic, social, and environmental] dimensions of sustainable development.” The literature has also fleshed out elements in the social, economic, and physical environment, including political inequality, that affect population health outcomes.

These social and environmental systems and policies have been called fundamental determinants of health and illness because they define the opportunities and obstacles facing individuals. These fundamental causes are also sometimes called distal or upstream drivers because they can filter through multiple pathways to expose people to health risks, influence behavior, affect access to care, and ultimately result in particular health outcomes. Importantly, the complex, iterative processes whereby these causes interact can mitigate or enhance their effects. Examples are legion. Wealth enables a good education, which in turn facilitates well-paying employment and well-constructed housing in a safe community, free from pollutants, with access to good nutrition. In contrast, young children living in poverty may be exposed to poor nutrition, violence, or toxic substances, such as lead, risking brain damage that impedes their development and educational opportunities.

Climate...
change affects access to potable water and sanitation, as well as what crops can be grown. Access to water can influence opportunities for education and income, which affect health status.

Urbanization may destabilize the accessibility and affordability of necessaries, such as clean water, adequate housing, safe food and employment. Current estimates suggest that by 2050, sixty-six percent of the world’s population is expected to be urban, with Africa and Asia urbanizing at faster rates than other regions. Discrimination on the basis of race, color, religion, sex or gender circumscribes opportunities for targeted populations in education, employment and housing, which undermines health; and discriminatory practices in the healthcare system can hinder access to the treatment that is needed as a result. Political equality and education for women and girls is linked to improved population health and economic growth. And poverty, possibly the most significant contributor to health disparities, is intertwined in complex ways with most of these other factors.


Attempts to express these relationships visually can be challenging. For example, Dahlgren and Whitehead’s depiction in Figure 1 above, which has been widely adopted and adapted, flattens the factors into spatial levels suggesting separate spheres. Figure 2 below attempts to illustrate some of the interactions among factors affecting health, suggesting forward movement from structural to intermediate factors without recognizing all of the circular dynamics that occur in reality.

FIGURE 1. THE MAIN DETERMINANTS OF HEALTH

FIGURE 2. WHO FRAMEWORK FOR ACTION ON SOCIAL DETERMINANTS OF HEALTH

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51 WHO, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 6 (2010).
Nancy Krieger points out that categorizing health risk factors as distal/upstream and proximal/intermediate/downstream fails to capture the dynamic interaction among these factors.\(^5^2\) It is true that such labels can imply uni-directional pathways, instead of the looping, iterative processes in which factors interact. Moreover, categorizing social and economic factors as distal suggests that they are far removed in time from, and therefore have less causal influence on, health outcomes than proximal factors. The reverse is sometimes true. Laws and policies that appear on the distal end of the visual spectrum can directly affect individuals in ways that prejudice their health. For example, laws governing conditions of employment can directly affect worker health, and policies governing health insurance coverage may directly affect access to necessary care.\(^5^3\) The introduction of unaffordable fees for privatized water systems can make it impossible for poor families to have enough water for drinking, much less sanitation and hygiene.\(^5^4\) And policy failures, such as Flint, Michigan’s decision to change its water supply, can cause contamination and illness in the population served.\(^5^5\)

Determining how to define health status can further complicate the picture. A person’s health is rarely the dichotomous presence or absence of disease.\(^5^6\) One’s health status changes from time to time during one’s life. Thus, the concept of health itself is evolving to include formulations such as well-being throughout the life course or the “ability to adapt and self manage.”\(^5^7\) This more flexible concept of health as well-being fits nicely with evaluations of chronic diseases and conditions, since some people are better positioned to adapt successfully to particular disabilities than others. Those with sufficient income, education, access to healthcare, and social support systems are more likely to function well with disabilities than those without these advantages. Thus, successful adaptation is likely to depend on social determinants of health; that is, the social, economic, political, and cultural systems, policies, and laws that make these advantages available. The development of a life course perspective on


\(^{57}\) Machteld Huber et al., *How Should We Define Health?*, 343 BRIT. MED. J. 1, 1 (2011); http://www.bmj.com/content/bmj/343/bmj.d4163.full.pdf [http://perma.cc/SUJ9-V9DS].
health enables researchers to identify the cumulative and interactive effects of these influences on health.58

Many factors that contribute to the relative rise in chronic diseases, as well as the persistence of many infectious diseases, have social and economic origins.59 Perhaps most influential is poverty.60 Low-income populations, especially the urban poor, live in the unhealthiest environmental conditions.61 The United States recession worsened the plight of the urban poor with the loss of job opportunities.62 The World Bank and the International Monetary Fund’s insistence on “austerity” measures exacerbated unemployment in other developed countries with national debt and created multiple stresses on the populations affected. In undeveloped nations, migration out of war zones, like Syria, compounded so-called economic migration from one country to another.63 In addition, trade policies may also affect health. For example, the reduction in trade barriers encouraged by the General Agreement on Trade and Tariffs64 allowed relaxation of laws governing the quality of health services and the environment, as well as trade in firearms, alcohol, and tobacco.65

Programs intended to address critical national problems in low-income countries are sometimes squeezed out by donor-driven policies that target specific diseases.66 Even well-meaning donors and NGOs with a specific disease agenda—for HIV,
tuberculosis, or malaria—can disrupt national and local priorities. There is concern that such aid encourages governments to reduce their own spending for programs in the areas that donors support, because aid funds are fungible. However, empirical studies have reported mixed effects in low and middle-income countries. These results are partly due to study design, but also reflect the variation in each country’s baseline resources and its level of commitment to specific programs.

IV. FUNDAMENTAL CAUSES AND LIFESTYLE INTERVENTIONS

Despite widespread recognition and promotion of the social determinants of health, the influence of lifestyle has emerged as the most salient target of policy interventions, especially those aimed at chronic and non-communicable diseases. Recommendations to change behavior, however, have limited potential to improve health, because they fail to address the fundamental causes of disease.

To be sure, there is ample evidence that certain behaviors, especially tobacco use, pose significant risks to health at the population level. The term “lifestyle” is often used to describe these behaviors. Indeed, multiple sources, including a United Nations magazine article, characterize chronic diseases as “lifestyle diseases.” The majority of specific recommendations to improve population health seek to change individual behavior rather than the social or economic environment. Multiple WHO reports emphasize tobacco use, unhealthy diet, physical inactivity, and harmful use of

67 See Christopher J.L. Murray, Shifting to Sustainable Development Goals – Implications for Global Health, 373 New Eng. J. Med. 1390, 1393 (2015) (noting that because three donors accounted for 61.3% of the funding increase between 2000 and 2014 to meet the Millennium Development Goals health agenda, the reactions of such donors may be “the most important aspect” in transitioning to the Sustainable Development Goals agenda).


69 See Marwa Farag et al., Does Funding From Donors Displace Government Spending for Health in Developing Countries?, 28 Health Affairs 1045, 1051 (2009) (finding that “the absolute impact of an increase in aid depends on the baseline levels of donor funding and government expenditures” and that the impact of the reduction in government health spending varies the most in middle-income countries and is “more serious in low-income countries”).

70 See generally HEALTH BEHAVIOR CHANGE IN POPULATIONS (Scott Kahan et al. eds., 2014) (providing information about how promoting health behavior and lifestyle changes across diverse demographic groups can create healthier societies); RESEARCHING HEALTH PROMOTION (Jonathan Watson & Stephen Platt eds., 2002) (examining then-current research performed to improve promotion practices). But see Paul D. Loprinzi et al., Health Lifestyle Characteristics and Their Joint Association With Cardiovascular Disease Biomarker in US Adults, 91 Mayo Clinic Proceedings 432 (2016) (finding that about 3% of US adults ate a healthy diet, did not smoke, were physically active, and maintained a healthy body fat percentage).


74 See, e.g., id.; WHO, GLOBAL STATUS REPORT, supra note 9, at ix.
alcohol as causes of chronic diseases. For example, WHO’s 2014 Global Status Report on Noncommunicable Diseases lists nine goals, half of which target individual behavior. The global health literature, too, emphasizes changing individual behavior and expanding primary preventive care as critically important ways to improve population health. In the United States, the Centers for Disease Control and Prevention, as well as most commentators, follow suit, emphasizing changing personal behavior as the best way to improve health. Some observers characterize lifestyle as the most important of the social determinants of health. Recommendations to reduce these risky behaviors are claimed to be “[i]nexpensive and cost-effective interventions [that] can prevent 80% of heart disease, stroke, type 2 diabetes and 40% of cancers.”

In the United States, this has been reinforced by research that identifies certain behaviors as the “actual causes of death.”

Recognition of the fundamental causes of health, however, should caution us against accepting lifestyle as the actual cause of deaths and disabilities. First, the behaviors targeted frequently have underlying causes of their own. Any analysis that

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76 WHO GLOBAL STATUS REPORT, supra note 9, at ix (listing, among the nine goals, reducing harmful use of alcohol, insufficient physical activity, salt intake, and tobacco use as well as increasing drug therapy and counselling to prevent heart attacks and stroke).

77 See, e.g., WORLD BANK, PROMOTING HEALTHY LIVING IN LATIN AMERICA AND THE CARIBBEAN: GOVERNANCE OF MULTISECTORAL ACTIVITIES TO PREVENT RISK FACTORS FOR NONCOMMUNICABLE DISEASES (Maria Eugenia Bonilla-Chacin ed., 2014) (recommending improved diets, increased physical activity, and less use of tobacco and alcohol for improving the health of individuals in Latin America and the Caribbean), http://openknowledge.worldbank.org/bitstream/handle/10986/16376/9781464800160.pdf?sequence=1&isAllowed=y; Al-Maskari, supra note 73; RESEARCHING HEALTH PROMOTION, supra note 70.

78 See, e.g., Bauer et al., supra note 30 at 46 (“The chronic disease burden in the USA largely results from a short list of prevalent factors—including tobacco use, poor diet and physical inactivity . . ., alcohol consumption, uncontrolled high blood pressure, and hyperlipidaemia . . . .”); Harold W. Jaffe & Thomas R. Frieden, Comment: Improving Health in the USA: Progress and Challenges, 384 LANCET 3, 4 (2014) (“Health in the USA can be improved by policies that protect health in the broadest segments of the population; by better access to, and improved quality of, health care; by increasing the delivery of preventive services within health-care settings; and by individual behavioural change.”); INST. OF MED., ACCELERATING PROGRESS IN OBESITY PREVENTION: SOLVING THE WEIGHT OF THE NATION (2012), http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/APOP/APOP_rb.pdf [http://perma.cc/M6U4-V8PH] (emphasizing how changes to diet and exercise habits can help solve and prevent obesity).

79 See Harry J. Heiman & Samantha Artiga, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, HENRY J. KAISER FAMILY FOUND. ISSUE BRIEF 1 (Nov. 2015) (“Health behavior, such as smoking and diet and exercise, are the most important determinants of premature death.

80 WHO GLOBAL STRATEGY, supra note 75, at 2.


82 See Kathryn C. Backett & Charlie Davison, LifeCourse and Lifestyle: The Social and Cultural Location of Health Behaviours, 40 SOC. SCI. & MED. 629, 631 (1995) (“[I]t has proved easier within existing research traditions to address relationships between social structural variables, such as socioeconomic status, and the personal behavioural components of lifestyles than it has to understand the culturally based meanings underpinning such relationships.”).
stops at the level of individual behavior fails to reach back to deeper, fundamental causes that could equally be characterized as the “actual causes.” Second, the concept of lifestyle implies personal agency and free choice, while also assuming that individuals can always control their own health. This type of logic can lead people to characterize others who are overweight or have chronic conditions as lazy, self-indulgent, or ignorant.83 Some companies even use the idea of personal responsibility as a reason to blame consumers for their health status, perhaps to deflect attention from industrial and commercial sources of health risks.84 In reality, however, the ability to practice “good” or healthy behavior is not equally distributed across populations for reasons ranging from economic policies to racial discrimination.85 The social and economic environment can constrict or expand opportunities and thereby strongly sway behavior, rendering exposure to particular health risks all but inevitable.86 Thus,

83 See, e.g., M. Gregg Bloche, Obesity and the Struggle Within Ourselves, 93 GEO. L.J. 1335, 1354 (2005) (arguing for shaming obese people as “a burden to others (medically and financially) and a sign of self-indulgence”); Daniel Callahan, Obesity: Chasing an Elusive Epidemic, 43 HASTINGS CTR. REP. 34, 37 (2014) (advocating “strong social pressure” to convince the public that “excessive weight and outright obesity are not socially acceptable any longer”). For works suggesting that weight is a moral issue, see AGAINST HEALTH: HOW HEALTH BECAME THE NEW MORALITY 1-2 (Jonathan M. Metzl & Anna Kirkland eds., 2010) (arguing that “health” is a term replete with value judgments,” including the notion that “when we encounter someone whose body size we deem excessive and reflexively say, ‘obesity is bad for your health,’ . . . what we mean is not that this person might have some medical problem, but that they are lazy or weak of will”); LYNEE GERBER, SEEKING THE STRAIGHT AND NARROW: WEIGHT LOSS AND SEXUAL REORIENTATION IN EVANGELICAL AMERICA 19-51 (2011) (comparing Christian perceptions of homosexuality and obesity, viewed as a manifestation of gluttony); and DEBORAH LUPTON, THE IMPERATIVE OF HEALTH: PUBLIC HEALTH AND THE REGULATED BODY 57 (1995) (describing the “deficit” model of human behavior, which assumes that “lifestyle habits are amenable to change, and . . . that most people, if rationally told the ‘risks’, will make effort to do so”).
84 See Kelly D. Brownell et al., Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue, 29 HEALTH AFF. 379, 379 (2010) (“The notion that obesity is caused by the irresponsibility of individuals, and hence not corporate behavior or weak or counterproductive government policies, is the centerpiece of food industry arguments against government action . . . [They] cast problems like obesity, smoking, heavy drinking, and poverty as personal failures.”).
85 See generally NORMAN DANIELS ET AL., IS INEQUALITY BAD FOR OUR HEALTH? 3 (2000) (noting that “the more affluent and better-educated members of a society tend to live longer and healthier lives,” and that “countries with a greater degree of socioeconomic inequality show greater inequality in health status”); KEVIN LANG, POVERTY AND DISCRIMINATION 348 (2007) (observing that the differences in medical treatment that “blacks suffer” and whites receive . . . in treatment for similar conditions are sufficiently large to contribute to higher death rates among blacks.”); MARMOT, THE HEALTH GAP, supra note 60.
86 See, e.g., Nancy E. Adler, Disadvantage, Self-Control, and Health, 112 PROC. NAT’L ACADEM. SCI. U.S. 10078, 10079 (2015) (“Members of disadvantaged groups have, on average, earlier age of onset of diseases of aging such as cardiovascular disease arthritis, diabetes, and some forms of cancer. Life expectancy at age 25 is shorter for those with less income and less education, as is true for African-Americans compared with European-Americans.”); Juan Du & Paul Leigh, Effects of Wages on Smoking Decisions of Current and Past Smokers, 25 ANNALS EPIDEMIOLOGY 575, 580 (2015) (study finding that rising wages were associated with lower smoking prevalence, with reductions of 5.5 to 6.6 percentage points in men for a 10% increase in wages); Mika Kivimäki & Ichiro Kawachi, Work Stress as a Risk Factor for Cardiovascular Disease, 17 CURRENT CARDIOLOGY REP. 1, 6 (2015) (“[E]vidence . . . suggests that work stressors, such as job strain and long working hours, are associated with a moderately elevated risk of incident coronary heart disease and stroke.”); Roman Pabayo, Ichiro Kawachi & Stephen E. Gilman, Income Inequality Among American States and the Incidence of Major Depression, 68 J. EPIDEMIOLOGY COMMUNITY HEALTH 110, 114 (2014) (finding that women living in “US states with high income inequality” are “more likely to experience a major depressive episode” than “those living in more equal states.”); Andrew Steptoe & Mika Kivimäki, Stress and Cardiovascular Disease: An Update on Current Knowledge, 34 ANN. REV. PUB. HEALTH 337, 337 (2013) (finding that “early-life stressors, such as childhood abuse and early socioeconomic adversity, are linked to increased cardiovascular morbidity in adulthood”); Damien de Walque, Does Education Affect Smoking Behaviors? Evidence Using the Vietnam Draft as an Instrument for College Education, 26 J. HEALTH ECON. 877, 877 (2007) (finding that
it cannot be assumed that everyone is able to eat well, exercise adequately, lose
weight, and avoid addictive tobacco, drugs, and alcohol.

Third, changing behavior is notoriously difficult, even for those who are
motivated to so. It is especially hard when the fundamental causes—circumstances
constraining opportunity—remain unaltered. Costly efforts are required to initiate and
maintain change. Fourth, it is difficult to predict which individuals who exhibit
particular behaviors will get a disease. Epidemiological studies that find associations
between specific behaviors and diseases in a population do not purport to identify
which individuals in that population will actually get the disease. Thus, public
policies addressed to an entire population will necessarily include expenditures and
interventions, sometimes with adverse consequences, for people who are not actually
at risk of disease.

In the absence of major policy changes in the social, economic and political
environment, exhortations to change behavior alone are not likely to achieve the
desired goals. For example, changing one person’s diet has no effect on population
health outcomes. Changing an entire population’s diet is virtually impossible without
major structural changes in the economic and social environment that determines what
kind of food is produced, how it is distributed, and at what prices. Thus, improving
population health, reducing chronic diseases, and increasing well-being will require
addressing fundamental causes.

Effective action to address fundamental causes—the structural elements of the
social determinants spectrum—is challenging. It requires knowledge of and

“education does affect smoking decisions: educated individuals are less likely to smoke, and among those
who initiated smoking, they are more likely to have stopped.”).

87 See Michael Siegel & Lynne Doner Lotenberg, Marketing Public Health: Strategies to Promote Social Change ix (2d ed. 2007) (noting instances “where people tend to know what they should be doing to improve their health and are motivated to do so but aren’t following through,” including the fact that “while 58% [of adults] want to lose weight, only 27% are seriously trying to
do so”).


89 See Margaret Sullivan Pepe et al., Limitations of the Odds Ratio in Gauging the Performance of a Diagnostic, Prognostic, or Screening Marker, 159 AM. J. EPIDEMIOLOGY 882, 889 (2004) (recognizing that predictive and diagnostic markers that are valuable for characterizing population variations in risk are a “very inaccurate tool for classifying or predicting risk for individual subjects”).

90 See H. Gilbert Welch, Lisa M. Schwartz & Steven Woloshin, Over-Diagnosed: Making People Sick in Pursuit of Health 170 (2011) (discussing how, “ironically, the drive toward more and earlier diagnosis can conflict with the goal of a healthier society”).

91 See, e.g., Katherine M. Keyes et al., The Mathematical Limits of Genetic Prediction for Complex Chronic Disease, 69 J. EPIDEMIOLOGY COMMUNITY HEALTH 574 (2015), http://jech.bmj.com/content/69/6/574.full.pdf;html.

92 The relationship between weight and mortality remains somewhat unclear, at least for those with a BMI between 18.5 and 35. See Katherine M. Flegal et al., Association of All-Cause Mortality with Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-analysis, 309 JAMA 71, 79 (2013) (finding that Grade 1 obesity (BMI of 30 to less than 35) is “not associated with higher mortality”); see generally Abigail C. Saguy, What’s Wrong with Fat? 10 (2013) (“[S]everal expert committees have noted that the implications of a child’s BMI for his or her future health remain unclear.”); B. Rokholm, J.L. Baker & T.I.A. Sorensen, The Levelling Off of the Obesity Epidemic Since the Year 1999—A Review of Evidence and Perspectives, 11 OBESITY REV. 835, 841 (2010) (noting that “BMI does not capture all the variation in health outcomes related to excess adipose tissue,” because “body composition and distribution of fat can be highly variable, even between individuals with the same BMI”).

93 See generally Deborah Stone, Policy Paradox: The Art of Political Decision-Making 259 (Rev. ed., 1997) (“Policy is more like an endless game of Monopoly than a bike repair. Hence the common complaint that policies never seem to solve anything.”).
engagement with the multiple public governance structures and private policies in non-health sectors that influence health, such as agriculture, consumer protection, education, energy, environment, housing, insurance, labor, taxation, transportation, and zoning. This type of cross-sector awareness and collaboration has been strongly encouraged in international resolutions and recommendations.  

94 See, e.g., WHO, Declaration of Alma-Ata, supra note 34 ("[E]xpressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world . . . ."), World Health Organization, Ottawa Charter for Health Promotion 1, 1 (1986), http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ [http://perma.cc/T7C6-GL7Z] ("[H]ealth promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."); Rio Political Declaration, supra note 32.


97 See Fran Baum et al., Evaluation of Health in All Policies: Concept, Theory and Application, 29 HEALTH PROMOTION INT’L i130, i130 (2014) (“C]rucial theoretical, methodological and practical issues that need to be considered when evaluating Health in All Policies (HiAP) initiatives.”); Theresa L. Osypuk et al., Do Social and Economic Policies Influence Health? A Review, 1 CURRENT EPIDEMIOLOGY REPS. 149, 149 (2014) (“[P]olicy makers should design future social policies to evaluate health outcomes using validated health measures; to target women more broadly across the socioeconomic spectrum; and to consider family caregiving responsibilities, as ignoring them can have unintended health effects.”).
V. FROM INDIVIDUAL HEALTH TO THE FUNDAMENTAL CAUSES OF HEALTH AND EQUITY

A. A HUMAN RIGHTS APPROACH

If the goal of a health system is to improve the health and well-being of everyone in the population, the system of governance—whether national or global—must address the fundamental causes of health, illness, and disability. This means identifying and changing policies, practices, and conditions that constitute fundamental causes. Social determinants are recognized as fundamental drivers of health; so it is not for lack of knowledge that the majority of health recommendations focus on individual behaviors and lifestyle. Rather, changing social and economic policies and laws is essentially a political endeavor. Most of the major advances in population health have resulted from social movements that produced key policy changes. Yet, as Lawrence Brown has written, “The public health community seldom acknowledges that its work is pervasively political.”

Political action seems most possible when John Kingdon’s “three streams” converge: the problem stream, the policy stream, and the political stream. First, a problem must be recognized; but identifying the problem is not enough. A feasible policy solution must be found and cogently explained. Finally, there should be a political window of opportunity during which policymakers are receptive to making change.

In the current environment, the political stream probably represents the most difficult obstacle to overcome. But, there is little point in tackling the politics until

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98 Keyes, supra note 40; Ruger, supra note 7, at 341.
99 See Ilona Kickbusch & David Gleicher, Governance for Health in the 21st Century 37 (2012) (“After two decades of focusing on individual behavioral change, health promotion showed (as did other areas of policy, such as the environment) that the problems have to be addressed at the causal level and that joined-up policy approaches are necessary.”). 
100 See Ilona Kickbusch & Martina Marianna Cassar Szabo, A New Governance Space for Health, 7 Global Health Action 23507, 23512-13 (2014), http://www.globalhealthaction.net/index.php/gha/article/view/23507/pdf_1 (“Health Ministers must now be concerned with priorities and activities of the security, trade, finance, agriculture, development, and employment industries if they are to effectively address health issues domestically and in global negotiations.”). 
104 Id. at 114 (“[P]roblem recognition is not sufficient by itself to place an item on the agenda. Problems abound . . . in the government’s environment, and officials pay serious attention to only a fraction of them.”)
105 Id. at 115 (“It does seem true . . . that linking a proposal to a problem that is perceived as real and important does enhance that proposal’s prospects for moving up on the agenda.”). 
106 See id. at 145.
both the problem and an effective policy response have been accurately identified. For example, if one defines the problem as lack of treatment, the policy response might be increased funding for medical care, providers, or research. If the problem is viewed in terms of human suffering, then the solution would be to prevent the disease by eliminating or at least reducing its causes.

When solving problems calls for eliminating or reducing their causes, recognition of the fundamental causes is essential, but few politicians are eager to challenge the powerful interests behind those fundamental causes. Moreover, when countries are faced with the challenges of responding to global migration, terrorism, and war, it should be no surprise that policymakers focus on immediate crises, rather than determinants of health. Even during crises like the Ebola pandemic, policymakers operating in economically stressed countries have found it easier to adopt laws that target individual behavior than to generate the revenues needed for necessary infrastructure and services to address the fundamental causes. For example, forbidding those suspected of Ebola infection from entering the country is simpler and cheaper than creating the economic and social conditions that would eliminate Ebola at its source. While these may be reasons for the limited success of major policy initiatives, they do not necessarily justify these actions.

A human rights perspective offers a useful conceptual framework for analyzing global health problems and solutions, because it draws attention to the role of the fundamental determinants of health. The Universal Declaration of Human Rights (“UDHR”) sets forth international norms that most countries accept at least as aspirational goals. The International Bill of Rights, consisting of the UDHR and its more specific Covenants, the International Covenant on Civil and Political Rights (“ICCPR”), and the International Covenant on Economic, Social and Cultural Rights (“ICESCR”), provides a comprehensive list of governmental obligations to their populations.

States have three duties to protect all human rights: (1) to respect individual rights and personal freedoms; (2) to protect people from violations of their human rights by external sources or third parties; and (3) to fulfill the needs of the population. Programs to protect human rights have grown since the 1993 Vienna Declaration and

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107 The Health in All Policies movement is beginning to identify problems and develop solutions, but most are small in scope and not widely publicized. See supra notes 95-96 and accompanying text.
In the field of global health and human rights, the right to health receives the most attention. Article 25(1) of the UDHR states:

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, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The right to health is also included in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The most authoritative interpretation of the right to health is Comment 14, issued by the Committee on Economic, Social and Cultural Rights. States must provide the conditions, care, and protection necessary to protect the health of everyone in their populations, to the extent feasible. In other words, States must pay attention the fundamental causes of health and disease.

Thus, if States seek to protect the health of their populations, they should not only keep communicable diseases from spreading, but they should also arrange to provide necessary medical and social services, and adopt policies that protect the population from the fundamental causes of illness and injury. In doing so, however, they must also respect individual rights and refrain from implementing policies and laws that
encroach on personal freedoms. These include all the rights and freedoms in the International Bill of Rights, not merely the right to health.

Of course, not all States fully respect human rights. This may be why some commentators prefer the concept of social justice over a rights-based model to describe a country’s obligation to provide for its population, even if they appear to embrace the same ideas. Michael Marmot argues that inequities in power, money, and resources make living conditions difficult and lead to poorer health. This is consistent with evidence that increasing socioeconomic status correlates with better health, yielding a health gradient. Thus, global commentary on the social determinants today refers not only to health but also to equity.

Equity calls for eliminating health disparities. Health disparities exist in most countries, including the United States. Differences in access to education, employment, housing, social and economic opportunities and political voice among different classes, races, ethnicities, and genders have well documented effects on population health. This is likely why the first of the Sustainable Development Goals is the eradication of poverty. On the other hand, Marmot does not argue for simply

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121 Id.
125 MARMOT, THE HEALTH GAP, Supra note 60.
130 SDG, supra note 36. The Sustainable Development Goals (SDG) include other goals addressing some of the social determinants of health, such as water, sanitation and gender equality. Id. The SDG ambitiously seek to achieve by 2030 what their predecessor, the Millennium Development Goals, failed to accomplish by 2015. See MDG, supra note 36. But the SDG do not provide a mechanism for reviewing compliance. UN G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development (2015), http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.
providing more money to the poor; rather, he argues for political empowerment. This depends substantially on respecting human rights, and suggests that attention to the human right to health is growing.

There is also concern, however, that a singular dedication to the right to health could permit the violation of other human rights. For example, a legislature eager to be seen as taking positive action to protect the population from an epidemic may enact onerous laws authorizing detention or forced treatment without due process. Governor Chris Christie’s order to hold Kaci Hickox in a makeshift quarantine tent upon her return from Sierra Leone is an example. Nurse Hickox undoubtedly knew more about the risk of Ebola infection than the Governor and instituted an action for violation of her rights under the Fourth and Fourteenth Amendments of the Constitution, as well as claims for false imprisonment and invasion of privacy. Unlike many persons who have been subjected to such treatment historically, Nurse Hickox was an educated, professional, white woman with access to the legal system and therefore in a position to challenge her detention. Similar actions too often deprive people, who do not have these advantages, of their human rights, while simultaneously failing to protect the general population’s health.

The International Health Regulations (“IHR”) similarly warn against a singular focus on disease control: “The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.” Article 23 (2) of the 2005 IHR forbids compelled medical examinations, vaccinations, prophylaxis and health measures on travelers “without their express informed consent or that of their parents or guardians.” Reacting to an epidemic by compelling such measures may violate human rights without reducing the spread of infection.

A different example of the dangers of a single focus on disease control is the growing adoption of health promotion or wellness programs, especially in the United States. Such programs tend to target the individual behaviors that have been

131 MARMOT, FAIR SOCIETY, supra note 126, at 34.
134 See Philippe Calain & Marc Poncin, Reaching Out to Ebola Victims: Coercion, Persuasion or an Appeal to Self-Sacrifice?, 147 SOC. SCI. & MED. 126, 129 (2015) (describing how a singular focus on preventing the spread of Ebola resulted in resistance among affected groups and unnecessary restrictions on human rights); A.M. Viens, Interdependence, Human Rights and Global Health Law, 23 HEALTH CARE ANALYSIS 401, 409-415 (2015) (pointing out that it is not necessarily true that “if health is promoted, then human rights are promoted”).
138 Id. at *3-4.
140 Id. at art. 23(3).
141 Mariner, The Affordable Care Act and Health Promotion, supra note 88, at 299.
emphasized as key causes of chronic disease, especially smoking and obesity. These programs have been criticized as encouraging discrimination against the disadvantaged and disabled by restricting public benefits or imposing extra costs on workers to obtain private, employer-sponsored health insurance. As noted in Part IV, these individual behaviors may be rooted in more fundamental causes of illness. Thus, while efforts to change behavior may benefit some motivated individuals, they are unlikely to significantly affect population outcomes.

Taking human rights seriously helps to avoid these problems. As these few examples demonstrate, many health promotion programs could violate the human rights to dignity, non-discrimination, privacy, and equality. Article 15 of the Convention on the Rights of Persons with Disabilities also upholds the right of persons with disabilities to the highest standard of health care, without discrimination, yet few health promotion programs provide needed assistance to persons with disabilities. Ensuring that both States and private sector actors actually protect human rights would channel efforts governing health promotion into fairer and more effective policies. Even if policymakers consider only the human right to health, they should remember that in protecting and fulfilling the right to health, States must also respect other human rights, including personal freedoms. The duties of States to protect the right to health should underscore their obligations to protect individual rights, to take effective action to regulate third parties, such as private companies that create risks to health, and to provide supporting health and social services to protect health. As United Nations Special Rapporteurs on human rights have reported, a human rights perspective can improve policymaking in general.

The Rio conference on sustainable development worked within a human rights framework to identify both problems and solutions:

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143 Id. at 226; Jill R. Horwitz et al., Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers, 32 HEALTH AFF. 468, 468 (2013).
144 See supra notes 82-86 and accompanying text.
145 See TOM R. TYLER, WHY PEOPLE COOPERATE: THE ROLE OF SOCIAL MOTIVATIONS 1 (2011) (arguing that people are more likely to be motivated to cooperate when authorities are believed to be sincerely acting in their best interests and using fair procedures).
146 UDHR, supra note 109, at Art. 1, 2, 12; see, e.g., Abby Phillip & Katie Zezima, GOP Tack on Heroin Crisis Underlines Racial Divide, WASH. POST A1, A9 (Nov. 28, 2015) (reporting that some US politicians support medical treatment instead of criminal prosecution for users of heroin, 90% of whom are white, but not for marijuana, where blacks are the overwhelming majority of those arrested despite using marijuana in about the same proportion as whites).
149 See Sofia Gruskin et al., supra note 132, at 131 (arguing scholars, especially in medicine and public health, often neglect rights-based approaches to improving population health).
150 Rio+20 Outcome Document, supra note 37, § 9, at 1-2, para. 9.
We reaffirm the importance of the Universal Declaration of Human Rights, as well as other international instruments relating to human rights and international law. We emphasize the responsibilities of all States, in conformity with the Charter of the United Nations, to respect, protect and promote human rights and fundamental freedoms for all.

While States are responsible for protecting human rights, they are no longer the only actors in global health. The private sector is assuming a significant role in what might be considered global health governance. Some donor aid organizations are beginning to integrate human rights protections into their programs. But, not all private entities have sufficient incentives, whether financial or regulatory, to protect human rights. Indeed, there are considerable incentives to shift responsibility for health to individuals. Thus, States that seek to improve population health will have to take stronger steps to protect human rights by regulating the private sector entities that disregard human rights and undermine the conditions that help people stay healthy.

Both government and private efforts to improve global health would do well to adopt the human rights framework. By identifying the fundamental causes of disease, public and private entities are more likely to find solutions that actually enhance human flourishing. While this approach is necessarily complicated by involving multiple actors and policies in the public and private sectors, it holds greater promise than the use of behavioral interventions to spur healthier lifestyle choices.

VI. INFECTIOUS DISEASES DEMAND ATTENTION

The history of international attention to disease is largely one of trying to avoid infectious, and especially communicable, diseases. For centuries, countries and communities have sought to seal their borders against penetration by communicable disease.
In today’s world, national, regional, and international efforts to prevent the spread of infectious diseases have much the same goal, but increasingly call it “health security.” This still typically takes the form of forbidding entry to anyone suspected of harboring infection and rooting out potentially infected residents. Agencies engaged in global health programs, from USAID to the WHO, focus much of their attention on discovering and containing epidemics of infectious disease, rather than preventing them. The International Health Regulations (IHR), for example, recommend a system of alerting other countries to the presence of a serious contagious disease, so that those other countries can take steps to keep infection out of their countries.

These efforts may prevent some of the spread of disease, but do not prevent the emergence of disease in the first place. That would require addressing the fundamental causes of disease. While public health officials concentrate on protecting their country’s population from infection, other sectors of the nation’s economy engage in practices and encourage policies that promote the development of chronic diseases. These include urbanization, migration, industrialization, poor working conditions, and war. Economic growth has some measurable benefits, including rising income levels for a portion of the population. But, as happened in much of the world, the population’s altered circumstances have enabled a rise in non-communicable and chronic diseases as well as injuries. The growing population of urban factory workers in many countries may have traded a miserable life of poverty in rural villages, living with the threat of infectious diseases, for a miserable life of slightly higher incomes in cities, where they are at higher risk of heart disease, cancer, stroke and injuries. Meanwhile, rural populations may still have little or no access to


Stefan Elbe, Should Health Professionals Play the Global Health Security Card?, 378 LANCET 220, 221 (2011) (arguing that health security has “orient[ed] the global health agenda around a fairly narrow set of [infectious] diseases,” or bioweapons of most concern to wealthy countries and donors, whereas the term should include endemic and chronic diseases that plague lower income countries).

WHO IHR, supra note 139, art.3, at 10. The International Sanitary Convention in Paris created the International Sanitary Regulations in 1851 following a cholera epidemic. LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW 179 (2014). In 1951, after World War II, the World Health Assembly adopted the International Sanitary Regulations to encourage nations to cooperate in preventing the cross-border spread of communicable diseases, particularly cholera, plague, small pox and yellow fever. These were replaced in 1969 by the first International Health Regulations, which were amended in 1973, 1981 and 2005 (after the SARS epidemic). WHO IHR, supra note 139; see David Heymann, Public Health, Global Governance, and the Revised International Health Regulations, in DAVID A. RELMAN ET AL., INFECTIOUS DISEASE MOVEMENT IN A BORDERLESS WORLD: WORKSHOP SUMMARY 183, 184-85 (2010).


Fran Baum, Health, Equity, Justice and Globalisation: Some Lessons from the People’s Health Assembly, 55 J. EPIDEMIOLOGY COMMUNITY HEALTH 613, 613 (2001) (“All the indications are that the
the benefits of economic development, leaving them vulnerable to endemic infections and periodic epidemics of communicable diseases.169

The 2005 IHR broadened the definition of public health risk to include “a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger.”170 In theory, this definition could be interpreted to include non-infectious diseases. In the post-9/11 world, however, the 2005 revision was more likely intended to cover biological weapons threats.171 Indeed, the public health field became intertwined with national security measures, both financially and conceptually, such that public health spoke in terms of “health security.”172 Nonetheless, the issues addressed and the measures described in the IHR all concern communicable diseases and contaminants that cross national borders.173

The IHR do not merely ignore the social and economic conditions that permit disease. Rather, the IHR is expressly intended not to interfere with the global market. Article 2 states the IHR’s “purpose and scope” as follows:

The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.174

A test of this regime came with the re-emergence of Ebola in Guinea, Liberia and Sierra Leone.175 The results were not encouraging. Médicins Sans Frontières (MSF), which had been treating Ebola infected patients since March 2014, warned of the growing epidemic months before WHO declared an international health emergency in August 2014.176 The 2005 IHR does not appear to have prevented or slowed the

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170 WHO IHR, supra note 139, art. 1, at 9.
173 WHO IHR, supra note 139.
174 Id.
175 Annas, supra note 163.
epidemic. Nor is it likely to affect the spread of the Zika virus.\footnote{WHO declared Zika a public health emergency of international concern, perhaps in reaction to its belated recognition of the Ebola epidemic. \textit{See Zika Outbreak: WHO's Global Emergency Response Plan}, WORLD HEALTH ORG. (Mar. 3, 2016), http://www.who.int/emergencies/zika-virus/response/en/ [http://perma.cc/SY9D-EJPQ].} This should not be surprising. The IHR have no enforcement mechanism. No country is obligated to accept the IHR.\footnote{\textit{See WHO IHR}, supra note 139.} And those who do comply do so voluntarily, in practice.\footnote{\textit{Id.}} Indeed, one might say that all reporting is voluntary, even when required by law.\footnote{The Global Health Security Agenda was created due to concerns over the low global rate of compliance with the 2005 International Health Regulations. \textit{See Global Governance Monitor: Global Health Timeline}, COUNCIL ON FOREIGN RELATIONS (2013) (“Country compliance with the IHRs has been inadequate, underscoring the need for additional mechanisms to persuade impoverished or recalcitrant states to cooperate and ease the flow of crucial information and viral samples for potential pandemic emergencies.”), http://www.cfr.org/global-governance/global-governance-monitor/p18985%23!/public-health#timeline [http://perma.cc/TK83-H3ZV].} Countries have multiple reasons, including fear of losing tourism and trade, for not wanting to admit that they harbor a communicable disease. And, of course, States may be loath to surrender their sovereignty to a strong global governance structure.\footnote{\textit{See Henry J. Steiner & Philip Alston, International Human Rights in Context: Law, Politics and Morals} 573 (2d ed. 2000); Norman Daniels, \textit{A Progressively Realizable Right to Health and Global Governance}, 23 HEALTH CARE ANALYSIS 330, 330-40 (2015).} With so much attention to epidemics, public health officials, often facing limited resources, can be forgiven for neglecting chronic diseases. Yet, with little to show for their efforts, one might hope for a different approach.\footnote{A recent response to Ebola was another call to strengthen the global system to report outbreaks of communicable disease and keep them within the country of origin. \textit{See Suerie Moon et al., Will Ebola Change the Game? Ten Essential Reforms Before the Next Pandemic. The Report of the Harvard-LSHTM [London School of Hygiene and Tropical Medicine] Independent Panel on the Global Response to Ebola}, 386 LANCET 2204, 2204-21 (2015). The first of ten recommended reforms is that the “global community must agree on a clear strategy to ensure that governments invest domestically in building” capacities to “detect, report and respond rapidly to outbreaks.” \textit{Id.} at 2204. The authors characterize their proposals as “concrete, actionable, and measurable,” but similar recommendations have borne little fruit. \textit{Id.}} All the attention to reporting and keeping infectious diseases outside one’s borders has consequences. First, it has had limited success in containing communicable diseases. Second, it diverts attention and funding away from the large burden of non-communicable and chronic conditions. Third, it fuels xenophobic human tendencies to divide into groups of the healthy “us” versus the dangerous, unhealthy “them.”\footnote{\textit{See generally James A. Morone, Hellfire Nation: The Politics of Sin in American History} (2003); Guenter B. Risse, \textit{Driven by Fear: Epidemics in Isolation in San Francisco’s House of Pestilence} (2016); Priscilla Wald, \textit{Contagious – Cultures, Carriers, and the Outbreak Narrative} (Susan J. Matt & Peter N. Stearns eds., 2008).} Fourth, it encourages communicable disease control with an emphasis on individual behavior as a model for public health action.\footnote{\textit{See U.N. Convention on the Rights of Persons with Disabilities, Article 1 (recognizing disability as a human rights issue), http://www.un.org/disabilities/convention/conventionfull.shtml [http://perma.cc/5HNN-CRGN]; WHO Framework Convention on Tobacco Control, \textit{WHO Framework on Tobacco Control} (2003) (including provisions addressing the price of tobacco products and limitations on labeling, advertising and promotion of tobacco products, as well as bans on sales to minors and smoking in certain areas), http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf [http://perma.cc/UBF5-XU7Q].}} Finally, too often it distracts from the equally important, if more difficult, task of addressing the fundamental causes of health.
VII. CONCLUSION

The value of having a healthy, resilient population that can resist epidemics has been known for decades. It is no less important in the absence of communicable disease threats. But, a healthy, resilient population depends on a fair governance system that can respect, protect, and fulfill human rights. Despite recognition of the social determinants of health, too many governmental recommendations still emphasize changing individual behavior without taking meaningful steps to alter the environment that produces unhealthy behavior. The focus on lifestyle creates the risk of increasing health disparities and health inequity, invites violations of human rights, and, as a practical matter, is unlikely to substantially improve health at the population level.

Addressing the fundamental causes of illness and injury may appear more difficult than closing the borders to infection because achieving equity requires effective political action. Yet opportunities to reduce major threats to health, to build healthy, resilient populations, and to increase equity exist everywhere: by focusing on political participation, employment, income, agriculture, nutrition, sustainable energy, and clean air, water, and shelter. Viewing the challenge from the perspective of the duties to respect, protect, and fulfill human rights illuminates the opportunities for meaningful change in all sectors of governance.

185 See, e.g., N. Howard-Jones, Origins of International Health Work, 1 Brit. Med. J. 1032, 1034 (1950) (“[Q]uarantine barrier methods are of very limited value and . . . resistance of a community to infection is dependent upon its internal conditions.”).

186 For a historical example, see Christopher Hamlin, Public Health and Social Justice in the Age of Chadwick: Britain 1800-1854, 144-47 (1998) (describing the Chadwick-Farr dispute over whether hunger and deprivation were causes of illness and antisocial behavior).


188 See 17 Health & Hum. Rts. J., supra note 133.

189 See Rio+20 Outcome Document, supra note 37, at 25 (“We call for the involvement of all relevant actors for coordinated multi-sectoral action to address urgently the health needs of the world’s population.”); Tom Farley, Saving Gotham: A Billionaire Mayor, Activists Doctors, and the Fight for Eight Million Lives 238 (W.W. Norton & Company, 1st ed. 2014) (“The health department of 1900 needed epidemiologists, microbiologists, sanitary engineers, inspectors, nurses, and doctors. The New York City health department of 2010 needed economists, lawyers, policy experts, data scientists, community activists, and specialists in using images and words in the mass media.”).