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Normative Foundations of Global Health Law

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Introduction

International health law, or what is now also called global health law, is a relatively new academic field. In its broadest definition, it includes all international legal regimes relevant to public health—international environmental law, international humanitarian and human rights law, international trade and labor law, international laws relating to arms control, and so on.[1] Construed more narrowly, it incorporates only those international legal regimes specifically designed to address health threats. The two most notable examples are the International Health Regulations (focused on infectious diseases) and the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) (focused on chronic diseases).

There is an important distinction between international health law and global health law. International health law connotes a more traditional approach derived from rules governing relations among nation-states. Global health law, on the other hand, is developing an international structure based on the world as a community, not just a collection of nation-states. This structure is inclusive of individuals and nongovernmental organizations, especially where health problems are seen as truly global. Globalization has heightened the need for worldwide public health cooperation.

International health law developed originally in the mid-nineteenth century to control infectious diseases and has transformed over time to include multiple norms and standards and to become a significant component of foreign policy.[2] Amidst these changes, however, a lack of normative theory has left the field without a basis for justice or common ground on the ethics and governance of threats to global health. Moreover, research to date has neglected normative problems, as well as the role of global health justice in addressing such problems, especially in establishing moral norms that guide the roles of international and domestic law as tools of public health.

This Essay offers a normative theory of global health law. It builds on a theory of health and social justice I have long been developing and extends this theory in evaluating the role of international law in health. This theory takes human flourishing as the end goal of a global society and proposes that global health law be examined in terms of an ethical demand for health equity.[3] This ethical demand will likely require legal instruments for realization, but it will also require individuals, states, and nonstate actors to internalize public ethical norms in support of global health goals. This Essay also argues that global health law should be examined in the contexts of international relations and global public policy and that law and

policy should be linked at the global and domestic levels. Philosophical underpinnings of global health law cannot be studied separately from other global and domestic tools to reach global health equity.

This Essay comprises three parts. Part I offers normative foundations for the future of global health law and presents a theory of global health equity. Part II analyzes the role of global health law in achieving health equity, examines the effectiveness and limits of international health law, and considers the conditions necessary for the effectiveness of global health law. Part III offers an analysis of global health law vis-à-vis domestic health law and policy. The Essay concludes by arguing that solutions to global health disparities and externalities require more than international treaties, conventions, and recommendations. They require domestic health policy, law, and institutional reforms establishing sustainable, government-sponsored health systems, including universal health insurance and public-health and health-care infrastructures. Thus, the success and future of global heath law depend as much on domestic health policy and law as they do on international health law itself.

I. Threats to Global Health and the Quest for Global Health Justice

A. INTERNATIONAL HEALTH RELATIONS

There is no academic field of what I would call international health relations. In the modern history of international relations theory, for instance, health has been peripheral and theories of international relations have paid health little attention.[4] The history of international relations related to health evolved from a Westphalian sovereign-state approach to infectious diseases; to multiple norms and standards in the post-Westphalian period; to contemporary bilateral and multilateral, cooperative efforts to prevent exogenous threats to national health and economic security.[5]

In the early days of international health law, the world's imperial powers dominated international health diplomacy, seeking to eliminate threats infectious agents posed to their populations and to international commerce. Beginning in the mid-nineteenth century and continuing through 1951, numerous international legal regimes addressing public health issues arose, particularly treaties dealing with infectious diseases, opium and alcohol, occupational hazards, and transboundary pollution. For example, the International Sanitary Convention—created originally in 1882 to control the transboundary spread of infectious agents like cholera—went through repeated revisions up to 1951, when the International Sanitary Regulations established international legal rules.[6] In the early part of the twentieth century, international treaties focused on the control of narcotic drugs and ranged from the 1912 International Opium Convention to treaties dealing with trade in alcohol.[7]

In 1946, the United Nations Economic and Social Council convened an international conference to consider creating a single international U.N. health organization. By 1948 the WHO was created and its constitution ratified; the first World Health Assembly convened in June 1948.[8] The WHO's establishment marked a new era of international health diplomacy characterized by norms and standards. "Health for All" was the hope, and a right to health was a guiding ideal. Despite their moral appeal, however, these efforts were mostly rhetorical, in some cases concealing underlying motives of self- and national interest and a

lack of political will at the global and domestic levels.[9] The WHO's vision of "Health for All" remains unfulfilled after sixty years. During this period, appeals to human rights and the right to health in particular have dominated international health discourse, but the human rights movement and the right to health especially have been viewed with considerable skepticism and doubt. Concerns abound over compliance with international human rights law and the effectiveness of human rights instruments in influencing state behavior and nonstate actors.[10] No normative theory has emerged during this time.

Today, international health diplomacy, with the exception of the health-related Millennium Development Goals, is dominated by powerful nationstates' increased attention to health as a foreign policy issue because pathogens and bioweapons pose national security threats.[11] Contemporary international relations have thus returned us to a Hobbesian view in which international relations concern states' rivalries.[12] Virtually no systematic efforts have emerged to deal with moral foundations of global health.

The few international relations scholars and practitioners who do focus on health issues have provided three dominant frameworks for international health cooperation: national and security interests; domestic and global economic development; and international human rights.[13] Human rights approaches have filled a "moral gap" in the global health discourse. But the human rights strategy has been only moderately effective, for example in efforts to control and mitigate the HIV/AIDS epidemic and to implement the constitution of the WHO.[14] More recently, international health law has been seen as a tool to ensure global public goods for health. The public goods approach is primarily positivist, however, and it lacks a strong normative component and is neutral with respect to equity.[15] Furthermore, neither international relations nor bioethics nor medical ethics as an academic discipline has focused on providing a theory—based in moral and political philosophy—of international or global health law.

Normative views from the field of global justice more broadly provide background, although they have generally lacked an institutional, international law, or health focus.[16] In the Hobbesian tradition, for example, collective security and self- and national interest are the primary aims of relations among states.[17] From this realist perspective, however, global health inequalities provide no moral motive for a remedy. Additionally, based on the theory of cooperative mutual advantage, both John Rawls and Thomas Nagel apply relational perspectives and ground the obligation of justice in the sovereign state.[18] From this perspective, global health inequalities have no moral standing; justice, an associative obligation, is owed only to a government's own citizens.[19] In literal form, both Rawls and Thomas Hobbes would require global sovereignty or world government to justify the duties and responsibilities of global actors—sovereignty would be elevated to the global level to require action.[20] Cosmopolitanism states that principles of justice apply to all individuals in the cosmos. This theory varies from strong demands for cooperation on a global scale to simple adherence to the no-harm principle—that is, that international institutions and agreements may not cause harm.[21] Neoclassical economics, which takes income and wealth as focal variables, relies heavily on free markets for the allocation of resources and gives health no special place.[22] Finally, utilitarianism, which targets utilities, desires, and

preferences as focal variables for assessing social arrangements, focuses on inappropriate ends for justice and an inappropriate methodology for aggregating social welfare.[23]

There is also the natural law tradition and the work of Hugo Grotius,[24] who rejected the theory of mutual advantage and grounded justice in human dignity and natural law.[25] These principles have had wide appeal in both global justice[26] and international law.[27] However, the natural law tradition pays little, if any, attention to the role international or global health law should play in delivering global health justice. Finally, bioethics and medical ethics have been virtually silent on global health justice. Although a comprehensive categorization is beyond this Essay's scope, these are some of the alternative normative frameworks relevant to global health in the global justice dialogue.

All these frameworks neglect moral norms for global health governance. International health diplomacy, over its 150-year history, has taken place without the necessary philosophical underpinnings for a moral foundation to govern state and nonstate actions related to health. In fact, with the exceptions of the WHO's creation and vision, the history of international health relations and doctrine of international law have expressed the realist or positivist world view that international health relations are the strategic interactions of self-interested nation-states.[28] From this perspective, there is no overarching moral order that guides and limits state behavior, and moral theorizing about international relations and international law serves no purpose.[29] From a legal nihilist view, international law itself fails as legitimate law,[30] and from a legal positivist view, non-textual international law is not a legitimate topic of philosophical inquiry.[31]

This Essay challenges these views and argues that a larger moral order should exist and can elucidate principles to govern interstate, intrastate and nonstate behavior. *International health relations do have a higher moral purpose, and the relatively undertheorized state of global health law requires the focus this Essay proposes*.

B. THE MORAL PURPOSE OF INTERNATIONAL HEALTH RELATIONS

Global health realities present compelling moral imperatives. Among the major issues of our time are global health inequalities and global health externalities posing fatal and morbid threats. Health inequalities are morally shocking and are growing around the world. A child born today in Afghanistan is eighty-six times as likely to die by age five as is a child born in Singapore, while a girl born in Sierra Leone can expect to live forty-five fewer years, on average, than can her Japanese counterpart.[32] Thus, while average global life expectancy has increased by twenty years over the past five decades, the very poorest countries have been left behind.[33]

Additionally, in a globalized world, the threats of morbidity and mortality have no national boundaries. The international spread of pathogenic risks to health is also morally shocking. Globalization and its continuously expanding connections among people and places worldwide mean that a deadly organism or a toxic consumer product in one corner of the world can, within days, cause injury, disease, and death in another. Negative externalities are particularly problematic. SARS, Avian Flu, poisoned toothpaste, lead paint, and extensively drug-resistant tuberculosis ignore national borders, threatening all peoples. They

are morally arbitrary. They demand to be addressed in a preventative manner, through surveillance, contact tracing, epidemiological investigations, consumer protection, and control systems at the international, national, and subnational levels.

A world divided by health inequalities—and one in which random pathogens or deadly toxins can kill in an instant—poses ethical challenges for the global health community. International cooperation in health to address these issues is complex and challenging. It must address both international externalities that threaten health (for example, the spread of infectious agents or pathogens across borders, transcending individual states) and gross inequities. The world needs theories of global health justice to propose principles, policies, and tools to address these inequalities and threats and to frame international and national collective action.

C. GLOBAL HEALTH EQUITY

One such theory of global health justice, which builds on a theory of health and social justice I have advanced over the past decade,[34] states that society's obligation to maintain and improve health rests on the ethical principle of human flourishing or human capability.[35] This approach has roots in Aristotle's political theory and Amartya Sen's capability approach,[36] but it moves extensively beyond and considerably extends this work for national and global health purposes. From this perspective, health is intrinsically and instrumentally valuable; all individuals should have equal capability to be healthy. It takes the individual as the central moral unit of justice.[37]

Under this approach, if we value, intrinsically and instrumentally, individuals' capabilities to be healthy, we regard deprivations of health capabilities as inequalities in individuals' capabilities to function. Decrements in a person's health constitute direct threats to his or her well-being and agency. Health capabilities are therefore prerequisites to other capabilities, and their moral importance calls for a sense of urgency. From this perspective, a global society and its constituent nation-states must address global health inequalities and global threats to human health. Primary moral responsibility falls on nation-states, within which health inequalities and the sources of health threats lie.[38]

The question then turns to what is meant by global health equity. This approach argues for the provision of capabilities for good health rather than for complete health equality, recognizing that individuals have different health capabilities—producing equal outcomes is not the main goal.[39] Global health equity, rather, involves equal realization of individual health potential. This approach takes a shortfall rather than an attainment perspective on equality. It asserts a threshold or norm of health against which to measure gaps in health performance.[40] This analysis focuses less on the accomplishments of health systems and health policies and more on what level of health should be possible and how to apply resources to attain it. Shortfall equality can help assess quantitatively how much a given society has realized its health potential and how much remains unrealized because the shortfall perspective compares the actual achievement of a given public policy or health system with the stated health norm. Achieving global health equity requires reducing shortfall inequalities in central health capabilities worldwide.[41]

D. KEY FUNCTIONS IN ACHIEVING GLOBAL HEALTH EQUITY

A moral theory of global health law needs to delineate implications for global and domestic institutions.[42] Determining what is required to reduce inequalities in central health capabilities is both a moral and an empirical question. The empirical program focuses on determining what risk factors are associated with global health inequalities and threats to health and what interventions, laws, and policies could reduce these factors. The ethical program focuses on determining who is responsible for collective action and organization to develop and implement these interventions, laws, and policies.

Empirically, research on global health inequalities in mortality, for example, suggests that such inequalities reflect broader social, political, and economic environments.[43] Both empirical and theoretical research also suggest that market mechanisms alone will not reduce health inequalities or health threats posed by negative externalities: government, law, and policy have important roles.[44] Nor will the health sector alone reduce disparities in mortality. Reducing health disparities and health threats posed by negative externalities requires social organization and collective action.

In previous work, I have identified four key functions associated with achieving global health equity: redistribution of resources, related legislation and policy, public regulation and oversight, and creation of public goods.[45] A comprehensive analysis of these key functions is beyond this Essay's scope, but briefly, the following aspects are important. Redistribution of resources is required among groups.[46] Policy measures necessary for redistribution include progressive taxation, equitable and efficient risk-pooling, redistributive expenditure patterns, and subsidies and cash transfers.[47] In legislation and policy, key functions include the financing of health care through health insurance; the public provision of health services where markets fail to deliver; and the provision of public health information, surveillance, and services.[48] For other policy sectors, measures include expanding economic opportunities and reducing poverty and unemployment; improving educational opportunities, especially for women; implementing institutional reforms to increase participation in trade; reducing social barriers to asset and skill development; and protecting against catastrophic financial risk.[49] Public regulation and oversight would focus on health care services, health insurance, health providers, pharmaceutical companies, and medical devices. Other pertinent functions are clean air and pollution control, toxic substance regulation, occupational safety, housing and building code regulation, risk management, and public goods creation.

E. ALLOCATING MORAL RESPONSIBILITY: THE ROLE OF GLOBAL AND DOMESTIC INSTITUTIONS

Who is responsible for addressing global health inequalities and health threats? Although my proposed framework's overarching principle delineates responsibilities for both national and international actors, the primary duty falls to nations, which have the most direct and preexisting obligations. The extent of extranational or international obligations evolves from the scope and limits of national obligations. A variety of institutions also have important roles. The framework calls for "shared health governance,"[50] whereby state and international governments and institutions—along with nongovernmental organizations,

communities, businesses, foundations, families, and individuals—share responsibility for correcting global health injustice.[51]

Global actors and institutions, although they serve a secondary role, nonetheless represent the international community's will to rectify global market failures, create public goods, and address concerns of fairness and equity on a global scale. Global actors and institutions should have a supportive and facilitative role such that countries can develop, flourish, and promote health.

Global health institutions have duties around four categories of work: to generate and disseminate knowledge and information; to empower individuals and groups in national and global fora; to provide technical assistance, financial aid, and global advocacy; and to coordinate institutions to avoid redundancies.[52] In knowledge and information, global institutions can help create new technologies; transfer, adapt, and apply existing knowledge; manage knowledge and information; create standards and international instruments; and help countries develop information and research capacity. In empowering individuals and groups, global institutions can help reform state and local institutions; help governments improve public administration; serve as advocates in national and international fora; and promote broader citizen decisionmaking. Finally, in health system development, global institutions can provide technical assistance in the following key domains: equitable and efficient financing to promote health; training of medical and public-health professionals; management of care facilities; regulation by agencies; surveillance to ensure food, drug, and consumer safety; infrastructure to promote public health; and implementation of standardized diagnostic protocols. Global organizations can also provide financial aid and mobilize resources.

Individual nation-states have primary and prior obligations to deal with health inequalities and sources of health threats. First, state actors and institutions have responsibility for creating conditions to fulfill individuals' health capabilities; states are in the most direct position to reduce the shortfall between the threshold norm and actual health. This includes efforts to deal with social, economic, and political determinants of health. Second, states are responsible for creating frameworks for equitable and affordable health care; public health; surveillance; and food, drug, and consumer safety. These frameworks provide equal access to quality health-related goods and services and to controllable determinants, including nutritiously safe food and potable drinking water, basic sanitation, and adequate living conditions. Regulation and stewardship of the health system are critical state actions.

F. THE CENTRAL ROLE OF PUBLIC MORAL NORMS

A coherent and defensible moral theory is a necessary, although not a sufficient, condition for achieving reforms at the national level. The political will and practical policy action required to achieve reforms must be firmly grounded in consistent moral principles; otherwise, those reforms will be vulnerable to recurrent failure. Without ethical commitments it is not possible to organize and redistribute resources.[53] Distribution from one group to another must be *voluntary*; otherwise, the effort will be coercive and thus unacceptable on moral grounds. Individuals must willingly give up some of their resources and autonomy to be regulated and to redistribute those resources to others. Once individuals

endorse and fully internalize ethical commitments, they freely enter into them and create obligations to obey them. Individuals need to internalize public moral norms that motivate them to behave altruistically. These norms prompt them to provide assistance to the person whose human flourishing and health is threatened. By extension, states and global entities (as mechanisms of implementing the people's will) must do the same.

II. Achieving Global Health Equity: What Role for Global Health Law?

International health law and global health law can serve as tools to prevent the international transfer of pathogenic threats and to ensure that all global citizens attain or exceed a threshold level of central health capabilities. International health laws have been developed and implemented to address both categories, though most international health law to date has focused on preventing cross-border pathogen transfers rather than on reducing global health inequalities.[54]

A. INTERNATIONAL HEALTH LAWS

Global actors have promulgated international health laws both bilaterally and multilaterally. International health law has also developed through constitutions and institutions, most notably the WHO.

By far some of the most important international health laws are the International Health Regulations (IHR), although international law regimes in other areas affecting health have also been influential.[55] The IHR constitute the only international health agreements on communicable diseases that are *binding* on WHO member states. They provide a unified and standardized code of conduct for infectious disease control. The World Health Assembly adopted the IHR in 1951 and revised them in 1969 and once again in 2005.[56] The purpose of the IHR has been "to ensure the maximum security against the international spread of disease with a minimum interference with world traffic."[57]

The WHO also plays a role in international health law; indeed, the WHO Constitution gives it the power to make and adopt treaties and binding regulations. Under Article 19 of the WHO Constitution, the World Health Assembly has the "authority to adopt conventions or agreements with respect to any matter within the competence of the Organization."[58] However, until the FCTC, the WHO had not exercised its treaty-making power.

Under Article 21 of the WHO Constitution, the World Health Assembly has the authority to adopt legally binding recommendations in five public health areas: sanitary and quarantine regulations; nomenclatures on diseases, causes of death, and public health practices; standards for diagnostic procedures for international use; standards for safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce; and advertising and labeling of biological, pharmaceutical, and similar products moving in international commerce.[59] However, member states may reject or submit reservations to adopted regulations.[60] The WHO was endowed by its 1948 Constitution with the legal powers to propose conventions, agreements, and regulations,[61] yet until the FCTC it had never proposed a convention or agreement and had adopted only one set of regulations (the precursors to the newly revised IHR).

B. THE NEED FOR GLOBAL HEALTH LAW

The motivation behind the revisions to the IHR, which the World Health Assembly adopted on May 23, 2005, and the international agreement on these revisions underscore the need for global health law to control infectious diseases.[62] And health threats such as SARS, Avian Flu, and West Nile Virus represent potential public health emergencies requiring global action.

The newly revised IHR seek "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."[63] The new IHR increase the list of diseases covered (from only cholera, plague, and yellow fever to all naturally occurring infectious diseases; noncommunicable diseases caused by chemical or radiological agents; and releases of biological, chemical, or radiological substances).[64] They incorporate human rights principles and comply with international human rights law. They require states to develop, strengthen, and maintain national surveillance and response capacities,[65] but they provide no financial or technical resources to do so. The new IHR also require states to notify the WHO of any potential international public health emergency detected within their borders (the WHO now has the authority to determine whether the event is of international concern and recommend nonbinding responses by states).[66] The WHO may also act upon information it receives from unofficial and nongovernmental sources through its Global Outbreak Alert and Response Network, so long as the state at issue verifies such information.[67] The SARS and Avian Flu episodes have demonstrated the value of unofficial sources of epidemiological information. The revised IHR do not, however, create a new enforcement mechanism for addressing compliance failure.

Noncommunicable diseases, like infectious diseases, also cause death and disability worldwide, and international legal regimes now also apply to these diseases. Tobacco consumption is a leading risk factor for various noncommunicable diseases. A critical example of an international legal regime in this area is the FCTC, which promotes national action on tobacco control. The FCTC is the first global health regime negotiated under WHO auspices.[68]

The need for a global tobacco control treaty was clear from the numerous international factors associated with tobacco use, including trade liberalization, direct foreign investment, global marketing and advertising, and international sales of contraband and counterfeit cigarettes.[69]

The FCTC requires countries to combat tobacco use on both supply and demand sides. The treaty seeks to reduce demand through price, tax, and nonprice measures, including protection from second-hand smoke; regulation of tobacco products' contents; regulation of disclosures concerning tobacco products; regulation of tobacco products' packaging and labeling; and provision for education, training, communication, public awareness, and smoking cessation efforts.[70] On the supply side, it focuses on illicit trade and sales to minors.[71] The treaty imposes restrictions on tobacco advertising, sponsorship, and

promotion; establishes new packaging and labeling requirements; establishes clean indoor air controls; and strengthens legislation against tobacco smuggling.[72]

The treaty now has 168 signatories, all of whom pledge their commitment to its goals.[73] For those member states that have ratified it, the treaty is legally binding. Each party to the treaty will "develop, implement, periodically update and review comprehensive multisectoral national control strategies, plans and programmes in accordance with this Convention and the protocols to which it is a Party."[74] Under Article 5.2, each party shall, "in accordance with its capabilities: (a) establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control; and (b) adopt and implement effective legislative, executive, administrative, and/or other measures and cooperate, as appropriate, with other Parties in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction, and exposure to tobacco smoke."[75]

The FCTC attempts to serve as a mechanism of international cooperation and state participation in tobacco control. The question is whether it will work.

C. EFFECTIVENESS AND LIMITS OF INTERNATIONAL HEALTH LAW

The developing body of international health law provides lessons for understanding the effectiveness of international health agreements, conventions, treaties, and organizations. The primary question is whether international health agreements—international health-related rules that are legally binding—lead to results on the ground in promoting health, preventing disease, and reducing health inequalities.

One analysis of the IHR's effectiveness over their fifty-six-year history concluded that they had been relatively ineffective in achieving their main objective, due primarily to a failure in their surveillance system and the ineffectiveness of protection measures (specifically, early failures to prevent the spread of cholera and smallpox).[76] Poor national surveillance systems, domestic barriers to reporting, and domestic reluctance to report for fear of reduced trade or tourism have all contributed to IHR failures. Adding to compliance failures, the WHO has no enforcement powers in conjunction with IHR duties, even though nonbinding recommendations and a dispute resolution procedure are in place to address any lack of notifications.[77] The WHO dispute procedure has not been used by WHO member states when IHR violations have occurred.

The IHR's history shows that WHO member states do not comply with legally binding rules and that states do not follow nonbinding WHO recommendations.[78] For example, only 41 of 212 countries and territories adopted WHO policy recommending that schools educate children about HIV/AIDS, and only 102 of 212 adopted WHO's Directly Observed Therapy Short Course (DOTS) policy for treatment of tuberculosis.[79] In general, the WHO has experienced a mixed record of state compliance with its recommendations.

Although it is too early to know the successes and failures of the FCTC, critics already question the FCTC's effectiveness in controlling tobacco use, highlighting that the regime might suffer from failure among member states to modify their behavior to achieve the

FCTC's objectives. Will states ban cigarette advertising? Will they prohibit sales of cigarettes to minors? Will they ban smoking in public places?

International health law has been viewed as "ineffective" in many senses of the word—in a legal sense due to states' failures to comply with stipulated legal rules; in a behavioral sense due to states' failures to change their behavior as a result of the treaty; and in a practical sense due to a treaty's failure to accomplish its objectives.[80]

D. WHAT CONDITIONS FOR THE EFFECTIVENESS OF GLOBAL HEALTH LAW?

Both theoretical and empirical literature in international law can inform questions about the effectiveness of global health law. The questions of whether international agreements are effective and what conditions are required for their effectiveness have long been studied in international law. A major issue is whether effectiveness depends upon enforcement mechanisms, such as military force or sanctions.

There are now numerous studies that explore the effectiveness of international treaties, conventions, and agreements. Theoretically, the enforcement model of states' behavior argues that states are rational actors maximizing utility and thus will adhere to or violate treaties depending on a cost-benefit calculation regarding their actions.[81] Under this model and its compliance theory, treaty regimes must have costly enforcement mechanisms to compel compliance.[82] A managerial model, by contrast, posits that states enter into cooperation with the intention of complying with treaties and that noncompliance is typically not willful but rather is the result of lack of capacity or clarity in terms of objectives.[83] Under this model, efforts to enhance treaties' effectiveness should focus more on barriers to compliance, capacity building, and technical and economic assistance than on punishment.

Despite hypotheses to the contrary, sanctions and threats are not the primary reasons for success stories in implementing international law. Multiple factors play roles. Treaty compliance[84] can result from reciprocity (a mutual exchange of goals based on a mutually beneficial bargain, typically between two states),[85] transparency (which "sets up a powerful dynamic for compliance with treaties"),[86] legitimacy (a shared commitment to good-faith adherence),[87] social learning (deliberation and interaction among agents),[88] mobilization (through the making and implementation of treaties), and internalization (integration of treaty rules into states' legal systems and bureaucracies).[89]

Analysis of past international agreements inspired several key design features in the FCTC. Some of these features are: clear, precise rules; easily verifiable rules (for example, minimum tax rates on cigarettes, packaging and labeling requirements for cigarettes, and advertising restrictions for tobacco); financial support where states lack the capacity to comply; and regular meetings among member states for information exchange and ongoing negotiation.[90] These features could make the FCTC more effective in achieving its goals.[91]

The FCTC and the IHR, as two of the most important and promising tools of international health law, can guide states in a social learning process to understand their interests in reducing global health inequalities and eliminating the threat of global health externalities.

Both the FCTC and the IHR also provide examples of overarching governance mechanisms for the technical and financial assistance required to implement each treaty and for the promotion of compliance among member states. By enhancing transparency, both treaties could act as deterrents to potential violators unwilling to risk their reputations on noncompliance. Finally, both treaties could become internalized in the domestic systems of member states.

III. Global Health Law, Domestic Health Law, and Domestic Health Policy

A. GLOBAL AND DOMESTIC HEALTH LAW: PUBLIC MORAL NORMS AND VOLUNTARINESS

Key to the study of the philosophical foundations of global health law is the relationship between global and domestic health law. In the field of international law more broadly, this relationship can unfold in three functional categories. The first is international law that is "downloaded" from international to domestic law or that is "internalized" or "domesticated" (for example, in human rights, the norm against "disappearances").[92] Second is international law that is "uploaded, then downloaded," like the guarantee of a free trial.[93] Finally, there is law that is "borrowed" or "horizontally transplanted" from one national system to another, like the right to privacy.[94]

One model in which international and domestic law interact is a process, known as the transnational legal process, by which nation-states and domestic and transnational private actors produce cycles of interaction-interpretation-internalization.[95] Actors interpret relevant global norms that are then internalized into states' domestic legal systems through agents of internalization. These agents include nation-states, transnational norm entrepreneurs, governmental norm sponsors, transnational issue networks, and interpretive communities.[96] While transnational legal process theory requires norm internalization, the theory remains primarily procedural and says little about the content of the norms to be internalized.[97] Moreover, it has been criticized for violating democratic principles of self-determination and self-rule at the domestic level.[98] The need remains acute for a theory grounding global health law in normative principles and developing normative commitments for global health governance.

Part I of this Essay presented the idea of an ethical demand for health equity rooted in shared national and international norms about health.[99] Part I also developed the idea of voluntariness in norm internalization—that individuals, groups, state, and non-state actors must voluntarily embrace such norms to achieve health equity effectively. The task ahead is twofold: *to achieve a global consensus on a health equity standard and to persuade domestic actors to embrace voluntarily and internalize the public moral norm of equity in health and to develop their own domestic laws and policies to achieve it.*

Another approach to the interaction between international law and domestic law is to argue that the future of international law is domestic and that the future function of international law is to enhance the capacity and effectiveness of domestic institutions.[100] Along similar lines, Anne-Marie Slaughter has argued that a new world order based not on nation-states, but rather on a world of government networks (of courts, regulatory agencies, ministries,

and legislatures creating links across national borders and between national and supranational institutions) would make a more effective—and potentially a more just—world order than would either the status quo or a world government of top-down global institutions and global rules.[101] However, while the future of international law may very well be domestic, the use of law as a tool for public health cannot be studied in isolation from the roles of domestic and global policy. The final two sections of this Essay focus on these links.

B. GLOBAL HEALTH LAW AND POLICY

The ethics and governance of global health inequalities and threats require both legal and policy instruments working in tandem to produce results on the ground. An empirical program will be necessary to determine the best combination of legal and policy instruments—for the surveillance and control of international health threats, for example, and for the development of norms and standards to regulate international transactions. The revised IHR hold promise, but financial commitments in overseas development assistance and private contributions are required. Global health cooperation also requires technical assistance to develop and strengthen the capacities of health systems in countries where health systems are failing. Global health policy, institutions, and decisionmakers have important roles to play in mobilizing and allocating resources and in providing technical assistance at the national and subnational levels.

The health challenges confronting global and national health communities require an alternative paradigm of global health cooperation. A significant proportion of global health problems have domestic origins, and the old paradigm of international health law failed to address them. International health law should give way to global health law resting on normative principles of global health equity. Global health law, unlike international health law with its roots in interstate legal systems, will require a new system that can reach and affect domestic heath policies and law and employ national health institutions in its achievement of global health goals.

In short, achieving global health equity requires global law and policy to strengthen the capacities and wills of domestic institutions, laws, and policies to address health issues *within their countries*; the future of global health law cannot be examined or understood as separate from domestic health law and policy. Global health law and policy also have key roles in the development and internalization of public moral norms to create and sustain health institutions, policies, and laws in the long term.

C. DOMESTIC HEALTH LAW AND POLICY

Despite this necessity for global law and policy, the primary moral responsibility for addressing global health inequalities and threats lies with national and subnational governments. A variety of other institutions—nongovernmental organizations, communities, businesses, foundations, families, and individuals—also share responsibility for correcting global health injustice.

At the level of the nation-state, I have argued elsewhere for a theoretical framework for health ethics, policy, and law that integrates both substantive criteria and procedural mechanisms to guide health-system reform and allocation of scarce health resources.[102] States must assume primary responsibility for creating an institutional framework for equitable and affordable health care and public health. This framework provides equal access to quality health-related goods and services and to proximal determinants, including nutritiously safe food, potable drinking water, basic sanitation, adequate living conditions, health care, public health surveillance, and health literacy.[103] In many cases, weak and failing states are the major obstacles to progress. Where government institutions are weak and national governments lack adequate resources, abilities, and technical capacities, the global health community, through global agencies and protocols, has an obligation to step in. The World Bank has an especially important role to play in providing both financial and technical assistance for sustainable national health systems.[104] Transnational nongovernmental and governmental networks also have roles to play. Vertical and horizontal networks that link domestic governmental and nongovernmental officials across the globe can be effective agents of change and action.

Conclusion

This Essay has argued that the global community has an ethical and moral responsibility to take positive actions to achieve health equity and should do so through global and domestic tools in law, policy, and institutions. It has presented a set of normative principles—moral foundations—for global health law as guidance on critical health issues. It has argued that, while legal principles have existed over the past several centuries, a coherent set of normative principles, grounded in moral theory, has been lacking. This approach does not argue that the global community has an enforceable (coercible) legal duty, as expressed in legal demands, legal claims (cognizable in international and domestic courts), and legal liabilities. Rather, it envisions global health law embedded in a framework of global health governance, whose purpose is realizing global health equity. It achieves its purpose through the voluntary internalization of the public moral norm of health equity and through subsequent domestic law and policy development and implementation. It views global health law not as a legally enforceable and coercively mandated set of rules forced on states or as a component of any one country's foreign policy or state interest, but as one of a collection of tools and processes for bringing together multiple transnational actors, both state and nonstate, through a global health system committed to shared health governance and global health equity.

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References

1. *See generally* David P. Fidler, International Law and Public Health: Material on and Analysis of Global Health Jurisprudence (2000).
2. For a comprehensive description of the historical trends in international health law from Westphalian governance—that is, governance based upon sovereign states—of infectious diseases to a post-Westphalian "Health for All" to a Neo-Westphalian conceptualization of exogenous threats to disease, such as bioweapons, as national security interests, see Fidler, David P. Caught Between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness. McGeorge L. Rev. 2004; 35:45, 55–72.
3. *See* Jennifer Prah Ruger, *Ethics and Governance of Global Health Inequalities*, 60 J. Epidemiology & Cmty. Health 998, 998–1000 (2006) [hereinafter Ruger, *Ethics and Governance*]; Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 Yale J.L. & Human. 273, 287–304 (2006) [hereinafter Ruger, *Toward a Theory of a Right to Health*]; Jennifer Prah Ruger, Aristotelian Justice and Health Policy: Capability and Incompletely Theorized Agreements (1998) (unpublished Ph.D. dissertation, Harvard University) (on file with author) [hereinafter Ruger, Aristotelian Justice].
4. Keohane, Robert O.; Nye, Joseph S. Power and Interdependence (3d ed.). 2001:20–32. From a political realist view, military competition, war, and preparation for war are the key activities in international relations.
5. *See* David P. Fidler, *The Globalization of Public Health: The First 100 Years of International Health Diplomacy*, 79 Bull. World Health Org. 842–49 (2001) [hereinafter Fidler, *Globalization of Public Health*] (describing the history of international health law and diplomacy, which—although it dates back to European quarantine practices in the fourteenth century—really began in the midnineteenth century).
6. *See* World Health Org. [WHO]. Ctr. for Health Dev., History of WHO and International Cooperation in Public Health. last visited Sept. 19, 2007http://www.who.or.jp/GENERAL/history_wkc.html
7. *See* Fidler, *Globalization of Public Health*, *supra* note 5.
8. WHO. Working for Health: An Introduction to the World Health Organization. 2007; 9 *available at*http://www.who.int/about/brochure_en.pdf.
9. For various perspectives on self-interest and other motivations in general, see generally Mansbridge, Jane J.Beyond Self-Interest. 1990
10. *See* Hathaway, Oona. Do Human Rights Treaties Make a Difference? Yale L.J. 2002; 111:1935–1938.
11. *See* Simon, Jeffrey D. Lederberg, JoshuaBiological Terrorism: Preparing To Meet the Threat. Biological Weapons: Limiting the Threat. 1999; 235:235–248.
12. For a description of the Hobbesian view, see Beitz, Charles R. Political Theory and International Relations. 1979:27–34.
13. *See* Ilona Kickbusch, *Global Health Governance: Some Theoretical Considerations on the New Political Space*, *in* Health Impacts of Globalization: Towards Global Governance 192 (Kelley Lee ed., 2003); Gill Walt, *Global Cooperation in International Public Health*, *in* International Public Health: Diseases, Programs, Systems, and Policies 667, 674–78 (Michael H. Merson et al. eds., 2001); Fidler, *Globalization of Public Health*, *supra* note 5.
14. *See* Farmer, Paul. Pathologies of Power: Health, Human Rights, and the New War on the Poor. 2003:18–19. 74–77, 194–95. Annas, George J. The Right to Health and the Nevirapine Case in South Africa. New Eng. J. Med. 2003; 348:750–754. [PubMed: 12594322]
15. *See* David Woodward & Richard D. Smith, *Global Public Goods and Health: Concepts and Issues*, *in* Global Public Goods for Health: Health, Economic, and Public Health Perspectives 3, 3–32 (Richard D. Smith et al. eds., 2003); *see also* Dean Jamison et al., *International Collective Action in Health: Objectives, Functions, and Rationale*, 351 Lancet 514, 514–17 (1998).
16. *See* Allen Buchanan, Justice, Legitimacy, and Self-Determination: MORAL FOUNDATIONS FOR INTERNATIONAL LAW 1–14 (2004).

17. *See generally* Thomas Hobbes, Leviathan (Richard Tuck ed., Cambridge Univ. Press 1991) (1651). A Hobbesian state of nature involves no global sovereign, equity of power, national interest, or struggle for military dominance among nations.
18. *See* John Rawls, The Law of Peoples 30–35 (1999); *cf*. Thomas Nagel, *The Problem of Global Justice*, 33 Phil. & PUB. Aff. 113, 128 (2005).
19. For an excellent critique of Rawls's theory and the social contract extended to the global plane, see Martha C. Nussbaum, Frontiers of Justice: Disability, Nationality, Species Membership 11–12, 22–24 (2006). For arguments with roots in Rawls's theory supporting globalized contractarianism, see generally Thomas W. Pogge, Realizing Rawls (1989).
20. Rawls was skeptical of global institutions. *See, e.g*., Rawls, *supra* note 18.
21. *See, e.g*., Pogge, Thomas W. World Poverty and Human Rights. 2002; 169
22. *See* Joseph E. Stiglitz, Globalization and Its Discontent 3–23 (2002). *See generally* William Easterly, The Elusive Quest for Growth: Economists' Adventures and Misadventures in the Tropics (2001).
23. *See* Sen, Amartya. Development as Freedom. 1999:58–63.
24. *See generally* Hugo Grotius, De Jure Belli ac Pacis Libri Tres (James Brown Scott ed., Francis W. Kelsey trans., Clarendon Press 1927) (1646).
25. *Cf*. Fernando R. Tesón, A Philosophy of International Law 73–98 (1998).
26. Martha Nussbaum has developed a theory of central human capabilities that relates to the Grotian view in that these capabilities are universal—without each, one cannot live a life "worthy of human dignity." *See* Nussbaum, *supra* note 19, at 78.
27. *See* Buchanan, *supra* note 16, at 118–90 (arguing that justice as a goal of international law is to be understood as respect for basic human rights and as a safeguard to ensure access to institutions of justice that protect basic human rights).
28. For a contemporary political science perspective on realism, see Keohane & Nye, *supra* note 4. *See also* Michael W. Doyle, *Kant, Liberal Legacies, and Foreign Affairs* (pts. 1 & 2), 12 Phil. & Pub. Aff. 205, 323 (1983).
29. For a discussion of the role of theory in explaining international law, see Waltz, Kenneth N. Theory of International Politics. 1979; ch.1
30. The legal nihilist view rejects international law as a legitimate legal system, due both to international law's lack of enforcement mechanisms for its rules and to its provision for only modest authority by the courts. *Cf*. H. L. A. Hart, The Concept of Law 124–37 (1961).
31. Legal positivism takes law as affirmatively enacted or written and looks to texts, treaties, and statutes as the law, whereas natural law scholars and practitioners look to moral or natural reasoning to determine what law is. This Essay does not engage with the naturalist/positivist debate; rather, it leaves that to others.
32. WHO. World Health Report; 2005. p. 174-179.*available at*http://www.who.int/whr/2005/en/index.html.
33. *See* Press Release, United Nations, World Population to Increase by 2.6 Billion Over Next 45 Years, With All Growth Occurring in Less Developed Regions, U.N. Doc. POP/918 (Feb. 24, 2005), *available at* http://www.un.org/News/Press/docs/2005/pop918.doc.htm; World Bank, World DEVELOPMENT Indicators 35–39 (2007), *available at* http://siteresources.worldbank.org/DATASTATISTICS/Resources/WDI07section2-intro.pdf.
34. *See generally* Jennifer Prah Ruger, *Ethics of the Social Determinants of Health*, 364 Lancet 1092 (2004) [hereinafter Ruger, *Ethics of the Social Determinants of Health*]; Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 Cornell J.L. & Pub. Pol'y 403 (2006) [hereinafter Ruger, *Health, Capability, and Justice*]; Jennifer Prah Ruger, *Health and Social Justice*, 364 LANCET 1075 (2004) [hereinafter Ruger, *Health and Social Justice*]; Ruger, Aristotelian Justice, *supra* note 3.
35. *See* Ruger, *Ethics and Governance*, *supra* note 3; Ruger, *Toward a Theory of a Right to Health*, *supra* note 3.
36. *See* Ruger, *Ethics and Governance*, *supra* note 3, at 999 (citing Aristotle, The Nicomachean Ethics (J.E.C. Welldon ed., Prometheus Books 1987) (n.d.); Amartya Sen, Commodities and Capabilities (1985)).

37. *See* Ruger, Aristotelian Justice, *supra* note 3, at 63–65, 112–16.
38. *See* Ruger, *Ethics and Governance*, *supra* note 3, at 1001–02.
39. *See* Ruger, Jennifer Prah. Rethinking Equal Access: Agency, Quality and Norms. Global Pub. Health. 2007; 2:84–87.
40. For an empirical cross-national study of global health inequalities from a shortfall perspective, see Ruger JP, Kim H-J. Global Health Inequalities: An International Comparison. J. Epidemiology & Cmty. Health. 2006; 60:928, 928–936.
41. *See generally* Ruger, *Health and Social Justice*, *supra* note 34; Ruger, Aristotelian Justice, *supra* note 3, at 115–16.
42. *See* Buchanan, *supra* note 16 (arguing that most political theory and political philosophy do not include institutional analysis).
43. *See, e.g*., Ruger & Kim, *supra* note 40, at 935–36.
44. *See* Ruger, *Ethics and Governance*, *supra* note 3.
45. *See id*. at 1001.
46. *See id*.
47. *See id*.
48. *See id*. at 1001–02.
49. *See id*.
50. Ruger, *Health, Capability, and Justice*, *supra* note 34, at 409.
51. *See* Ruger, Jennifer Prah. Global Health Governance as Shared Health Governance. 2007 May 25.:13–17. (unpublished manuscript, presented at *Values and Moral Experiences in Global Health* Conference at Harvard University) (on file with author).
52. Ruger, *Health and Social Justice*, *supra* note 34, at 1079–80.
53. Elsewhere, I argue for widespread internalization of the public moral norm of willingness to pay taxes for others' health insurance to achieve domestic health care reform on universal health insurance in the United States. *See* Ruger, Jennifer Prah. Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making. J. Health Pol. Pol'y & L. 2007; 32:51, 73–78.
54. *Cf*. Fidler, David P. Revision of the World Health Organization's International Health Regulations. ASIL Insights. 2004 Apr.last visited Sept. 9, 2007http://asil.org/insights/insigh132.htm
55. Examples of such regimes include Trade-Related Aspects of International Property Rights (TRIPS) regulation in international trade law and Sanitary and Phytosanitary (SPS) regulation in international food safety law.
56. *See* Fidler, *supra* note 54.
57. *See id*.
58. U.N.World Health Org. Const. art. 19.
59. *Id*. art. 21.
60. *Id*. art. 22.
61. *See id*. art. 2.
62. *See generally* Michael G. Baker & David P. Fidler, *Global Health Surveillance Under New International Health Regulations*, 12 Emerging Infectious Diseases 1058 (2006) (assessing the revised IHR's surveillance system).
63. International Health Regulations (2005) art. 2, *adopted* May 23, 2005, *available at* http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_3-en.pdf (last visited Sept. 9, 2007).
64. *See id*. art. 1.
65. *See id*. arts. 5, 13.
66. *See id*. art. 6.
67. *See id*. art. 9.
68. *See* Roemer, Ruth, et al. Origins of the WHO Framework Convention on Tobacco Control. Am. J. Pub. Health. 2005; 95:936–936. [PubMed: 15914812]

69. *See* Taylor, Allyn L.; Bettcher, Douglas W. WHO Framework Convention on Tobacco Control: A Global "Good" for Public Health. Bull. World Health Org. 2000; 78:920, 923–925. [PubMed: 10994266] (discussing the globalization of the tobacco epidemic).
70. *See* WHO Framework Convention on Tobacco Control arts. 6–14, *adopted* May 21, 2003, 2302 U.N.T.S. 166.
71. *See id*. art. 16.
72. *See id*. arts. 8, 11, 13, 15.
73. *See* WHO, Updated Status of the WHO Framework Convention on Tobacco Control, http://www.who.int/tobacco/framework/countrylist/en/index.html (last visited Sept. 18, 2007).
74. *See* WHO Framework Convention on Tobacco Control, *supra* note 70, at art. 5, para. 1.
75. *Id*. art. 5, para. 2.
76. *Cf.* Fidler, David P.; Gostin, Lawrence O. The New International Health Regulations: An Historic Development for International Law and Public Health. J.L. Med. & Ethics. 2006; 34:85–85.
77. *See id*.
78. It has been argued that the numerous international treaties leading up to the IHR—and the IHR themselves—created rules of customary international law through state practice motivated by perceived obligations under these treaties. Examples of such perceived obligations include the duty to report infectious disease outbreaks and the duty not to apply excessive measures when another state experiences an outbreak. For a discussion of this line of argument and its implications for customary international law rules and state responsibility, see Fidler, David. International Law and Infectious Disease. 2000:81–82. 99–104.
79. WHO. Report on Infectious Diseases: Removing Obstacles to Healthy Development. 1999; ch. 8 *available at*http://www.who.int/infectious-disease-report/pages/graph23.html.
80. For more on the different meanings of effectiveness in international law, see generally David G. Victor et al., The Implementation and Effectiveness of International Environmental Commitments: Theory and Practice (1998); Oran R. Young, *The Effectiveness of International Institutions: Hard Cases and Critical Variables*, *in* Governance Without Government: Order and Change in World Politics (James N. Rosenau & Ernst-Otto Czempiel eds., 1992); Ronald B. Mitchell, *Compliance Theory: A Synthesis*, 2 Rev. Eur. Cmty. & Int'l Envtl. L. 327 (1993).
81. *See* Goldsmith, Jack L.; Posner, Eric A. The Limits of International Law. 2005:83–106.
82. *See, e.g., id*.
83. *See* Chayes, Abram; Chayes, Chayes. The New Sovereignty: Compliance With International Regulatory Agreements. 1995:109–112.
84. *See generally* Arild Underdal, *Explaining Compliance and Defection: Three Models*, 4 Eur. J. Int'l Rel. 5 (1998).
85. *Cf.* Ausubel JH, Victor DG. Victor, Verification of International Environmental Agreements. Ann. Rev. Energy & Env't. 1992; 17:1–31.
86. *See* Chayes & Chayes, *supra* note 83, at 135.
87. *See* Franck, Thomas M. The Power of Legitimacy Among Nations. 1990:3–26.
88. *See* Jeffrey T. Checkel, *Why Comply? Social Learning and European Identity Change*, 55 Int'l Org. 553, 560–64 (2001); *cf*. Ryan Goodman & Derek Jinks, *International Law and State Socialization: Conceptual, Empirical, and Normative Challenges*, 54 Duke L.J. 983, 984–89 (2005).
89. *See* Martha Finnemore & Kathryn Sikkink, *International Norm Dynamics and Political Change*, 52 Int'l Org. 887, 904 (1998); *see also* Harold Hongju Koh, *Why Do Nations Obey International Law?*, 106 Yale L.J. 2599, 2646 (1997).
90. *See generally* WHO Framework Convention on Tobacco Control, *supra* note 70.
91. *See* Daniel Bodansky, *What Makes International Agreements Effective? Some Pointers for the WHO Framework Convention on Tobacco Control*, *in* WHO FRAMEWORK Convention on Tobacco Control Technical Briefing Series 7, 37 (WHO ed., 1999).
92. *See* Koh, Harold Hongju. Is There a "New" New Haven School of International Law? Yale J. Int'l L. 2007; 32:559–567.
93. *See id*.

94. *See id*.
95. *See* Koh, Harold Hongju. Transnational Legal Processes. Neb. L. Rev. 1996; 75:181, 183–184.
96. *See id*.; *see also* Thomas Risse & Kathryn Sikkink, *The Socialization of International Human Rights Norms into Domestic Practices: Introduction*, *in* The Power of Human Rights: International NORMS AND Domestic Change 1, 1–38 (Thomas Risse, Stephen C. Ropp & Kathryn Sikkink eds., 1999).
97. *See* Mary Ellen O'Connell, *New International Legal Process*, *in* The Methods of International Law 79, 79, 87 (Steven R. Ratner & Anne-Marie Slaughter eds., 2004).
98. *See* Chander, Anupam. Globalization and Distrust. Yale L.J. 2005; 114:1193, 1232–1233.
99. *See* Ruger, *Toward a Theory of a Right to Health*, *supra* note 3, at 275 (arguing for a universally agreed-upon and shared view of health).
100. *See* Slaughter, Anne-Marie; Burke-White, William. The Future of International Law Is Domestic (or, the European Way of Law). Harv. INT'l L.J. 2006; 47:327–330.
101. *See* Slaughter, Anne-Marie. ANewWorld Order. 2004; ch. 5
102. *See* Ruger, *Health, Capability, and Justice*, *supra* note 34, at 435–40.
103. *See* Ruger, *supra* note 39.
104. Ruger, Jennifer Prah. What Will the New World Bank Head Do for Global Health? Lancet. 2005; 365:1837, 1839–1840. [PubMed: 15962458]