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Public Health and the Rights of States

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States, when claiming political authority, do not merely assert the fact of their actual power over a number of people, or over a circumscribed area. What they claim is rights of various sorts with a moral grounding. In this respect they claim to be different from other kinds of human associations that have power over persons, such as gangs of criminals. States claim authority in exercising coercive power over their subjects, and when they meet certain criteria justifying their use of coercive power, we speak of legitimate authority. States have claimed rights to enforce requirements against persons residing on their territory, to control uses of the resources on their territory, to control movement across their borders, and to exclude outsiders from the use of resources on their territory. Can public health considerations provide support for the justification of legitimate authority with these features? In this paper I will consider whether or not public health arguments can help justify some rights states have claimed, and I will explore some constraints on the justificatory force of public health considerations.

I outline two arguments about the moral grounds for states' rights with regard to public health. Some rights might be thought justified by the principle of fairness, emphasizing that those who benefit from public health measures ought to contribute their fair share in upholding them. Alternatively, states' rights might be justified by a natural duty of justice binding subjects to abide by just rules and requiring outsiders not to obstruct the working of just institutions implementing public health policies. Although I do not attempt to defend the latter position in detail, I will indicate some reasons for preferring it to the former one.

I will go on by arguing in detail, however, that the assignment of some rights to states via public health based justification is undermined on several counts. First, it is no longer clear that domestic political institutions can still effectively perform their functions in protecting domestic public health at current levels of the international movement of persons and goods. Furthermore, trans-border public health threats pose collective action problems at the global level. Finally, concerns about human rights work against the assignment of some rights to states. I conclude by arguing that these concerns

call for global coordination even without postulating a general cosmopolitan duty to promote global health. Hence, some rights claimed by states ought instead to be assigned to supra- or international institutions.

The rights of territorial states

States, when claiming political authority, make a moral claim to rights of various sorts in their exercise of coercive power. We can sort these rights into three categories.[1] First, states claim rights over their subjects. They are regarded as entitled to impose and enforce legal requirements on their subjects, who in turn are thought to have a corresponding moral obligation to obey these requirements. Second, states claim rights against aliens. These include a state's right not to be interfered with in governing their subjects or their territory by other persons, groups of persons, or states, and a right to control and prohibit movement across their borders, including a right to restrict immigration.[2] Finally, they claim rights over the use of their territory. These include rights such as "rights to reasonably full control over land and resources within the territory that are not privately owned", rights to specify property by enacting a property law regime governing the acquisition and transfer of property, as well as laws in criminal law against force and fraud in seizing property, and also rights to restrict the uses of property on their territory – e.g. by zoning laws, laws regulating the exploitation of natural resources, laws restricting hazardous activities in populated areas etc (Copp, 1999). States also claim the right to tax and regulate uses of privately owned resources on their territory.

Many of the rights states claim are relevant for public health either because public health considerations can be directly used to justify them, or because, even if not themselves based on public health grounds, some of these rights have an effect on public health within the population. Consider some examples for each type of rights.

Mandatory vaccination programs for certain infectious diseases impose a legal requirement on subjects to comply, and are one instance of states' rights over subjects.[3] Other examples include quarantine, isolation, and mandatory treatment of individuals to contain epidemics, as it happened during the SARS outbreak in countries such as Hong Kong and Canada (Dawson and Verweij, 2007: 4). Finally, the legal requirement of

physicians to report HIV cases by name also represents the exercise of state's right over its subjects (Bayer and Colgrove, 2002: 98-101).

With regard to rights against aliens, states claim rights to restrict travel or immigration on public health grounds, thereby restricting the freedom of movement of foreign citizens. For example, aliens may be denied admission to the U.S. if they cannot document their vaccination against certain vaccine-preventable communicable diseases (Fidler, 2002: 153). Also, would-be immigrants might be required to undergo detailed screening or pre-arrival treatment for a number of communicable diseases in order to be granted entry (Holland, 2007: 164).

Finally, rights over territory also have public health dimension. Laws restrict certain hazardous activities in populated areas on public health grounds. In cases of public health emergency, states claim the right to seize and appropriate private property in defense of public health, for example by using it for care, treatment, and housing of patients, or by destroying contaminated materials (Gostin, 2002: 84). Laws regulating the advertising of tobacco or alcohol products and the zoning of their sales also have public health grounds. Perhaps less obviously, policies reducing socioeconomic inequalities have a public health dimension insofar as these inequalities shape the health status of a population through the social gradient of health.[4]

These public health functions are couched in terms of rights and obligations. Since these are asserted not merely as legal but also as moral rights and obligations, they are in need of moral justification. Suppose a state introduces a policy of prohibiting the immigration of people from certain parts of the world characterized by high incidence of infectious diseases, or denies entry to HIV positive persons into the country on public health grounds. The question is by what, and to what extent, are such exercises of power against aliens, over subjects, and over territory, justified? In what follows I will briefly outline two of the potential moral grounds for these rights and obligations, a fairness based and a justice-based one, and indicate some reasons for preferring the second of these. In the main part of the paper I will discuss some limits to the justice-based justifications of the rights of states.

Public health measures as public goods

The fairness-based justification of the rights of states is closely related to the public good nature of public health, hence first I describe the key characteristics that make a wide range of public health measures public goods and then turn to the normative arguments underlying states' rights with regard to them. By public health I will understand throughout the paper a set of institutions, policies and actions that aim to improve or protect population health by collective means.[5]

One important function performed by states is the provision of public health for their residents. Many public health policies have been widely recognized to possess the characteristics of public goods. The benefits they provide are nonexcludable and their consumption is non-rival. That is, no one within the relevant population can be excluded from the benefits provided, not even those who did not contribute to their production; on the other hand their consumption by one person does not reduce the quantity or quality available for others.

One good example of the public good character of public health measures is creating population immunity against certain communicable diseases by mass vaccination. Population or herd immunity is a property of a group that results from the fact that a sufficient number of people within the group are immune to a disease. When population immunity exists, the likelihood of a non-vaccinated person's coming into contact with the disease drops to a very low level. This is because most people in the population who come into contact with an infected individual already have immunity and therefore will not pass on the disease.[6] The benefits of population immunity are such that people who decide not to get vaccination cannot be excluded from these.

That the provision of public goods notoriously engenders collective action problems has been regarded as central to the justification of political authority with powers of coercion. This is because their existence is made possible only through the joint effort of a significant part of the population, which is not likely to be forthcoming to a sufficient extent without coercion. Public goods can be provided only if a substantial portion of the population contributes to their production, however, contribution to their provision involves some cost for individuals. Since everyone in the public can benefit from the good whether or not one contributes, once provided, it will not be in their individual interest to contribute to it. This creates an incentive for free-riding for all those

who stand to benefit from the public good in question and calls for assurance that an agreement to contribute one's share is carried out. For this reason, policies and institutions involving enforcement mechanisms are frequently necessary for public good provision. This consideration seems like a good candidate for justifying the rights of states with regard to public health.

Mandatory vaccination is a case in point. Routine vaccinations in mass immunization programs entail some small risk of serious harm to the vaccinated individual and might lead to serious health damage and even death in extreme cases. On the other hand, over a certain threshold proportion of the public being vaccinated, population immunity already exists. Whether or not an individual undergoes vaccination, she will be protected from the disease. Considering the cost of individual health-risk posed by vaccination, and the fact that one is likely to be prevented from the disease by population immunity anyway, people are likely be tempted to avoid vaccination, given that the added benefit of being vaccinated may not be very significant. Mandatory vaccination might be a necessary means of bringing about and maintaining the necessary level of protection for the population. This may seem a good reason for state coercion against subjects in the field of public health. A significant public health benefit of immunity from dangerous infectious diseases cannot be provided unless there are some coercive sanctions to make it the case that people do not find it in their interest to free-ride on the effort of others and are assured that other people will also contribute their fair share.

The argument from fairness

Some public good type public health benefits such as mandatory vaccination could not be provided without coercive measures backed up by state power. This consideration does not by itself morally justify such measures, however. One step is missing from the argument for granting states rights over their subjects with regard to mandatory public health policies. What are the moral grounds for coercing people to undergo potentially harmful treatment, even if it is necessary to provide some common benefit? An argument adapted from the literature on political obligation readily suggests itself: the argument from fairness.

The duty of fairness requires that participants deriving benefits from an ongoing practice contribute their fair share to maintaining it. Those who fail to contribute are free-riding on the effort of others and are for this reason unfair to other participants.[7] The moral requirement of fairness might in certain cases justify coercion in order to assure compliance with the cooperative practice creating and maintaining public goods. George Klosko argues that in the case of goods that are necessary for making decent lives possible, all individuals who benefit from these goods have an obligation to cooperate.[8] Since these goods are essential for living acceptable lives, so the argument goes, state coercion in securing compliance with their provision is justified. The goods that are typically listed among these essential goods include law and order and protection from external threats, but the same description applies to public health policies as well. Without basic public health policies acceptable lives would not be possible, the benefits associated with them are provided through collective effort, and they are characterized by non-rivalrousness and non-excludability. Coercive public health measures such as mandatory vaccination may then be justified by pointing out the significant benefits citizens derive from these programs and their obligation grounded in fairness to contribute their share.

Fairness considerations have their shortcomings, however. One general reason behind these is that the argument from fairness focuses on benefits one has actually received or stands to receive from an ongoing cooperative scheme. The argument states that once one has benefited or stands to benefit from an ongoing scheme, she has an obligation to contribute her share, and if the benefits in question are essential for living acceptable lives and are provided by the state, authorities are justified in coercively enforcing this obligation. Once there is a public health program that is up and running from which one benefits, one may legitimately be required to obey the rules and shoulder part of the burden in connection with the program. Fairness considerations have nothing to say, however, about the legitimacy of establishing or extending public health policies in the first place.

Also, fairness considerations do not extend to practices that once provided benefits, but are no longer capable of doing so. Thus, the argument from fairness in the justification of states' rights over subjects is likely to be undermined by the effects of

globalization. One of the argument's premises is that important public goods are being provided by states through public health policies to their subjects. As we shall shortly see, some changes described under the heading of globalization have resulted in states' diminished capacity to provide some public health benefits they could previously provide. The impact of these trends on domestic public health policies and on the argument from fairness is the following. Some public health functions previously exercised by states can no longer effectively be exercised by them. Therefore, the obligation of subjects to obey coercive public health measures is significantly weakened, or even cancelled, since the relevant public health benefits which triggered a fairness-based obligation to obey are no longer provided by the state. In the absence of an agency actually providing these public health benefits no one has an obligation to contribute to their provision even if this were possible through alternative means.

A final shortcoming of the argument from fairness is that it cannot justify all the moral rights states claim in performing their public health functions. At best, it can justify subjects' obligation to obey, however it has nothing to say about rights states claim against foreigners. To provide an essential public good states must be able to enforce public health policies not only against their own citizens or residents. In many cases, the provision of some public health benefit involves coercive measures against foreigners or control over a certain territory as necessary instruments. However, aliens cannot be regarded as providers of a public benefit in the sense relevant for public goods. Even when they abide by the regulations other states impose on them, they merely refrain from interfering with the public good provision rather than being positive contributors. Even more importantly, under no plausible description can they be regarded as beneficiaries of the public health policies of other states to an extent sufficient to generate obligations of fairness to the scheme. Therefore, even if it were true that providing some public health benefit requires that states exercise power over foreign individuals, fairness considerations are insufficient to establish a moral right of states against aliens. For this and the previous reasons, I turn to a different rationale for granting states rights in public health.

Public health as a requirement of justice

Let me now outline an alternative view that stands a better chance of justifying some rights political institutions exercise over their subjects, against aliens, and over their territory. The argument from fairness is neutral concerning whether or not there is a moral requirement to promote public health. It only states that once policies for the promotion of public health are cooperatively pursued, everyone benefiting from them has an obligation to contribute their fair share. We can plausibly start out from a stronger premise, however. There are good reasons for holding it as a matter of justice that public health ought to be promoted.[9] Political institutions with powers over subjects, territory, and against aliens are necessary for carrying out this task.

We can justify the rights of political institutions by introducing a further premise: that every person has a natural duty of justice that requires the following things. First, all those individuals subject to a currently existing just or nearly just scheme of institutions are required to contribute their fair share to upholding it, which involves the requirement to comply with the rules of the scheme. Second, those outside an existing just or nearly just scheme must not obstruct or undermine its working. Finally, individuals must further the establishment of just institutions in case they do not yet exist.[10] The requirements following from our natural duty of justice can give a moral grounding to the rights claimed by states in protecting public health. If the provision of policies to promote public health is part of what it means to have a just scheme of institutions, state rights backed up by powers of enforcement and corresponding requirements on individuals, are morally justified by the natural duty of justice.

To illustrate, subjects might be required by their duty of justice to undergo mandatory vaccination necessary to provide the population with immunity against an infectious disease that would otherwise impose a substantial burden of disease on the population even when vaccination involves some cost to those undergoing it. In the absence of such a policy the public health function of political institutions would be seriously compromised. Furthermore, public health within a country can in some cases only be promoted by imposing certain restrictions on some freedoms of aliens, such as their freedom of movement. In these cases, political institutions may be justified in making and enforcing such restrictions against aliens, who in turn have a corresponding duty not to obstruct these rules. International travel restrictions might thus be justified in

the case of the emergence of a highly contagious disease that represents catastrophic risk, and travelers are in such cases expected to abide by these restrictions.[11] Rights over territory may also be justified on public health grounds. For example, political institutions might have to restrict the movement of health-related goods across borders in defense of the health care system serving the relevant population, if free imports would undermine some important public health aims.[12]

Whether such public health policies are justified is to a large extent an empirical question. The justifiability of mandatory vaccination policy for a contagious disease, for example, depends on a number of facts about the character of the epidemic and the organization of society. It might be the case that voluntary vaccination programs result in higher participation rates than mandatory programs do. However, under certain circumstances mandatory vaccination might be the only way to go. If mandatory vaccination is the only available means to sustain population immunity, one might argue that individuals have a duty of justice to undergo vaccination and states have an obligation to establish a mandatory vaccination policy.[13]

The limits of state sovereignty: the erosion of state capacities, global public goods

The rights states have in promoting the public health within their borders are not without limits, however. Not all the rights states have historically claimed are justifiable. There are several reasons why nation-states in their current form might not be the appropriate bearers of at least some of these territorial rights, hence why the state-system as we know it may need to be supplemented or replaced by some alternative global political regime. These considerations significantly constrain the justification of specific institutional arrangements capable of performing the functions necessary for promoting public health.

In what follows, I will look at two such constraints on states' rights: the need for global coordination due to the erosion of state capacities and the prospect of achieving better health outcomes on one hand, and concern about human rights on the other hand.

Let me first outline some public health-based considerations that have made some territorial rights usually associated with states outdated in the sense that, due to modern developments, either most states are no longer capable of exercising certain functions that could be used to justify these rights, or it is desirable that functions previously exercised

by territorial states be transferred to supranational institutions. Recent institutional, social, economic, ecological, and technological developments have brought about both the demand for supranational coordination in many areas and also the capacities that were lacking in previous institutional arrangements. This applies to public health too.

Some of the most pressing current public health issues have taken a global dimension. Recent epidemics such as HIV/AIDS, cholera, ebola, SARS and avian flu all presented or threatened with global public health problems with potentially catastrophic consequences. States' capacity to protect public health by exercising their rights has been significantly diminished by changes in social networks, the global economy, ecology, and technological developments, such as the increase in the volume of the movement of persons, goods, and ideas. In turn, improved domestic health outcomes are now possible by better global coordination that involves removing some elements of state sovereignty and granting additional rights to other entities, such as supranational institutions. These changes have undermined the moral rationale for granting some of the rights states have claimed for themselves.

This process can take several forms. One obvious case relates to the movement of persons such as travel and migration. Infectious diseases can spread across populations more rapidly than ever, due to the rapid speed of travel enabled by modern technology and the increasing numbers of people traveling. Early detection of and response to some dangerous infectious diseases on the state level is made difficult or impossible by the relatively short travel time of even the longest international flights compared to the incubation period of these diseases. Not only is the transmission of existing strains of infectious diseases facilitated, their mutation and development of new strains is also made easier by the same changes. These changes have decreased the capacity of individual states to effectively prevent or contain the spread of communicable diseases.

Moreover, potential responses to these global public health issues suffer from similar collective action problems to what we saw characterizing domestic public health policies. Global coordination is necessary to effectively promote public health in most societies, however, such cooperation may not be forthcoming or may not be efficient due to some built-in problems. Increased global travel and trade volume facilitating the

spread of infectious diseases is made a global collective action problem by the incapacity of individual states to achieve the globally desirable outcome by acting alone.

Consider the example of the role of antibiotics in facilitating the emergence of resistant strains. It is now well known that the overuse of antibiotics contributes to the emergence of drug resistant strains such as multidrug resistant tuberculosis, creating negative externalities for countries with responsible drug-policies. Suppose country A is aware of the threats of drug misuse and decides to restrict the use of antibiotics by imposing strict regulations on their prescription. This means that it has to incur substantial costs and to forgo some potential minor benefits of a more liberal use of antibiotics in order to prevent the emergence of resistant strains. For example, it has to devote resources to monitoring patients' drug use, patient support, and quick introduction of alternative drug regimens when resistance begins to emerge (Kremer, 2006: 32). Suppose, however, that other countries are less strict in regulating the use of antibiotics and for this reason multidrug resistant forms of a disease emerge. Given the rapidity of the movement of persons across borders, country A will no longer be able to benefit from its more restrictive regulations, while still bearing its costs. Without international cooperation the desired aim cannot be reached.[14]

Control of the use of antibiotics is one case of global public goods in public health that present global collective action problems, however there are other important cases too. Let us see a brief list of these.

Eradication efforts. In the case of communicable diseases that are close to eradication, like polio today, a global public good can be created by efforts targeted at its final eradication. In the case of polio, the benefits of its eventual eradication would be mostly enjoyed by rich countries which at the moment have to expend considerable resources on vaccinating their population. The costs would, however, have to be borne disproportionately by poorer countries which otherwise have other priorities, considering some more pressing public health problems they face and the low prevalence of polio in these countries (Kremer, 2006).

Disease surveillance. Early information gained from global surveillance is necessary for controlling the spread of some communicable diseases. However,

individual countries have an incentive to free-ride by benefiting from the efforts of neighboring and other countries without contributing their share. Disease reporting might be costly for them, for example, because of the economic effects of adverse publicity or travel bans or recommendations by other countries or WHO.

Medical knowledge generation and dissemination. Medical research is usually costly, on the other hand the benefits generated from it are sometimes enjoyed also by countries that did not contribute their share of the costs. In economic terms this means that there is a tendency to under-invest by rich countries and private companies into R&D on vaccines and drugs targeting diseases in poorer countries, for example into developing vaccines for schistosomiasis or malaria, since they cannot recover the costs. One main reason is that patent protection, which is the main safeguard in rich countries for pharmaceutical companies to recover the costs of their investment into research and development, is less comprehensive in developing countries that have chosen to limit patent protection for drugs. This has resulted in under-investment in R&D for drugs most needed by low- and middle-income countries. This problem can be overcome by devising and financing programs that encourage the provision of R&D in pharmaceutical research into drugs that can most effectively reduce the burden of disease in poor countries.[15]

In addition to providing incentives for R&D in drugs and vaccines for neglected diseases, the establishment of public health norms and standards is also an important form of medical knowledge generation. WHO already performs this function for a range of activities, such as diagnosis, treatment, prevention, surveillance, and health information. These norms and standards, such as the International Classification of Diseases and Injuries and the Essential Drugs List developed by WHO, also constitute important global public goods because, once they exist, most people will benefit from their application.

These are examples of potential global public health measures that would bring about better health outcomes in many countries, which, however, require global cooperation due to the public good nature of these benefits. They provide us with a further reason to think that states should give up some rights they have claimed for themselves, which should instead be assigned to transnational bodies. If justice requires the effective provision of public health for a given population or within a given territory,

political institutions ought to be so organized as to carry out this task on pain of injustice. Global collective action problems impose significant limits on what states can achieve by way of public health policy. On one hand, they reduce capacities states formerly had in protecting public health. On the other hand, they prevent potential improvements in public health outcomes states cannot individually achieve. These constraints can be overcome only by greater global coordination, which is then required by justice.

Justice then requires the provision of global public goods in public health because these goods enable the promotion of public health for any given population or territory. The fact that there are available mechanisms to provide global public goods that promote public health make it the case that people have a duty to implement these mechanisms and abide by their rules.[16]

Notice that the normative force of a requirement to establish these policies and institutions need not be stemming from a commitment to global justice which requires the promotion of global public health by the relevant agents. For the argument to go through, it suffices if we recognize the importance of promoting domestic public health. Assuming that domestic justice requires the promotion of public health within society, and that the only way to do so is by overcoming the global collective action problems outlined above, global public health institutions and policies are required even on what are essentially domestic justice grounds. Thus the justification of global public health measures can be premised on the more modest requirement to promote domestic public health.

The limits of state sovereignty: human rights

In addition to the erosion of state capacities and the need for global coordination, the human rights of citizens and aliens as well limit state sovereignty in public health protection. These considerations emphasize that, due to the importance of some other values, not all the rights states have claimed may be justified even by considering the public health benefits they would yield, and thus some of them are to be rejected. The reason is that they might be in conflict with the requirements of human rights enshrined in various international human rights documents, guiding the working of international institutions.

Under the concept of human rights, persons possess a universally valid claim to certain rights, regardless of race, gender, or nationality. Although the foundations and nature of human rights are a contested issue, there is sufficient consensus about the content of a minimal list of human rights that allows for prescribing some limits on the rights of states against their citizens and aliens. This list is likely to include rights such as rights against violence, enslavement, coercion and torture, and also rights to freedom of conscience and expression, and to free movement. When acknowledging an internationally accepted list of human rights, I do not include a human right to health on this list. It remains questionable whether it is even conceptually coherent to talk about a human right to health as such, neither does this right command wide acceptance internationally. There is, however, convergence on a narrower list that significantly constrains the rights of states.[17]

One way to see the doctrine of human rights is that there is a minimum content of political morality that must constrain any setup of political institutions. Initially it emphasized the significant limit posed by human rights to what states may do to their subjects. It is now widely accepted that states ought not to violate the basic human rights of their subjects in imposing and enforcing their institutions and policies. On the other hand, more recently there has been a growing consensus that in addition to the human rights of citizens, the rights of outsiders as well place a limit on state sovereignty. The lives of outsiders are directly or indirectly significantly affected by the way states operate, hence the rights states have against aliens are subject to assessment from the point of view of the interests of outsiders as well. For example, states' right to prohibit movement across their borders is significantly qualified by the aliens' right to free movement, or their right to seek asylum. A blank denial of entry to residents of certain countries on public health grounds can be hard to justify, for example, in the face of the fact that some of these immigrants are persecuted in their home country, or cannot fulfil even their basic needs due to crushing poverty. The strength of considerations supporting denial of entry is also much weaker in the case of epidemics that unfold relatively slowly over years, such as HIV and tuberculosis, than it is in the case of rapidly progressing epidemics because the urgency of the problem is smaller. Travel or immigration restrictions cannot be justified across the board, only in some well-circumscribed cases: factors such as the

speed of transmission, the risk entailed, and the harm potentially afflicting the would-be immigrants in the case of denial of entry also need to be taken into account. We can convincingly claim that prohibiting immigration in some such cases would violate human rights, thus states do not have an unqualified right to do so. Even when some restrictions may be allowed in the interest of public health, the existence of other considerations entail that these can be in effect only temporarily.[18]

Human rights have stronger force than mere normative aspirations. Not only do they act as normative constraints on the moral justifiability of rights claimed by states, but as legal rights they can also successfully limit state powers. That human rights impose limits on what states are entitled to do to their subjects and aliens has been recognized by the various fundamental human rights documents that have become part of international law in the second half of the 20th century, such as the Universal Declaration of Human Rights, or the International Covenant on Economic, Social and Cultural Rights. These legally binding covenants have been ratified by many governments, and the rights they embed often substantially limit state sovereignty. In addition to being incorporated in international law through the various human rights documents, human rights have also entered global governance through the working of international institutions, networks, and NGOs, which have employed human rights standards either in defining their aims or in limiting the permissible means to achieving their aims. Such entities, even though not created through international human rights documents, have explicitly or implicitly made reference to human rights norms in their working, with an effect on health outcomes. One notable example is the WHO's new International Health Regulations. Countries subject to IHRs are required to cooperate in preventing international public health emergencies. However, in applying the regulations, states are required to respect human rights and fundamental freedoms of persons, notably they should "treat travellers with respect for their dignity, human rights and fundamental freedoms" (WHO, 2005).

Other international and regional institutions have also incorporated human rights norms in their public health-relevant policies. At the international level, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and United Nations Development Program (UNDP) have explicitly adopted human rights norms into their health strategies

and policy guidance. Regionally, the Pan American Health Organization (PAHO) addressed human rights issues in the treatment of HIV-infected persons.

Human rights considerations are relevant for delimiting the rights of states in public health even if we do not think there is a human right to health, or that a focus on human rights would provide us with the best means of promoting global public health. Instead of defining the aims of public health policies, human rights act as important constraints on the promotion of public health, whether it is domestic or global. Since in some cases they conflict with the rights claimed by states in promoting public health, the transfer of public health powers from state to global institutions is required if the transfer can resolve this conflict.

The rights of states and global governance in the face of global public health challenges

Returning to the rights of states, we need to see what follows from the above considerations. We saw earlier that states have claimed some rights against their subjects, against aliens, and over their territory, which can be justified by pointing out that state powers are necessary for performing public health functions which ought to be discharged as a matter of justice. I further argued, however, that there are good reasons why political institutions are not entitled to all the rights traditionally associated with territorial states.

Some non-public health based considerations such as human rights standards constrain the justification and the exercise of state powers, and even public health considerations must respect them. On the other hand, the need for global coordination necessary for the provision of public health domestically has undermined the justification of granting some of the rights to states.

The diminishing of state powers, however, does not defeat the justice-based argument for public health promotion as it would fairness-based arguments. Whereas in the absence of effective public health policies there would be no requirement of fairness to set up such policies, our natural duty of justice requires the establishment of institutions and policies capable of effectively performing public health functions. Since states with their traditional territorial rights do not necessarily represent the best currently available institutional setup, justice considerations with regard to public health may call

for the establishment of alternative institutional schemes capable of effectively performing public health functions.

One might object here that the mere existence of weak states does not provide an argument for moving away from state authority. One might conclude instead that state powers should be strengthened, especially in light of the fact that they might be reluctant to waive parts of their sovereignty. However, there are compelling reasons to resist this conclusion. First, I have argued that this might not be possible because global collective active problems in public health provision impose significant limits on what nation-states can achieve by way of public health policy. In these cases there is simply no way to strengthen states to cope with these problems, and global coordination is required. Second, in other cases it is not morally desirable to strengthen nation-states: for example if doing so would undermine or violate some human rights. Therefore, there seems to be no viable alternative to setting up transnational institutions and actors.[19]

Such reforms are facilitated by the fact that, in addition to creating new problems, recent changes provide new opportunities for achieving better health outcomes worldwide. The current global institutional setup already provides new instruments for promoting public health and represents a departure from the nation-state system. A large number of non-state actors have appeared as competitors challenging territorial governance by states on the domain of public health as well. For instance, an increasing number of functionally defined, nonterritorial institutions are already in place. Territorial political authority has in practice already been supplemented by a horizontally dispersed, functionally defined system of global governance. As a result, some of the nation-states have in fact already given up a substantial part of their sovereignty.

The current global setup of health-related institutions is extremely complex. One significant player with global reach in public health is the WHO. The WHO is an international organization with 192 member states, with global, regional and national offices, responsible for some aspects of public health globally. Its primary aim is global health promotion, with functions in setting health policy positions and norms, monitoring their implementation, managing information and promoting R&D, facilitating national and global health cooperation, and promoting the development and testing of new technologies and practices for disease control, health care delivery and risk reduction. In

some cases it is entitled to pursue its objectives even without the mediation of national government agencies, which makes it capable of overcoming some global collective action problems in public health promotion.

For example, prompted by the need for increased global cooperation in infectious disease surveillance and response, the new International Health Regulations (IHRs) adopted in 2005 grant the WHO substantial authority to obtain information about outbreaks from sources other than national authorities, which sometimes have incentives to defer reporting or to downplay the scope of the problem. In performing its role in preventing the global spread of communicable diseases the WHO now collects information from local media reports and the internet, which it uses for issuing travel recommendations. It does so by sometimes sidestepping government channels of the countries concerned, e.g. by scanning internet reports about suspicious outbreaks. This works against states' traditional rights over their territory, however, it makes it easier to overcome one of the global collective action problems outlined earlier. It enables improved global infectious disease surveillance and as a result, it helps prevent the global spread of infectious diseases, such as SARS. On the other hand, the IHRs also enable governments to perform their domestic public health functions by providing for them advance notice to prepare for an outbreak on their territory, for example by obtaining the necessary vaccines. The IHRs also grant WHO the authority to take action in response to outbreaks. It may in some cases issue travel bans or invoke quarantine even in the face of protests by some individual countries concerned.[20] It also has the authority to allocate stockpiles of vaccines in public health emergencies. These competences enable the WHO to contribute to the global provision of a number of health-related public goods.

Other transnational institutions and bodies also play a role in promoting public health. Some of these have other primary objectives than health promotion, however, their working has a public health dimension and sometimes public health is an explicit consideration in their policies. For example, WTO regulation in the context of free trade requires adherence to public health criteria. It grants the right to officials from importing states to inspect and test goods within the territory of the exporting country to prevent health risks potentially affecting their residents by importing diseases through commerce (Fidler, 2002: 154). Another transnational organization, the World Bank commits

substantial part of its lending each year for health, nutrition and population projects in developing countries where it has been one of the largest supporters of HIV/AIDS programs. A further example of an international body with public health relevance is the shown by the role of UNICEF in providing vaccines for child immunization worldwide: it supplies about 40 per cent of the world's vaccines for children (Kremer, 2006: 28).

Other institutions have less than global scope, still they transcend national boundaries in the application of their policies affecting public health. For example, regional development banks such as the Inter-American Development Bank and African Development Bank also provide funds for combating communicable diseases.

Yet another form of transnational institutions in the public health domain is represented by specialized agencies or public-private partnerships that have a limited scope of competence in public health promotion, typically extending to some well-circumscribed set of diseases. The Joint United Nations Programme on HIV/AIDS (UNAIDS) plays a role in extending antiretroviral treatment to an ever larger number of people living with AIDS in developing countries, following the "3 by 5" initiative targeting the provision of ARV treatment to three million patients by the end of 2005. The Global Fund to Fight AIDS, Tuberculosis and Malaria funds investments in the local public health infrastructure and the scale up of prevention and treatment of these diseases. The Global Alliance for Vaccines and Immunization (GAVI) aims to increase children's access to vaccines in developing countries by funding immunization services.

Finally, non-governmental organizations have an increasing impact on global public health. The most notable example is the Gates Foundation that has committed large funds to battling HIV/AIDS, tuberculosis, malaria and other neglected diseases that have a large share in the global disease burden. Other philanthropic foundations include the Rockefeller Foundation which has supported R&D to improve global health. Another NGO, ProMED-mail, developed an electronic disease surveillance and early warning system that worked in competition with those operated by states and international organizations like WHO. NGOs influence global health not only by expending funds and providing care, but also by influencing policymaking by states and international organizations. For example, NGOs featured prominently alongside states and international organizations in the debates about intellectual property regulation applying

to antiretrovirals in the TRIPS negotiations. The campaign lead by Medecins Sans Frontieres on improving access to antiretrovirals played a major role in shaping the intellectual property rights regime governing the working of pharmaceuticals in developing countries (Fidler, 2002: 158). Thus, in addition to the effects of international institutions, NGO activism in global health has considerably affected global public health and constrained state territorial sovereignty. They successfully challenged some territorial rights of states on grounds of better global health outcomes that could be achieved with an alternative scheme.[21]

This proliferation of initiatives, actors, interests, norms, processes, and funding streams in global public health has had two effects. First, as some observers have noted, the importance of health in world politics has grown in the last ten years (Fidler, 2007: 3). This is partly because health has come to feature as an issue in a range of other policy areas such as security, trade, environmental protection, development, or human rights. Second, the elements of this complex system do not constitute a coherent structure of governance. Competences are overlapping. Some agencies channel resources through domestic institutions, others have their own permanent staff in countries. NGOs and multinational corporations are involved in making domestic and international health regulation and in implementing health policy, for example by drafting regulations or participating in public-private partnerships. As a result, these institutions, initiatives, NGOs, and multinational corporations constrain states' exercise of public health sovereignty by reducing exclusive control of states over their subjects and their territory. They grant some rights over a state's subjects and territory to other states, international organizations, and non-state actors, thereby reducing the potential sphere of rights states are capable of exercising over their own subjects and territory.

Critics have claimed that the lack of coordination between various actors in global health has had adverse effects on health justice globally. For example, given the focus of many of these initiatives on a small number of diseases, especially on HIV/AIDS, priorities get skewed.[22] If this is so, this would mean that in addition to solving some problems in global public health, the proliferation of global health initiatives gives rise to some additional problems that need to be tackled on the global level, as they cannot be solved by individual states. These problems can also take the "tragedy of the commons"

form, with non-state actors appearing as yet another group of agents whose pursuit of their own aims leads to collectively suboptimal global health outcomes. For example, the entry of NGOs like the Gates Foundation to the health care sector in developing countries has been claimed to cause an internal "brain-drain" due to the substantial differences in incomes between health workers in the public sector and NGO-financed projects (Daniels, 2008: 330). This in turn might hinder the scaling up of other health-promoting projects in the same countries. This illustrates how lack of coordination can lead to worse health outcomes even among institutions that aim at promoting health.

Nevertheless, this multilayered system does have an effect on global health, even though it might not be optimal and might not resemble domestic health systems. It contrasts with the traditional territorial nation-state model, being rather a mixture of various levels and forms of governance making up a system with "criss-crossing lines of authority" (Kis, 2001: 223). Jurisdictions within it are not clear-cut, but often competing or overlapping, "generating ambiguities about the principal location of authority and political responsibility." (Held and McGrew, 2002: 10) Some of the institutions making up this system have powers of enforcement, others operate on the basis of voluntary self-regulation. Some norms are incorporated in international law as "hard law", others are followed as "soft law" by state and non-state actors on other grounds, such as in view of positive incentives. Some institutions are functionally rather than territorially defined, and even in the case of those with territorial jurisdiction, authority is often not located at the level of nation-states. Some of these institutions perform a limited set of functions, others have a wider scope of authority (Kis, 2001: 223). This is a complex, multilayered scheme of institutions performing supra- and transnational, regional, and local governance with a mixture of functionally and territorially defined authority.

Should we applaud this trend toward non-state level public health activities? If we think justice requires adequate public health policies for a given population or within given territory, political institutions ought to be so organized as to carry out this task. The empirical considerations showing emerging global public health threats and available new non-state instruments demonstrate, on one hand, that nation-states' capacity to carry out this function has diminished, and, on the other hand, that there are available alternative actors and institutions capable of bringing about improved public health

outcomes. Therefore, justice requires the application of these new instruments, even if its requirements hold only within a restricted population or territory.

Conclusion

The numerous initiatives and actors that affect global health now constitute a system that is substantially different from the model of the nation-state system where units have final and exclusive authority over a fixed territorial space. The elements of this new scheme have been set up for a variety of reasons. Considerations of the value of health or of justice may not figure very prominently behind many of these. However, the justice-based requirement to promote public health, as well as the requirement to respect human rights, prompt us in the direction of relying on some of the existing elements, reforming others so that they better fit human rights and more effectively promote public health, and establishing new ones, rather than returning to the system of territorially defined nation-states. Considerations of public health and focus on the capacities provided by this new institutional setup support the claim that, for a range of human activities, nation-state based territorial governance may not be a good, or the best, way of regulation.

[1] I borrow this typology from (Copp, 1999: 18, 22-3), and (Simmons, 2001: 302-6).
[2] In including the right to control and prohibit movement across the state's borders under this category I diverge from the categorization provided by (Simmons, 2001: 306).
[3] There is a continuum between voluntary choice about immunization and mandatory immunization. States sometimes make some prospective benefits conditional on receiving immunization, such as when they make school enrolment conditional on proof of the child's vaccination. See (Holland, 2007: 138). However, mandatory vaccination is considered and used as a policy instrument in some cases.
[4] See the rich literature on the social determinants of health. One place to start is (Marmot, 2004).
[5] This is not intended as a precise definition, and I am fully aware of the complexities the demarcation of the field of public health engenders. In the paper I am concerned with measures that I take to be relatively uncontroversially falling within the domain of public health. For a rich exploration of the concept of public health see (Verweij and Dawson, 2007).
[6] See (Dawson, 2007). Dawson, following (Paul, 2004), distinguishes between herd protection and herd immunity, where the former is taken to refer to the diminished likelihood of someone's contracting a disease because of other persons' being immune to it, and the latter means acquiring individual immunity through the secondary spread of the agent used in the immunization. I do not follow this terminology in this paper, but I would like to point out that population immunity in my usage corresponds to herd protection in that terminology.
[7] The principle was first suggested by (Hart, 1955). The most elaborate and influential defense of the principle with regard to political obligation is provided by (Klosko, 1992).
[8] Some additional criteria must also be fulfilled: the goods in question must be worth their costs and must be fairly distributed (Klosko, 1992: Ch.2).
[9] I do not have the space here to defend this claim. For one convincing detailed argument see (Daniels, 1985) and (Daniels, 2008). For the purposes of this paper, however, I want to remain neutral about the grounds for viewing public health as a matter of justice, without committing to Daniels's equality of opportunity based version of the defense.
[10] John Rawls argues that we have a natural duty of justice that "requires us to support and comply with just institutions that exist and apply to us", and "it also constrains us to further just arrangements not yet established, at least when this can be done without too much cost to ourselves." (Rawls, 1999: 99). My characterization of this duty is more expansive in that it requires outsiders not to undermine just institutions. This can plausibly be seen as a natural extension of Rawls's formulation.
[11] For one such proposal see (Epstein, 2006).
[12] The fairness-based and justice-based arguments I have outlined are of course not exhaustive of the list of potential justifications of state rights on public health grounds. Notably, I do not discuss here justifications based on the no-harm principle. For reasons I do not have the space to go into here, I believe that that principle cannot be successfully invoked in defense of a wide spectrum of public health measures that are characterized by public good properties.
[13] I thank an anonymous referee of this Journal for raising this point.
[14] For the history of the emergence of MDRTB and some ethical issues raised by its global spread, see (Selgelid, 2008: 10-20), and (Selgelid, 2007: 218-229).
[15] See the proposals by Michael Kremer and Thomas Pogge. For Kremer see (Glennerster and Kremer, 2004). For Pogge, see (Hollis and Pogge, 2008).
[16] An interesting question arises in connection with global public goods about the legitimacy of transnational coercive mechanisms that might be necessary for the creation and maintenance of cooperation yielding global public goods. What criteria of legitimacy do these structures have to meet? Do they call for a global democracy or egalitarian global distributive requirements? One can plausibly argue that at the very least these structures trigger requirements to include affected parties in the decision-making mechanisms determining their distribution. Similarly, if these mechanisms enable wealthy states to advance their interests in health promotion, but leave poor countries with no or little benefits, then the interests of all have not been adequately taken into account in decision-making, if significantly greater benefits could be

gained by the worst-off states at little sacrifice by others. However, transnational coercive mechanisms may generate more demanding requirements too. One might argue that global public goods in health ought to be distributed equally. For example, if we can show that the current global intellectual property rights regime incentivising pharmaceutical research and development primarily benefits affluent countries, and these can be replaced or supplemented with some alternative regime that enables better health outcomes in poor countries, rich countries may have a duty to reform the existing scheme (Hollis and Pogge, 2008). Lack of space prevents me from giving a detailed account of the legitimacy-grounding conditions of global cooperation.

[17] For the purposes of the paper's argument, I need not take a stance on the controversial issue of global socioeconomic justice. Regardless of whether requirements of socioeconomic justice apply across countries, it suffices here to acknowledge that there are some human rights that can successfully constrain the rights of states in public health.

[18] This is not to say that many states do not in fact impose stricter regulations on immigration. It is arguable, however, that in these cases they violate human rights, both as moral rights and as legal rights embedded in international legal documents.

[19] I thank an anonymous reviewer of this Journal for raising this point.

[20] In the case of the SARS epidemic in 2003, this is what happened when China and Canada lobbied against WHO's recommendations against traveling in these two countries.

[21] It was suggested to me by Bruce Jennings that these forms of global cooperation might be thought to give rise to fairness-based obligations for the individual countries benefiting from them to contribute their share. This may be so, but even in this case this point would not undermine the justice-based justification of global public health measures. Rather, the two types of obligation – i.e. fairness-based and justice-based – would be mutually reinforcing. The justice-based obligation would hold even in cases when no such cooperation exists, prescribing the establishment or extension of public health policies. On the other hand, fairness-based obligations, alongside justice-based obligations, would be triggered when public-good generating cooperation already exists.

[22] Between 1996 and 2005, annual spending on AIDS programs in developing countries increased from $300 million to $8 billion, in contrast with the $2 billion share allocated to malaria and tuberculosis together that jointly account for a comparable part of the global disease burden. See (Cohen, 2006). For a comprehensive critique of the anarchical nature of global health initiatives see (Garrett, 2007).

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