doi:10.1017/amp.2023.3

THE NEW STATE OF EMERGENCY: INDIVIDUALS AND INTERNATIONAL LAW

This panel was convened at 2:00 p.m. on Wednesday, April 6, 2022 by its moderator, Atsuko Kanehara of Sophia University, who introduced the speakers: José E. Alvarez of NYU School of Law; Kentaro Nishimoto of Tohoku University; Anita Ramasastry of the University of Washington School of Law; and Tina Stavrinaki of the University of Cyprus Department of Law.

The Missing Global Right to Health

By José E. Alvarez

The World Health Organization's (WHO) Constitution affirms, in its preamble, a fundamental and non-discriminatory right to health and health care. In doing so, it echoes a number of widely ratified treaties and other international legal instruments with a strong claim to having the status of customary international law, including the International Convention on the Elimination of All Forms of Racial Discrimination, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women, the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the ILO Convention on Indigenous and Tribal peoples in Independent Countries, and the Standard Minimum Rules for the Treatment of Prisoners.[1] Most recently, the *Institut de Droit* affirmed that same fundamental right in Article 4 of its September 2021 Resolution on Epidemics, Pandemics, and International Law.[2]

But, rhetoric aside, the global health regime (both before and after the establishment of the WHO) has ignored this. The WHO's Constitution has not become the "Magna Carta" for the individual right to health that its proponents sought. The WHO is instead a state-centric regime that seeks to balance *states'* interests in preventing the entry of foreign diseases with their interest in free trade. Contrary to the theme of this annual meeting, the right to health has not been "personalized" within the organization designed for its protection. As the COVID pandemic tragically illustrates, this needs to change.

While the 2005 revision of the WHO's International Health Regulations (IHR) is seen as "incorporating" human rights, when one looks closely, what they actually do is impose human rights *limits* on government measures taken in response to external global health threats. Those limits, contained in Articles 3.1, 23.2, 23.3, 23.4, 23.5, 31.1, 31.2, 32, 42, 43.2, 45.1, 45.2, and 45.3 of the IHR, ostensibly require states to respond to public health emergencies with full respect for the dignity, human rights, and fundamental freedoms of all. But the IHR do little to actually enforce these duties and do nothing to impose positive obligations in furtherance of a human right to health. Apart from general rules protecting the confidentially of medical data for identified individuals and urging states to avoid overtly discriminatory health measures on travelers, the WHO's

[1] See particularly, CESCR General Comment No. 14, The Right to the Highest Attainable Standard of Health (Art. 12), Aug. 11, 2000, E/C.12/2000.4.

[2] Institut de Droit, Resolution on Epidemics, Pandemics and International Law, On-Line Session, Sept. 4, 2012.

principal legal instrument does little to fill out the contours of what a human right to health would mean for governments or for the WHO itself.

The WHO's silence on the global individual right to health helps to explain why it proved helpless in limiting autocracies and even some ostensible democracies from overreaching in the age of the coronavirus. The human rights limits in the IHR, ill-defined and even less enforced, have not prevented the abuse of executive powers under the guise of a public health emergency. They did not prevent, for example, Hungarian Prime Minister Viktor Orbán from using a decree in response to a "state of danger" to suspend protective laws, cancel scheduled elections, and create new crimes, Bolivia from postponing its elections, Israel from shutting down its courts, or, many countries (including China, South Korea, and Singapore) from further advancing intrusive surveillance of persons. The global health regime's human rights gaps enabled many states, including the United States, to use COVID as an excuse to close their borders, even to asylum seekers. In continent after continent the global pandemic led to an epidemic of repressive measures, allowing persons to be detained indefinitely and authorizing repressive infringements on basic freedoms of assembly and expression. These measures were not always proportionate to the needs to protect public health and were often authorized without sunset provisions that would ensure removal once the ostensible threat passes. From the Philippines to Jordan to Thailand, emergency powers seemed directed at political dissenters or averse media outlets rather than those posing genuine threats to health. Worse still, as others on this panel address, states have ignored their international legal obligations (including under the IHRs) to avoid *de facto* or *de jure* discrimination in responding to COVID. One consequence has been a global "color of COVID" phenomenon whereby rates of infection or death or degree of access to care, medicines, or vaccines correspond, all too often, to the color of one's skin or other disfavored status.[3] Low-caste persons in India, those with the "wrong" skin pigmentation or having Indigenous status in Brazil, or members of Latinx, Indigenous, or Black communities in the United States have been among those paying the price.[4] Irrespective of wealth or gross domestic product, countries around the world have used proclamations of public health emergencies to disproportionately trample the rights of persons that they have made vulnerable through long-standing impediments to access to health care—from ethnic minorities to immigrants.

But the global health regime has not only failed to limit governmental overreach; it has also failed to prevent equally harmful government underreach, meaning fatal omissions to take actions recommended by health care professionals.[5] Donald Trump's and Jair Bolsonaro's notorious failures to act—both leader's tendency to underplay the health threat, repeated failures to compel prevention measures while promoting harmful falsehoods about how the disease spreads or may be "cured"—were not called to account at the international level. In case after case over the past two years, the WHO failed or, more accurately, ignored the positive human rights obligations states have to advance the human right to health and health care of their own populations (including minorities). And only more recently, faced with a virulent form of vaccine nationalism that was hard to ignore, did the WHO embrace states' collective duties to cooperate to advance the right to health outside their borders—as affirmed under the ICESCR.[6]

[3] *See, e.g.*, José E. Alvarez, *The Case for Reparations for the Color of COVID*, 7 UCI J. Int'l, Transnat'l & Comp. L. 7 (2022).

[4] *See id*., Annex A (written by Daniel Rosenberg).

[5] *See, e.g.*, David E. Pozen & Kim Lane Scheppele, *Executive Underreach, in Pandemics and Otherwise*, 114 AJIL 608 (2020).

[6] *See, e.g.*, Olivier De Shutter et al., *Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights*, 34 Hum. Rts. Q. 1084 (2012).

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The WHO's failures to respond to either government overreach or underreach are a predictable consequence of that organization's failure to embrace human rights as part of its core mission. The WHO's IHR presume that states will develop core medical capacities to deal with global health threats but fall short of providing the technical or other assistance to countries that are willing but unable to achieve those capacities. The IHR also fail to impose clear obligations that are essential components of the right to health.[7] They do not insist that states take concrete and specific actions, for example, to diminish infant/child mortality, provide medical assistance, especially primary health care, take positive measure to combat diseases and malnutrition, ensure occupational health and safety and address environmental threats to health, provide pre-natal and post-natal health care, raise awareness and ensure access to accurate health information, or develop preventive health care.

These lessons have yet to be taken to heart by those engaged in global health reforms. The EU's contemplated pandemic prevention treaty and the United States' competing proposals to amend the IHR may tighten the scrutiny over, but not really displace, the delegation of power and ample discretion accorded to states when they respond to pandemics. It is also likely that the post-COVID WHO will continue to rely on a soft "managerial" model of compliance and continue to rely largely on information supplied by governments and less than independent experts. Moreover, global health reforms on offer remain "racially neutral"—even as it has become clear that proactive steps need to be taken to respond to the tendency governments have to ignore, during pandemics as well as otherwise, structural discriminations leading to disproportionate deaths by skin color, class, or other disfavored status.

The WHO reforms now under serious contemplation do not go far in making that organization less of a "human rights free zone" than others in the UN system.[8] While some reform proposals—as to enable greater consideration of timely reports from civil society or independent media—may help prevent the spread of future pandemics, they are likely to do little to prevent the starkly disparate health impacts within and among states seen during COVID. Nor, absent fundamental change in the state-centricity of the WHO, will that organization prevent the "every state for itself" aspects of COVID response. States' repeated failures to coordinate and to cooperate doom all of us to the rise and spread of virus variants. No one is safe—no global pandemic can be truly prevented—if we ignore the weakest vaccine links both within states and among them. If the proposed "pandemic prevention treaty" fails to "personalize" the WHO by embracing the human right to health, it will not successfully prevent future pandemics.

If governments were serious about the human right to health and health care, they would take seriously the proposition that its violation—by either states or international organizations like the WHO—constitutes an international wrongful act that triggers all the forms of legal responsibility identified in the respective articles on state or international organization responsibility.[9] If they did so they would now be establishing, at the national and subnational levels, forums to provide effective remedies to those harmed by the color of COVID. Millions have died or faced catastrophic economic losses due to international discrimination as well as more subtle refusals by governments to respond to structural forms of intolerance during the age of COVID. Reparations akin to those measures for transitional justice that we consider necessary after other mass atrocities are not only

[7] *See, e.g.*, JOHN TOBIN, THE RIGHT TO HEALTH IN INTERNATIONAL LAW (2011). For a particular example of an attempt at judicial enforcement of the right to health, see Cuscul Piraval v. Guatemala (Inter-Am. Ct. Hum. Rts. Aug. 23, 2018).

[8] *Compare* Philip Alston, *The World Bank as a Human Rights-Free Zone*, *in* DOING PEACE THE RIGHTS WAY: ESSAYS IN INTERNATIONAL LAW AND RELATIONS IN HONOUR OF LOUISE ARBOUR (Fannie Lafontaine & François Larocque eds., 2019).

[9] GA Res. 71/133, Responsibility of States for International Wrongful Acts (Dec. 19, 2016); GA Res. 66/100, Responsibility of International Organizations (Dec. 9, 2011); *see also* Institut de Droit Resolution, *supra* note 2, Art. 15.

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morally and legally justified under human rights treaties, they are pragmatically desirable. Governments that do not accept accountability for unnecessary COVID deaths, not to mention millions who survive with long-term COVID, are unlikely to take the measures needed to mitigate the spread of COVID variants or future pandemics. According to one study by epidemiologists who examined the U.S. state of Louisiana, had the United States undertaken reparations to Black descendants of persons enslaved in the United States, COVID transmission rates in that state would have been reduced by between 31 to 68 percent among all Louisiana residents, Black and white alike.[10]

Recognizing the responsibility of states for ensuring everyone's right to health and health care is, in short, key to the successful prevention or mitigation of future pandemics. This is not an argument for "suing China" for failing to report the origins of COVID in a timely fashion or for "suing the United States or others" for failing to contain its spread. *Interstate* responsibility is politically unlikely and legally difficult. States are also extremely reluctant to accept extraterritorial responsibilities for the health of other nations. No government now seems inclined to accept anything other than a *moral* responsibility to distribute COVID vaccines to the maximum of its abilities, for example. But, by word and deed, states have long accepted responsibility for respecting and ensuring the human rights of their own peoples. It is past time that they accept their legal responsibilities for evident failures to respect and ensure the human right to health care of their own nationals. This can begin, at the local level, where all of us live (and die).[11]

[10] Eugene T. Richardson et al., *Reparations for Black American Descendants of Persons Enslaved in the U.S. and Their Potential Impact on SARS-CoV-2 Transmission*, 276 Soc. Sci. & Med. 113741 (2021), *at* https://www.sciencedirect.com/science/article/pii/S0277953621000733.

[11] *See, e.g.*, Resolution of the NYC Board of Health Declaring Racism a Public Health Crisis (*adopted* Oct. 18, 2021) (recommending that, given the documented racial inequities in health both before and after the current pandemic and the structural racism underpinning them, the NYC Health Department "participate in a truth and reconciliation process with the communities harmed by these actions").

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