

VIEWPOINT

Trump's War on Clean Air

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Air pollution rarely appears on death certificates. With a notable exception from a London coroner's report following the death of a nine-year-old girl in 2013, individual deaths are not typically attributed to air pollution.¹ Yet in the United States, an estimated 100,000 to 200,000 people die prematurely each year because of polluted air.² These deaths receive less attention than they merit in large part because air pollution's effects are insidious, cumulative, and difficult to attribute to a single cause.

Air pollution harms lungs—causing lung cancer and exacerbating pneumonia and asthma—but it more frequently kills through cardiovascular pathways, including strokes and heart attacks. It also affects the brain, contributing to cognitive decline, dementia, and even depression. As scientific understanding evolves, the evidence of harm continues to expand. Even at levels below current regulatory thresholds, air pollution has measurable adverse health effects.

The burden of these harms is unevenly distributed. Children, older people, those with preexisting health conditions, and communities that are low income or racial and ethnic minorities are disproportionately exposed and more vulnerable to the effects of polluted air. This unequal distribution contributes to the systemic masking of air pollution as a public health crisis.

If understanding the health impacts of air pollution is inherently challenging, it has become significantly more so during President Trump's second term. The administration has systematically dismantled elements of the regulatory framework designed to protect air quality, weakening multiple pollution standards and reducing the institutional capacity of the federal agency tasked with implementing the Clean Air Act.³ These moves represent a form of regulatory regression that is increasingly incompatible with the right to the enjoyment of the highest attainable standard of physical and mental health under international human rights law.

As early as 2000, the Committee on Economic, Social and Cultural Rights noted in its General Comment 14 that the right to health includes “the prevention and reduction of the population's exposure to harmful substances ... and harmful chemicals or other detrimental environmental conditions that directly

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or indirectly impact upon human health.”⁴

The Environmental Protection Agency (EPA)’s recent rollbacks are both intricately technical and profoundly consequential. In 2024, the EPA strengthened the primary National Ambient Air Quality Standards (NAAQS) for fine particulate matter (PM_{2.5}), lowering the allowable annual concentration from 12 to 9 micrograms per cubic meter.⁵ The agency’s scientific modeling estimated that the new standard could prevent up to 4,500 early deaths, 800,000 cases of asthma symptoms, and 290,000 lost workdays annually by 2032.⁶

However, in November 2025, the EPA took the unprecedented step of asking the United States Court of Appeals for the District of Columbia Circuit to vacate the revised standard. In justifying its reversal, the EPA’s press office stated that the rule would cost Americans “hundreds of millions, if not billions of dollars” if fully implemented.⁷

It is unlikely the EPA has the statutory authority to consider implementation costs when setting NAAQS. The US Supreme Court has previously ruled the EPA must set NAAQS based exclusively on what is necessary to protect human health.⁸ But the move flagged a deeper methodological shift.

Other rules under the Clean Air Act do permit the EPA to undertake a cost-benefit analysis of their implementation. In January 2026, the EPA finalized a rule limiting nitrogen oxide emissions from gas turbines and industrial sources.⁹ While the rule quantified emissions reductions, it departed from long-standing practice by declining to monetize the health benefits associated with those reductions.¹⁰ In effect, the agency’s cost-benefit analysis considered the compliance costs to industry while excluding the economic value of avoided deaths, reduced hospitalizations, and improved public health. The Environmental Protection Network—an association of former EPA career staff—has described this as “zeroing out lives saved,” a phrase that succinctly captures the cooking of regulatory books.¹¹

By eliminating the monetization of health benefits, the EPA is structurally excluding the value of human life and health from regulatory decision-making. This can be clearly seen in the

EPA’s decision in February 2026 to rescind a recent strengthening of federal emissions standards for mercury and other toxic pollutants.¹² In 2024, the EPA estimated that stronger rules would generate US\$260 million in health benefits—decreased cardiac and pulmonary risks, avoided mortality, avoided health care costs, and economic benefits associated with fewer missed work and school days—alongside US\$130 million in climate-related benefits between 2028 and 2037.¹³

But these benefits were effectively erased from the regulatory calculus when the EPA neither quantified nor monetized the health impacts associated with increased emissions of particulate matter and ozone.¹⁴ This represents a clear example of how methodological changes can produce outcomes that systematically undervalue public health.

Behind the details are real and foreseeable human consequences. A child with asthma in California’s San Joaquin Valley may experience more frequent attacks and missed school days. A construction worker in Pittsburgh may develop chronic obstructive pulmonary disease after prolonged exposure to particulate pollution. An older adult in Fairbanks may suffer a fatal cardiac event during winter inversions that trap pollution close to the ground.

The US government’s moves stand in stark tension with a growing body of international human rights law recognizing the right to health, and its interdependence with other human rights, when it comes to air pollution. In March 2026, the United Nations Special Rapporteur on the right to a healthy environment called on states to “enact and regularly update air quality standards and progressively strengthen and avoid regressions, based on best available science, including World Health Organization guidelines and considering particularly vulnerable populations.”¹⁵

The United States is doing the opposite. World Health Organization guidelines are considerably more stringent than EPA thresholds. For example, the World Health Organization recommends an annual average PM_{2.5} limit of 5 micrograms per cubic meter.¹⁶ The move from 9 (micrograms per cubic meter) to 12 is a move in the wrong direction.

This weakening of pollution thresholds represents a form of regulatory retrogression incompatible with the right to health.

General Comment 14 makes clear that retrogressive measures are not permissible except where the state can show that they are fully justified by reference to the totality of rights in the International Covenant on Economic, Social and Cultural Rights and that the state has carefully considered all alternatives.¹⁷ The US has signed but not ratified the covenant.¹⁸ Though it is not formally bound by its provisions, the United States, as a signatory, has an obligation to refrain from taking steps that undermine their “object and purpose.”¹⁹

Although the United States has historically resisted a right to health in US law, clean air is increasingly understood as interdependent with other human rights. For example, a recent report of the Special Rapporteur on the right to a healthy environment notes that the impacts of air pollution “undermine the rights to life, health, a healthy environment and an adequate standard of living, and to equality and non-discrimination.”²⁰

Comparative human rights jurisprudence reinforces this position. In *Inhabitants of La Oroya v. Peru*, the Inter-American Court of Human Rights found that Peru violated numerous rights when failing to control air, water, and soil pollution from a metallurgical facility in the city of La Oroya.²¹ The court not only relied on the right to health but derived the obligation to control pollution from a broader set of rights, including the right to life and the right to a healthy environment. The court found that it was sufficient for the plaintiffs to show that exposure to pollution created a significant health risk, without having to prove causation of a specific health condition or disease.²²

Recent jurisprudence from the European Court of Human Rights is also instructive. In *Canavacciuolo and Others v. Italy*, the European Court of Human Rights held that Italy’s failure to prevent and respond to widespread toxic waste pollution in Campania exposed residents to a real and immediate risk to life, thereby violating the obligation to protect the right to life.²³ As in *La Oroya*, the court found a violation of the right to life on the basis of

exposure to toxic pollution rather than evidence of specific health impacts.²⁴

The Trump administration’s deregulation of air quality regulations demonstrates how technical regulatory changes can have profound consequences for human health. As international human rights law increasingly recognizes a right to clean air, these policy shifts place the United States at odds with emerging global standards. The right to health and its interdependence with other human rights provides a critical framework for challenging these changes and re-centering environmental governance on its fundamental purpose: the protection of human life.

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