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Imagining Global Health with Justice

Lawrence O. Gostin
Georgetown University

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This article offers a way to achieve global health with justice as a global health imperative. It is possible to have global health without justice, meaning that improvements in health outcomes could be achieved, but without a fair distribution of the benefits of good health. It is also possible to have justice without global health, where health outcomes are evenly distributed across the population but overall health is not improved. With this understanding, this article challenges current ways of understanding global health, and argues that absolute reductions in morbidity and premature mortality are not robust indicators of success in the absence of equity. Taking existing and prevailing global health narratives, this article focuses on answering two fundamental questions to address the question of how we can achieve global health with justice: What would an ideal state of global health look like? What would an ideal state of global health with justice look like? These may seem like naïve questions, but if we could answer them, we would go a long way toward a healthier and fairer world.

L'auteur propose un moyen de parvenir à la santé mondiale en prenant l'équité comme impératif mondial en matière de santé. Il est possible d'avoir la santé mondiale sans équité, ce qui signifie que des améliorations en matière de santé pourraient être obtenues, sans qu'il y ait répartition équitable des avantages d'une bonne santé. Il est également possible d'arriver à l'équité sans la santé mondiale, si les résultats de santé sont répartis uniformément sur toute la population, mais que dans l'ensemble, la santé n'est pas améliorée. Ces prémisses étant établies, l'auteur remet en question les façons actuelles de comprendre la santé mondiale, et il fait valoir qu'en l'absence d'équité, les réductions absolues de la morbidité et la mortalité prématurée ne sont pas des indicateurs précis de succès. À partir des propos qui ont cours actuellement sur la santé mondiale, l'auteur entreprend de répondre à deux interrogations fondamentales pour savoir comment nous pourrions arriver à la santé mondiale avec l'équité : À quoi ressemblerait un état idéal de santé mondiale? À quoi ressemblerait un état idéal de santé mondiale avec l'équité? Ces questions peuvent sembler naïves, mais si nous pouvions y répondre, nous aurions fait beaucoup de chemin vers un monde plus sain et plus équitable.

* Lawrence O Gostin, University Professor and Founding O'Neill Chair in Global Health Law at Georgetown University, is Director of the O'Neill Institute for National and Global Health Law, and the Director of the World Health Organization Collaborating Center on Public Health Law & Human Rights. This article is based on his book, *Global Health Law* (Cambridge: Harvard University Press, 2014), online: <www.hup.harvard.edu/catalog.php?isbn=9780674728844>.

Introduction

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Introduction

The singular insight in global health is that absolute reductions in morbidity and premature mortality are not robust indicators of success in the absence of equity. That is, we can achieve high levels of global health but still lag in justice. What would be truly transformative is to achieve both overall population health and fair distribution of the benefits—in other words, *Global Health with Justice*. What would global health with justice look like? Before answering this pivotal question, consider contrasting narratives, showing how global health can exist in a state of inequality.

I. *Global health narratives*

I have reflected on the fact that there exist two prevailing global health narratives, one from leaders with power and ample resources and one from the poor and disadvantaged. What appears odd about these two narratives is that they have conflicting realities, yet both are true.

The prevailing global health narrative from the most prominent global health leaders who have power and stature is one of ever-increasing improvements in health among the world's population. The *Gates Foundation/ONE, Living Proof: Real Lives, Real Progress* campaign champions once unimaginable global health achievements.¹ Success

1. Bill and Melinda Gates Foundation, Press Release, "Bill Gates and ONE Launch the Living Proof Campaign in France: Smart Aid Saves Lives" (4 April 2011), online: Bill & Melinda Gates Foundation Press Room <<http://www.gatesfoundation.org/Media-Center/Press-Releases/2011/04/Bill-Gates-and-ONE-Launch-the-Living-Proof-Campaign-in-France-Smart-Aid-Saves-Lives>>.

stories are pervasive, and with good reason. International assistance has skyrocketed, while child and maternal mortality has plummeted and millions are accessing treatment for HIV/AIDS. These health improvements closely track the United Nations Millennium Development Goals (MDGs),² now replaced by the Sustainable Development Goals (SDGs).³ Beyond the MDGs, polio eradication is on the horizon, with game-changing vaccines within reach for malaria and dengue. It is no small wonder that global health leaders urge the political community not to give up on global health, but rather to invest ever more resources, with tangible benefits.

This narrative of success is true and inspiring, but also listen to an alternative narrative. Consider two children—one born in sub-Saharan Africa and the other in Europe, North America, or another developed region. The African child is almost 18 times more likely to die in her first five years of life. If she lives to childbearing age, she is nearly 100 times more likely to die in labour. Overall, she can expect to die 24 years earlier than the child born into a wealthy part of the world.⁴ Collectively, such vast inequalities between richer and poorer countries translate into nearly 20 million deaths every year—about one of every three global deaths—and have for at least the past two decades.⁵ Put simply, the health gap between the rich and poor is pervasive and unjust, with no sign of improvement.

This alternative reality is captured by the voices of two young people living in poverty, abridged from my book, *Global Health Law*.⁶

Namubiru (Gaba, Uganda). I live in a rowdy place, with no clean water, no good toilets or bathrooms. At night, the conditions worsen, with hardly any electricity. The mosquito noise fills up the place. Cockroaches move around me. My mother would help me with medication fees, but she is dying of AIDS. A lot of sexual violence happens to me. I want to get an education and a job, but I know the salary will be too small. I am so sad. I need a new life.⁷

2. *United Nations Millennium Declaration*, GA Res 55/2, UN GAOR, 55th Sess, UN Doc A/RES/55/2 (2000).

3. United Nations, “Sustainable Development Goals Knowledge Platform,” online: <sustainabledevelopment.un.org/sdgs>.

4. World Health Organization (WHO), *World Health Statistics 2013* (Italy: WHO, 2013) at 58-59; World Health Organization et al, *Trends in Maternal Mortality: 1990–2010* (France: WHO, 2012) at 19 (the life expectancy at birth of high-income countries in 2011 was 80 years, compared with 56 years in sub-Saharan Africa).

5. Juan Garay, “Global health (GH)=GH equity=GH Justice=Global Social Justice: The Opportunities of Joining EU and US Forces Together,” *Newsletter of the European Union of Excellence at UC Berkeley* (Winter 2012), online: <eucenter.berkeley.edu/newsletter/winter_12/garay.html>.

6. *Supra* note *.

7. *Ibid* at 5-6.

Johnny (Blackfeet Tribal Reservation, Montana, USA). I start my day with a cup of Joe, then corral and break horses, and smoke a bowl of weed. My father snorts coke and gets drunk, taking my birthday money. He beats all the kids. When your family is broken due to drugs and alcohol everyone is hurt. What I mean is what little kids get to eat or not to eat, did they get the shoes or clothes they needed, it depends on whether adults do drugs. I want to shout, “when you do meth hey, don’t let your kids be here.” My life is gone, but what about the kids?⁸

Namubiru’s and Johnny’s lives are vastly different: she struggles to survive as an impoverished woman in sub-Saharan Africa. He suffers from physical and mental abuse on an Indian Reservation in one of the world’s most prosperous countries. Johnny’s story shows that health inequalities are just as stark and jarring within countries as among them. But what really strikes me about these two young people is not how their circumstances differ, but rather how much they have in common. Both children express deep despair and hopelessness. Namubiru pleads for a new life, and Johnny believes that the comfort and joy of life has simply passed him by.

These two global health narratives are both true but opposite, and they illustrate why I use the term global health *with* justice, rather than global health justice. It is possible to have global health absent justice. That is, we can achieve ever-increasing improvements in health outcomes, but these global public goods are inequitably distributed. It is also possible to have justice without global health. That is, we could imagine a world where overall health advances stagnate, yet health outcomes are more evenly distributed across the population, irrespective of sex, race, disability, or socioeconomic status.

My claim is that we need both global health *and* justice. The hard question is how we can achieve these dual global public goods? It is helpful to ask three simple questions, so simple that they may appear naïve: What would an ideal state of global health look like? What would an ideal state of global health with justice look like? And how do we get there? (In this article I focus on the first two questions. Readers interested in my analysis of the pathways to achieving global health with justice can find a long discussion in my book.) Although these questions are highly simplified or idealized versions of a complex reality, I think it is helpful to simplify. Often overly complex arguments can lose the central importance of an idea, while simplification can bring a measure of clarity.

8. *Ibid* at 7.

II. *What would an ideal state of global health look like?*

What does it take to achieve—as closely as possible—an ideal state of global health? That is, how can society assure the conditions in which people can be healthy? This question may sound obvious, but the global health system is organized in ways that largely ignore the evidence about how to improve the public's health. Properly re-imagined, global efforts should be directed toward universal assurance of the essential conditions for health: population-level strategies drawn from the toolbox of public health; fully affordable, accessible, and high quality health care for all; and a wide range of socioeconomic policies beyond the health sector to address the social determinants of health.

1. *Public health services: A population-based perspective*

The first condition needed for good health is the provision of public health services—that is, services not allocated to particular individuals, but rather provided to the population as a whole. Classical population-based services include hygiene and sanitation, potable water, clean air, vector abatement, injury prevention, and tobacco and alcohol control. Conceived more broadly, public health services include built environments conducive to good health (such as green spaces for recreation), walking and bike paths, access to nourishing foods, safe vehicle and road design, and environmental controls. Public health requires surveillance, data systems, and laboratories to monitor health within the community. In short, governments must provide all the goods and services needed for a safe and healthy life in a well-regulated society.

Most public health services offer low technology solutions to ill health and premature death. Erecting and maintaining an adequate public health infrastructure has long been a fact of life in the developed world. In robust democracies, people do not tolerate living in filthy and chaotic environments that breed disease and expose individuals to horrific injuries in their daily lives. The progressive and sanitary movements revolted in horror at the squalor, filth, and unsafe conditions of the Industrial Revolution. In the 19th century, great public health figures devoted their lives to sanitary reform, including Villermé in France, Shattuck in the United States, Chadwick in England, and Virchow in Germany. Each of these campaigners stressed the devastating effects of urbanization, industrialization, and poverty on morbidity and premature mortality.⁹

9. Lawrence O Gostin & Lindsay F Wiley, *Public Health Law: Power, Duty, Restraint*, 3rd ed (Berkeley: University of California Press, 2016).

Once basic public health reforms are implemented, they quickly come to be seen as a baseline requirement for a functioning society—their widespread or sustained disruption is treated as a crisis. In the United States, for example, it recently came to light that the water supply for Flint, Michigan, was contaminated with lead, which is toxic to the development of young children. Although public officials at first refused to acknowledge the depth of the health crisis, once it was understood there was a public outrage, they did. In other words, in high-income states, the public simply will not tolerate the absence of the basic necessities of life, such as clean water, safe food, and sanitation.

What seems remarkable is that modern conceptions of global health rarely focus on fundamental public health services. What rich countries take for granted in their domestic policies, they rarely prioritize in international health assistance. Governments in lower-income states—in part responding to the inducements of global aid—also focus attention and resources on specific diseases and high technology solutions. What health and development partners forget is to provide the basic necessities of good health—an environment that is clean, safe, and conducive to living a healthy life. If there were a single message I could convey to global health leaders, it would be to first attend to the task of building a habitable, safe environment.

2. *Universal health coverage*

A basic standard of sound medical care will become an expectation of every society. Research-rich countries may come to see that achieving basic health care throughout the world is a strategy to promote stability and peace....To improve global health requires the educational and economic development that are essential for societies to achieve a reasonable standard of health. The moral mandate here only becomes stronger as clinical progress continues to accelerate in developed societies.

*Isaac S. Kohane, Jeffrey M. Drazen &
Edward W. Campion (2012)*¹⁰

The second essential condition for good health is the provision of health care services to all individuals. The modern parlance for this idea is universal health coverage, which is a major target in the SDGs. Comprehensive health care coverage includes clinical prevention (e.g., testing, counseling, and vaccines), medical treatment for injury and disease, and supportive care for those who are suffering. These services

10. Isaac S Kohane, Jeffrey M Drazen & Edward W Campion, "A Glimpse of the Next 100 Years in Medicine" (2012) 367:26 *New Eng J Med* 2538.

range from primary care to emergency and specialized services, through to pain relief. Universal health coverage aims to make all vital health care services available, affordable, and accessible to the entire population—poor and rich, physically and mentally able and disabled, and urban and rural. Effective health systems require healthcare facilities (e.g., clinics, hospitals, nursing homes), human resources (e.g., doctors, nurses, and community workers), and essential medicines to serve the full range of needs within the population.

Universal health coverage is particularly beneficial to the poor, who otherwise may forgo care due to resource constraints. Consequently, key health metrics such as infant and maternal mortality and life expectancy tend to be improved as societies move toward universal health coverage.¹¹ The introduction of user fees, or enrolment obstacles, can easily undo the benefits to the poor, however, allowing the middle and upper classes to capture an ostensibly public system. Where countries opt for mixed public-private arrangements, well-to-do classes often stream into the private system, leaving an under-funded public system as a safety net for the poor. Likewise, a lack of comprehensiveness (e.g., offering coverage only for in-patient care) undermines the effectiveness of universal coverage, and leaves individuals impoverished from having to pay out-of-pocket costs.

More broadly, gains from universal health coverage are easily undone through failings in governance. Health systems, therefore, must guard against the debilitating effects of corruption and poor management, fostering better public sector administration and provider accountability with the rollout of universal coverage.¹²

The growing emphasis on universal health coverage arises in part in response to shortcomings of disease-specific initiatives. There is a palpable futility in efforts to save lives through antiretrovirals or bed nets if survivors then face a fusillade of other, equally avertable, threats—e.g., maternal mortality, diarrheal diseases, cervical cancer. This sense of futility is not a license for inaction. Rather, preventive and therapeutic efforts must be expanded and rationally prioritized to address the health of the whole person (or the whole population, as public health advocates prefer to say).

Achieving universal health coverage requires systematic and inclusive planning, engaging affected communities; training, education, and good

11. WHO, *The World Health Report 2010—Health Systems Financing: The Path to Universal Coverage* (Switzerland: WHO, 2010).

12. Rodrigo Moreno-Serra & Peter C Smith, “Does Progress Towards Universal Health Coverage Improve Population Health?” (2012) 380:9845 *Lancet* 917.

career prospects for the full cadre of health professionals; adequate funding that is predictable and sustainable over the long term; and governance that is honest, transparent, and accountable for the health of the population. Universal health coverage is within the means of most low- and middle-income countries. Ghana, for example, has financed a universal, single-payer system through consumption taxes, with revenues earmarked for the National Health Insurance Scheme. Although legitimate concerns exist about the impact of consumption taxes on the poor, the Ghanaian experience suggests the tax can be structured as a progressive financing mechanism.¹³ External funding remains an indispensable gap-filler for states that lack the capacity to meet the full spectrum of national health needs.

One would expect that universal health coverage and public health services would go hand-in-hand. Yet there is good evidence that countries that move toward universal health coverage tend to spend on average *less on public health*.¹⁴ The reasons why are unclear, but it may be that political leaders see a finite percentage of gross domestic product going for health. The more they spend on health care, therefore, the less will go to public health.

3. *Socioeconomic Determinants of Health*

Once upon a time the overstressed executive bellowing orders into a telephone, cancelling meetings, staying late at the office and dying of a heart attack was a stereotype of modernity. That was before the Whitehall studies of British civil servants in the 1960s found that the truth is precisely the opposite. Those at the top of the pecking order actually have the least stressful and most healthy lives. Cardiac arrest—and, indeed, early death from any cause—is the prerogative of underlings.

The Economist (2012)¹⁵

The third essential condition for good health is the assurance of socioeconomic determinants that undergird healthy and productive lives. Key underlying determinants include education, income, housing, employment, social inclusion, and gender/racial/ ethnic equality. Socioeconomic factors affect health through a wide variety of causal pathways. The underlying (or upstream) determinants just mentioned are linked to more direct (or

13. Gina Lagomarsino et al, “Moving Towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia” (2012) 380:9845 *Lancet* 933.

14. Harald Schmidt, Lawrence O Gostin & Ezekiel J Emanuel, “Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Coexist?” (2015) 386:9996 *Lancet* 928.

15. “Social status and health: Misery index—Low social status is bad for your health,” *The Economist* (14 April 2012), online: <www.economist.com>.

downstream) risk factors such as smoking, exposure to air pollution, endangerment at home and in the workplace, addiction, and stress.¹⁶ Having a functioning social safety net for every inhabitant is the hallmark of solidarity, and should be seen as foundational to the global health system.

The dramatic rise in life expectancy in high-income countries over the past century has been primarily the result of improved socioeconomic determinants, along with public health services, as opposed to breakthroughs in clinical medicine.¹⁷ Even in high-income countries with systems of universal health care, the distribution of disease and early mortality continues to be strongly patterned on socioeconomic factors.¹⁸

Addressing the socio-economic determinants of health can set in motion a virtuous cycle, yielding long-term benefits for development, as individuals are enabled to thrive in their work and family lives, as well as their health.¹⁹ Effective interventions require action beyond the governmental health sector, and indeed beyond government—requiring both an “all-of-government” and “all-of-society” strategy. If the health sector is to play a leading role, it needs to mobilize and coordinate this inclusive societal response.

The World Health Organization has proclaimed the importance of social determinants, notably in the Marmot report in 2008, which found that the conditions in which people are born, grow, live, work, and age powerfully affect their health. In the 2011 *Rio Political Declaration on Social Determinants of Health*, world leaders made commitments on five action areas: governance for health and development, participation in policymaking and implementation, reorienting health systems towards reducing inequities, global governance and collaboration, and monitoring and accountability.²⁰ Regrettably, the *Declaration* established no new resource commitments to support social determinants in developing countries. The specifics (and effectiveness) of monitoring and accountability mechanisms remain to be seen.

16. Steven H Woolf & Paula Braveman, “Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse” (2011) 30:10 *Health Affairs* 1852.

17. John P Bunker, Howard S Frazier & Frederick Mustelier, “Improving Health: Measuring Effects of Medical Care” (1994) 72:2 *Milbank Q* 225.

18. See generally Steven H Woolf & Laudan Aron, eds, *US Health in International Perspective: Shorter Lives, Poorer Health* (Washington, DC: The National Academies Press, 2013).

19. WHO, *Closing the Gap in a Generation: Final Report of the Commission on Social Determinants of Health* (Geneva: WHO, 2008).

20. *Rio Political Declaration on Social Determinants of Health*, WHO, 21 October 2011, online: WHO <www.who.int/en/>.

Although all three essential conditions for good health—health care, public health, and socioeconomic determinants—call for distinct investments and governance strategies, taken as a whole they are mutually reinforcing. Thus, for example, population-level prevention marshaled under the banner of public health will ease the strain of injuries and disease epidemics on health care systems. Conversely, universal health coverage will advance public health—notably through clinical prevention, immunizations, and improved access for the poor.²¹ Finally, investments in public health and universal health care will advance the social determinants of health by easing the financial burdens of health care on individuals and families. In turn, improving socioeconomic determinants will strengthen social cohesion and civil society, and empower disadvantaged populations to demand responsiveness from their government.

A country's ability to provide these essential conditions of health is of course partly a function of its overall level of development. Yet population health and broader development do not move in lock step, as evidenced by the fact that countries with comparable levels of per capita GDP show highly divergent life expectancies.²² The U.S. health disadvantage, for example, refers to its poor health outcomes relative to OECD states.²³ Thus health outcomes are not primarily dictated by inexorable forces of global economics, but rather reflect policy choices made by governments susceptible to domestic and international pressures for improvement.²⁴

III. *Setting global priorities: A thought experiment*

Among the three essential conditions for good health, global health actors have focused intently on the provision of health care—often neglecting or deemphasizing the other two major conditions for health and wellbeing. Even when leaders focus on health care services, they tend to take a narrow perspective. Rather than devoting resources to broadly strengthen health systems, efforts are often targeted at particular diseases, such as AIDS, tuberculosis, and malaria. Or inordinate resources are marshaled in response to rapidly emerging infectious diseases (e.g., novel influenzas) or bioterrorism (e.g., anthrax). The enduring burdens of injuries, mental health, and non-communicable diseases are often left behind in the

21. *Supra* note 10.

22. Organization for Economic Co-operation and Development, *Health at a Glance 2015: OECD Indicators* (OECD Publishing, 2015) at 46.

23. *Supra* note 16.

24. Norman Daniels, Bruce P Kennedy & Ichiro Kawachi, "Why Justice is Good for Our Health: The Social Determinants of Health Inequalities" (1999) 128:4 *Daedalus* 215.

political struggle, notwithstanding their immeasurable toll on health and well-being.

This disease-specific focus remains, but global health actors are now starting to expand into health system strengthening. Major actors such as the Global Fund for AIDS, Tuberculosis and Malaria, and the U.S. President's Emergency Plan for AIDS Relief have incorporated health systems into their funding and programs,²⁵ while the World Health Organization has promoted the idea of universal health coverage, which is now incorporated in the post-2015 UN Sustainable Development agenda.

It is too early to predict whether the recent trend toward health systems is only the latest global health fashion, or whether it will have sustaining power. Given the lessons of history (from Alma Ata²⁶ onwards), there is ample reason for skepticism about whether the international community will make the necessary investments to fully achieve universal health coverage. But even if global health leaders did give serious and sustained attention to health system development, two essential conditions of health would remain largely unaddressed: public health and the socio-economic determinants of health.

Does this tacit prioritization of medical care make sense, given finite resources? To get some purchase on this question, consider a thought experiment loosely modeled on political philosopher John Rawls's veil of ignorance. Suppose—without knowing your life's circumstances (young or old, rich or poor, healthy or ill, or living in the Global South or North)—you were forced to choose between two stark options for the future of global health. Under option one, provision of health care would be strongly prioritized. You could see a health-care professional whenever you want, attend high quality clinics and hospitals, and gain access to advanced medicines. This scenario would achieve the ideal of universal health coverage, but would be highly oriented toward medical care, leaving gaps in population-level public health services and the social determinants of health. Universal health coverage would best serve the interests of individuals already ill and suffering, but it would have limited impact in preventing illness, injury, and early death.

25. Till Bärnighausen, David E Bloom & Salal Humair, "Going Horizontal—Shifts in Funding of Global Health Interventions" (2011) 364:23 *New Eng J Med* 2181.

26. Adopted in the International Conference on Primary Health Care in 1978, the Declaration of Alma Ata is the first international instrument that recognized primary health care as fundamental to achieving "Health for All." It called on "governments, health care and development workers, and the world community" to urgently take action to "protect and promote the health of all the people of the world." (World Health Organization, *Primary Health Care, Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 (WHO, Sept. 1978)*).

Under option two, scarce resources would be directed primarily toward population-level prevention strategies. As a result, everyone would live in an environment in which they could turn on the tap and drink clean water; breathe fresh, unpolluted air; live, work, and play in sanitary and hygienic surroundings; eat safe and nourishing food; be free from infestations of malarial mosquitoes, plague-ridden rats, or other disease vectors; not be exposed to tobacco smoke or other toxins; and not live in fear of avoidable injury or violence. This scenario would make unsparing use of public health measures, but would offer no assurance of medical treatment.

Blinded to your life's circumstances, and facing these stark options, there are compelling reasons for choosing option two—and I believe most people would prefer to live in a safe, habitable environment. If the day-to-day circumstances of your life do not allow for the maintenance of good health, medical treatments cannot fill the gap. Health care operates primarily *after* sustaining an injury or disease, and even following a successful medical outcome, patients will return to the same unhealthy and hazardous conditions. It is better to live in an environment that significantly lowers health risks, preventing exposures to pathogens, toxins, vermin, and treacherous conditions. Unfortunately, the world's poorest countries are at times the worst offenders in this regard, investing in expensive tertiary care or genomic research while neglecting elementary public health measures.

Historically, the greatest strides in combating disease and extending life expectancy have been achieved through population-level interventions. In his seminal study of population health in England, for example, Thomas McKeown found that improved standards of living, nutritional gains, and infectious disease control were primarily responsible for the major declines in mortality.²⁷ Modern historians have also stressed the relative importance of sanitation,²⁸ and government's vital role in ensuring the socioeconomic determinants of health.²⁹ The 20th century witnessed miraculous scientific achievements in clinical medicine, but the payoff in saved lives has been primarily through population-based public health. Given the choice between high-technology solutions and raising a family in wholesome, clean, and safe conditions, I believe the decision is clear.

27. Thomas McKeown, *The Modern Rise of Population* (New York: Academic Press, 1977), at 152-154.

28. Bernard Harris, "Public Health, Nutrition, and the Decline of Mortality: The McKeown Thesis Revisited" (2004) 17:3 *Social History of Medicine* 379.

29. Simon Szretzer, "Rethinking McKeown: The Relationship Between Public Health and Social Change" (2002) 92:5 *American J Public Health* 722.

While clinical interventions deliver benefits primarily at later stages of life, investments in public health are essential in guarding against threats that arise in infancy, childhood, and adolescence. Life expectancy is dragged down in the developing world in large part due to childhood deaths owing to elementary gaps in public health: under- and over-nutrition, unsafe water, raw sewage, suboptimal breastfeeding, and vitamin A and zinc deficiencies.³⁰ A selling point of public health interventions, then, is that they effectively address health needs upstream in a human lifespan.

The same reasoning applies to the maladies that afflict the developed world. When investments in tobacco control targeting adolescents succeed, a host of risk factors are drastically mitigated for a lifetime. And so it is with a whole range of public health investments—for example, there is a window in childhood where malnutrition can be ruinous to cognitive development, imposing a setback with lifelong effects. The same is true with the problem of childhood overweight, with evidence showing that healthy eating and physical activity habits in childhood will be carried on through adulthood.³¹

The public is often scandalized by stories of inaccessible or inadequate medical care, or failure to make available a particular medicine or technology. This is due in part to media attention to the latest scientific breakthroughs and the visibility of a sympathetic patient denied treatment. Public health, however, is concerned with creating broad environmental and behavioral changes for the masses, such as the many children saved by access to potable water. In focusing attention on heroic medical treatments, it often goes unnoticed that the 60-year-old heart-attack patient or diabetes sufferer is above all a victim of government's chronic under-investment in proven prevention strategies.

Under-investment in public health is especially apparent in the developing world. While inhabitants of high-income countries continue to take public health services for granted (even though population health receives only a fraction of health spending), those in lower-income countries still often live in crude, unsafe, and filthy environments. Visit most major cities in the developing world and experience the insecurity felt from consuming contaminated food and water, being bitten by vector-borne mosquitoes, driving on chaotic roads in rickety cars and buses, being exposed to raw untreated sewage, or breathing fumes belching from

30. WHO, *Global Health Risks: Mortality and burden of disease attributable to selected major risks* (France: WHO, 2009).

31. Verra Mikkilä et al, "Consistent dietary patterns identified from childhood to adulthood: The Cardiovascular Risk in Young Finns Study" (2005) 93:6 *British J Nutrition* 923.

unregulated vehicles and industrial factories. The essential corrective to these hazardous conditions is to prioritize population-level strategies, using well-understood, relatively low cost interventions.

Despite the manifest benefits of healthily built and natural environments, structural factors often push governments toward discrete, disease-based health care over broader public health infrastructure. Driven by domestic political pressures and international donors to show clear, measurable, near-term benefits, governments often under-invest in public goods whose benefits accrue over the long term. The problem manifests itself in many public sector services that affect health, such as roads, mass transit, schools, electricity, and clean energy.

Beyond the pressure to deliver short-term results, governments face a “rescue imperative,” which often drives political leaders to spend disproportionately on specialized medical and emergency services. Whether it is a little girl in a well or a mother with advanced breast cancer, identifiable lives have faces, names, and stories that are politically compelling. It is much harder to mobilize resources for the statistical lives that might be saved over the long term through population-level strategies.

Consider the effectiveness of even the most prominent humanitarian relief effort. The international community poured \$8 billion into Haiti—one of the world’s least developed countries—in the aftermath of the devastating 2010 earthquake. Yet, years after the crisis, despite billions of dollars in reconstruction aid, the most obvious, pressing needs—potable water, sanitation, safe and stable housing, and electricity—remained unmet. Only a fraction of aid disbursed went to building a public health infrastructure, with the lion’s share going to current programs, medicines, and a teaching hospital. With all the good will and money pouring in, international officials were determined to transform not only an intractably poor country, but also an ineffectual humanitarian relief system. But weak governance, donors’ pet projects, and the continuation of the aid-business-as-usual undercut those lofty goals.³²

Even though public health investments are hard to achieve, they are well worth the expenditure of economic and political capital. The health of a population can never be realized when interventions are medically based and primarily directed at individuals. Rather, the building blocks of public health must be in place before a society can effectively realize the benefits of strong healthcare systems. The public health approach, therefore, will

32. Deborah Sontag, “Rebuilding in Haiti Lags After Billions in Post-Quake Aid,” *The New York Times* (23 December 2012), online: <www.nytimes.com/2012/12/24/worldamericas/in-aiding-quake-battered-haiti-lofty-hopes-and-hard-truths.html?_r??u>.

likely get us a long way toward the goal of markedly improved global health, but it would do more than that: it would embed justice in the environment in which everyone shares, rich and poor alike. Global health *with justice* is the subject to which we now turn.

IV. *What would global health with justice look like?*

Looking at aggregate metrics, the international community has made remarkable progress in global health over the past half century. Global life expectancy increased from 47 years in 1955 to 68 in 2010. The global infant mortality rate per 1000 live births was 148 in 1955, and has dropped to 43 today.³³ Yet amidst these positive overall trends, deep inequities persist. As we have seen, progress in global health often conforms to a distributional pattern: advances accrue to the well-off first, and trickle to disadvantaged populations slowly, if at all. We have seen this pattern emerge with virtually every major challenge: AIDS, tobacco, injury rates, etc.

Is this distribution of health acceptable, provided there is continuing improvement in overall outcomes? The first point to clarify is that inequitable distribution of health is by no means a necessary precondition of aggregate improvements. Economic inequalities—which are deeply intertwined with health disparities—are sometimes rationalized on grounds that promoting equity would slow overall growth, leaving everyone worse off. It may be comforting for those privileged by current arrangements to explain away global health inequalities along similar lines. Or high-income governments may be so proud of their concrete measures of success in foreign assistance (e.g., persons in treatment, eradication of disease, or lives saved) that they do not stop to ask whether the benefits accrue to all equitably.

Whatever the merits in economics or politics, these rationalizations of inequality are implausible when carried over to global health.³⁴ Whether inequality is good for economic growth—and this is a doubtful proposition³⁵—it is demonstrably bad for health. In international comparisons, countries with more equal wealth distribution have higher life expectancies regardless of per capita GDP. The same phenomenon exists within countries. In the U.S., for example, states with the largest

33. Global life expectancy increased from 46.9 years in 1950–1955 to 70 in 2010–2015. The global infant mortality rate per 1000 live births was 134.7 in 1950–1955, and has dropped to 36.8 in 2010–2015. (United Nations, *World Mortality Report 2013* (UN, 2013) at 13, 21).

34. UNICEF, *Narrowing the Gaps to Meet the Goals* (New York: UNICEF, 2010).

35. Andrew G Berg & Jonathan D Ostry, *Inequality and Unsustainable Growth: Two Sides of the Same Coin?* (Washington: International Monetary Fund, 2011) at 4.

health disparities have the slowest increases in life expectancy. In short, there is no reason to fear that the promotion of health equity will drive down aggregate health outcomes as the evidence is quite the contrary: justice, it turns out, is “good for your health.”³⁶

1. *Embedding justice in human ecology*

The poor performance of the United States in life expectancy and other major health outcomes, as compared with its global peers reflects what the nation prioritizes in its health investments. It spends extravagantly on clinical care but meagerly on other types of population-based actions that influence health more profoundly than medical services. The health system’s failure to develop and deliver effective preventive strategies continues to take a growing toll on the economy and society.

*Institute of Medicine*³⁷

Given the reality of limited resources, there is an implicit tradeoff between a society’s investment in state-of-the-art medical interventions, on the one hand, and investments in population-level health strategies, on the other. In the developed world, the United States offers an extreme example of this tradeoff: at once a world leader in cutting-edge medical technology, while trailing much poorer countries in population health metrics (e.g., infant mortality and longevity)³⁸—spending only three per cent of health dollars on public health.³⁹ At the same time, the U.S. has one of the world’s highest levels of economic inequality. The problem is not how much the U.S. spends—no country spends more on health, per capita. It is rather a question of skewed priorities, and a severe, and worsening, underinvestment in population-level prevention strategies.

The stakes in this tradeoff are much higher in the developing world, where many live at the very margins of survival for lack of basic necessities. At least in the U.S., inhabitants—rich or poor—for the most part can drink clean water, use flushing toilets, eat uncontaminated food, remain free of malarial infected mosquitoes, and rely on reasonable health and safety regulations at work, at home, and in consumer products. The same cannot be said for the masses in many lower-income countries or for that matter in powerful emerging economies such as Brazil, Indonesia, or Thailand.

36. Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2008).

37. Committee on Public Health Strategies to Improve Health; Board on Population Health and Public Health Practice & Institute of Medicine, *For the Public’s Health: Investing in a Healthier Future* (Washington: The National Academies Press, 2012).

38. Gerard F Anderson & Bianca K Frogner, “Health Spending in OECD Countries: Obtaining Value Per Dollar,” (2008) 27:6 Health Affairs 1718.

39. *Supra* note 37 at 9.

Above, we saw that investments in public health yield tremendous benefits in improved health outcomes. What is less often understood is that such investments will generally have the added benefit of promoting equity in the *distribution* of health. When countries invest in genuinely public goods—water supply systems, sanitation, sewage systems, safe roads, vector abatement, pollution control, and so on—the benefits will, for the most part, accrue to rich and poor alike. The key point is that when government embeds healthy and safe conditions within the environment (not simply allocating services to particular individuals or groups), all human beings who live in that setting will benefit simply by the fact they inhabit the same space.

Viewed in this way, the primary manifestations of justice in global health may look rather mundane. Justice in health is not primarily realized by delivering heroic medical interventions, or through courtroom victories vindicating an individual's right to some particular therapy. Rather, justice will primarily be embedded in features of day-to-day life that are often taken for granted: the tap emitting clean water, the toilet that flushes, the neighborhood market selling nourishing food, public sanitation controlling the spread of disease, well regulated industries, and so on.

Adopting this perspective involves, in part, a broadened understanding of the institutional actors responsible for promoting and protecting global health justice. While national governments, and particularly their ministries of health, must bear primary responsibility, it is clear that a host of other actors have a vital role to play.

To begin, given the wide range of factors implicated in public health and the socio-economic determinants of health, it is imperative that all ministries of government coordinate in the protection and promotion of health. In recent years, across many countries, we have seen the gradual adoption of a Health-in-All-Policies (HiAP) approach within government.⁴⁰ The trend reflects the recognition that health outcomes are largely determined by policies falling outside the traditional portfolio of health ministries. The HiAP approach is a kind of process innovation: governments commit to routinely assessing the health impact of policy initiatives, with a view to promoting optimal health outcomes. When effectively implemented, the HiAP strategy achieves many of the foundational principles of good governance discussed in chapter 3 of my book *Global Health Law*.⁴¹ civic

40. Ilona Kickbusch & Kevin Buckett, eds, *Implementing Health in All Policies: Adelaide 2010* (Adelaide: Department of Health, Government of Australia, 2010).

41. *Supra* note *.

engagement, transparency, and accountability for the health impacts of government action and inaction.

However, responsibility cannot rest with government alone. It requires an all-of-society strategy. As we have seen with tobacco control and HIV/AIDS, political institutions often fail to initiate action, or make progress, without the backing of social movements. And as we saw in the discussion of non-communicable diseases, efforts to build a healthier world are bound to fail without the engagement of the private sector and the media, whose decisions shape the health landscape in myriad ways, ranging from dietary options and physical activity to workplace safety. And when the private sector fails to transform toward healthier and safer products, governments have a responsibility to regulate their activities.

Many of the basic conditions of health are beyond the power of national governments to control, even where they have enlisted cooperation from all of society. As explored in previous chapters, globalization drives multiple risk factors: infectious diseases through travel and trade; non-communicable diseases through urbanization, trade in tobacco, and the harmonization of marketing and cultures; and injuries stemming from global supply chains for consumer products. Just as at the national level, international actors must consciously prioritize health among competing norms (e.g., trade and development). The international community, moreover, has an obligation to provide financial and technical support to assist poorer countries in securing the essential conditions of health for all.⁴²

This picture of what justice in global health looks like entails a fundamental shift in our understanding of the right to health. The right to health must be conceived primarily as a collective right, imposing obligations on governments, and in turn implicating all of society. There remains an important role for safeguarding individual rights, and the rights of vulnerable groups, but the implementation of broader public health measures is a precondition for securing these more targeted rights. This is the population-based approach, which brings the benefits of improved health for all with an embedded form of social justice.

All this considerably complicates the conventional picture of rights holders and correlative duty bearers. With so many actors at the table, and such diffuse obligations, how do we establish order out of the chaos? That question will await section 2 below, which sketches the institutions and

42. UNCESCR, Office of the High Commissioner for Human Rights, *CESCR General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd Sess, UN Doc E/C 12/2000/4, 2000 at para 45.

monitoring and enforcement mechanisms needed to achieve the vision of global health with justice.

2. Correcting barriers to access

As indicated, investments in public health tend, broadly speaking, to promote equity by default; insofar as these are mostly non-divisible, non-excludable goods and services, their benefits flow to all. It will not suffice, however, to simply invest in public health and trust that everyone will benefit. There will often be barriers to access, particularly for disadvantaged groups or those in either crowded inner cities or remote rural villages.

In some cases, barriers exist in the literal sense. The homeless may be denied access to benefits of public water systems—the dignity of a private, safe space in which to bathe or urinate. For those living in remote regions, or simply outside urban centres, distance may be a barrier to public health interventions (e.g., vaccination campaigns). For persons with disabilities, services may be accessible only with appropriate accommodations. Where interventions take the form of information and knowledge then language, culture, or illiteracy may block access.

These examples reflect comparatively straightforward and foreseeable accessibility barriers. Often, problems of accessibility are detected only after the fact, as surveillance reveals that a given group is experiencing outcomes or risk exposures that lag behind the population as a whole. It remains an open question, for example, why disadvantaged socioeconomic groups have seen limited benefit from tobacco control or why they have vastly higher rates of tuberculosis and HIV/AIDS.

Challenges related to accessibility are solved, ultimately, through adherence to principles of good governance. Interventions must be carefully vetted and monitored on an ongoing basis for their effectiveness at reaching vulnerable populations. The objective is to identify and eliminate financial and non-financial barriers, and ensure that public health interventions are of uniformly high quality—reaching all people wherever they live. The active participation of marginalized communities in policy-making processes is invaluable in detecting and effectively resolving barriers to access.

3. Equitable allocation of scarce goods and services

Although I have highlighted the efficacy, and in-built equity, of population-level strategies, the dilemma of allocating scarce resources cannot be avoided altogether. Putting aside the broad question of access to health care, allocative challenges may arise in the context of prevention services targeted to populations—as with the rollout of “treatment as prevention” strategies to combat HIV/AIDS, the distribution of vaccines for novel

influenzas, or in disaster preparedness and relief. Notice, for example, the neglect of the most disadvantaged in the aftermath of Hurricane Katrina in the United States. Instructing everyone to evacuate or store up on food and water may seem egalitarian until one considers that the poor, elderly, and disabled do not have the means.

There is no template solution to these allocative dilemmas; what bears emphasizing again is the importance of accountable, transparent, and participatory governance. In the face of public health threats, disadvantaged populations are especially reliant on government as a provider of last resort. While disadvantaged groups are least equipped to secure health services, the stressors of poverty and marginalization create a heightened risk of injury and disease. It stands to reason that government must be especially accountable to these groups. In practical terms, this special accountability is achieved through advance scrutiny of allocative decisions to assess their impact on vulnerable populations, followed by monitoring their actual impact. In the interests of transparency, accountability, and participation, representatives of affected groups should have a seat at the table as this process plays out.

V. *Epilogue: Lessons from the Ebola epidemic*

The West African Ebola epidemic was a transformative moment for the future of global health. Ebola took only 11,000 lives, which is only a fraction of the lives taken each year from endemic infectious diseases (e.g., AIDS, tuberculosis, and malaria) and noncommunicable diseases (e.g., cancer, cardiovascular disease, and diabetes). Yet beyond the health impact of Ebola, there was a deep moral dimension. How could the international community sit idly by while an entirely preventable outbreak spun out of control in three of the world's poorest countries?

This was a classic illustration of the perversion of health justice. The World Health Organization was particularly unresponsive to the needs of this impoverished region, waiting four months after the first international spread to declare a public health emergency of international concern.⁴³ This unconscionable neglect resulted in four global commissions, each sharply condemning the international effort, while proposing sweeping

43. Lawrence O Gostin & Eric A Friedman, "Ebola: A Crisis in Global Health Leadership" (2014) 84:9951 *Lancet* 1323.

reforms of the global health security system.⁴⁴ The lesson learned is that global health with justice can be achieved only with robust national public health systems at the foundation and an empowered WHO at the apex. Above all, the optimistic narrative of a world with ever greater health improvements is a mirage in the absence of justice.

44. WHO, *Report of the Ebola Interim Assessment Panel* (Switzerland: WHO Press, 2015), online: <who.int/csr/resources/publications/ebola/report-by-panel.pdf>; Commission on a Global Health Risk Framework for the Future, *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises* (Washington: The National Academies Press, 2016) DOI: <10.17226/21891>; United Nations, Press Release, SG/A 1558 “Secretary-General Appoints High-Level Panel on Global Response to Health Crises” (2 April 2015), online: UN Meetings Coverage & Press Releases <www.un.org/press/en/2015/sga1558.doc.htm>; Suerie Moon et al, “Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard–LSHTM Independent Panel on the Global Response to Ebola” (2015) 386:10009 *Lancet* 2204.

