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GLOBAL HEALTH LAW GOVERNANCE*

*Lawrence O. Gostin***

My lecture is going to search for solutions to the most perplexing problems in global health. I am not going to take an optimistic or rosy view. I am going to take a hard-headed view about what the deep problems are that face world health, problems that are so important that they affect the fate of millions of people with economic, political, and security ramifications for the world's population. I think we would all agree that no state acting alone can insulate itself from major health hazards. The determinants of health do not originate solely with the national borders, pathogens, air, food, water, and even lifestyle choices. Health threats, rather, spread inexorably to neighboring countries, regions, and even continents, and it is for this reason that safeguarding the world's population requires cooperation and global governance.

If I am correct that ameliorating the most common causes of disease, disability, and premature death require global solutions, then I am afraid the future is demoralizing. The states that bear the disproportionate burden of disease have the least capacity to do anything about it, and the states that have the wherewithal are deeply resistant to expending the political capital and economic resources necessary to truly make a difference to improve health outside their borders.

When rich countries do act, and they are beginning to, it is often more out of a narrow sense of self-interest or a humanitarian instinct than a full sense of ethical or legal obligation. The result is a spiraling deterioration of health in the world's poorest regions, with manifest global consequences for cross-border disease transmission and systemic effects on trade, international relations, and security.

There are a variety of solutions that activists and scholars propose to improve global health and close the yawning health gap between rich and poor.

* Portions of this speech were excerpted from Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework on Global Health*, 96 GEO. L.J. 331 (2008).

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State advocates argue forcefully that global health is in the national interest of major states' powers, or that states owe an ethical obligation to act, or that international legal norms, notably the right to health, require effective action. However, arguments based upon national interest, ethics, or international law have logical weaknesses. The coincidence of national and global interests is much narrower than scholars claim, and ethical arguments unravel when searching questions are asked about who exactly has the duty to act and at what level of commitment. International law has serious structural problems of application, definition, and enforcement. Moreover, current policies and practices, as we can all see, are not working on the ground, and they are not likely to do so in the future unless we change things and change them quickly.

But even suppose that we were able to overcome all of these problems and that the international community became convinced that amelioration of global health hazards was in the national interest of each of its members, or that they otherwise accepted the claim that they have an ethical or legal obligation to act—would the consequent funding and other efforts make a difference? If past history is any guide, the answer may be, sadly, no. Most development assistance is driven by high profile events that evoke public sympathy, such as a natural disaster in the form of a hurricane, tsunami, drought, or famine, or an enduring catastrophe such as AIDS, and politicians may lurch from one frightening disease to the next, irrespective of the level of risk, ranging from anthrax and smallpox to SARS, influenza A, H5M1, and bioterrorism. The fundamental problems of global health remain.

What is truly needed is to meet what I call basic survival needs, which is what richer countries instinctively, although not always adequately, do for their own citizens. Basic survival needs include sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines, and functioning health systems for the prevention, detection, and mitigation of disease and premature death. By focusing on these major determinants of health, the international community could dramatically improve prospects for good health. Meeting everyday survival may lack the glamour of high-technology medicine or dramatic rescue, but what they lack in excitement they gain in their potential impact on health precisely because they deal with the major causes of common disease and disabilities across the globe.

If meeting basic survival needs can truly make a difference for the world's population, and if this solution is preferable to other paths, then how can international law play a constructive role? Existing legal solutions have deep

structural faults. The most glaring problem, widely debated by scholars, is whether international law is law at all in the traditional sense, with clear standards and systematic enforcement. Standard setting and enforcement are particular problems in health, even more so than in other fields of transnational law, but the debate over whether international law really is law does not even address the hardest problems in global health.

International law principally has bite, if at all, in governing relations between and among states, such as international trade law, or it may hold states accountable for the treatment of its own citizens, such as international human rights law. It is rare for international law to force states to provide funding, services, or protection for the population of other states, but this is exactly what is required to solve the most intractable problems in global health.

If law is to play a constructive role, it will require an innovative way of structuring international obligations, and this in turn will require states to accede to a new model. A vehicle such as a framework convention on global health could be a starting point. Such a framework convention could commit states to a set of benchmarks, both economic and logistical. It could set achievable goals for global health spending as a proportion of the GNP. It could define areas of cost-effective investment to meet basic survival needs. It could build sustainable health systems, including trained health care professionals, surveillance, and laboratories, and it could create incentives and systems for scientific innovation for affordable vaccines and essential medicines.

The World Health Organization or a newly created institution could set ongoing standards, monitor progress, and mediate disputes. A framework convention on global health or a similar mechanism would not be easy to achieve, and it certainly would not provide an ideal solution, but at least a framework convention would go toward the heart of the problem—that is, it would address states' obligations to act outside their borders and thus establish the level of commitment and the kinds of interventions necessary to make a meaningful difference for the world's population.

Let me address, first, the most basic problem in global health, which is why health hazards seem to change form and migrate everywhere on earth. Second, I shall inquire why governments should care about serious health threats outside their borders. I look here at questions of direct health impacts on rich states, questions of economics and trade, and then finally questions of national security. And third, I shall explore the compelling issue of global health

equity: is it fair that poor people in regions that suffer from such disproportionate burdens of disease, disability, and premature death should suffer that way?

Human instinct tells us that it is unjust for large populations to have such poor prospects for good health and long life simply by the happenstance of where they live. The appeal of reducing inequities is unmistakable. However, asking another simple question reveals the complexity of the problem. Whose responsibility is it to alleviate all the sickness, disability, and premature death? Although almost everyone believes it is unfair, do we have a common understanding of what the ethical, let alone the legal, obligation is to help the downtrodden, and if there were a public consensus would it break down if we ask the questions, “Who has to provide the assistance, under what circumstances, and at what level of commitment?”

Fourth, I shall describe how the international community focuses on a few high-profile heart-rending issues while largely ignoring deeper systematic problems in global health. By focusing on what I call basic survival needs, or the major determinants of health, the international community could dramatically improve prospects for world health. And then finally, I shall examine the value of international law and propose a mechanism for a framework convention on global health.

My first question is the globalization and spread of disease, which is man-made and therefore controllable. It’s axiomatic now that infectious diseases do not respect national borders, but this simple truth does not convey the degree to which pathogens migrate great distances to pose health hazards everywhere. It also suggests that the rapid movement of infectious diseases is inevitable, but in another sense the underlying causes are principally man-made and therefore are controllable.

Human beings congregate and travel, live in close proximity to animals, pollute the environment, and rely on overtaxed health systems. This constant cycle of congregation, consumption, and movement allows infectious disease to mutate and spread across populations and boundaries. The global population is also vulnerable to deliberate manipulation and dispersal of pathogens.

There are multiple reasons for this kind of migration of disease so that a disease in one region affects us everywhere. They include questions of mass congregation, migration, and travel. They also include very intense animal-

human interchange where people and animals are in very close proximity to one another, which causes animal diseases like BSE and foot-and-mouth disease, but also affect humans. For example, animals, particularly wild animals, are the source of seventy percent of all emerging infections, and these processes have transnational dimensions with thriving international markets in cattle, meat, and poultry.

We have also degraded our ecosystem of air, sea, forests, and soil, and that degradation has multiple adverse health effects in terms of air and water pollution, gastrointestinal diseases, and cancers.

Health systems are also to blame. The lack of sterilizing equipment, safe blood supplies, and basic infection controls in resource-poor countries puts health care workers and patients at risk. Weak public health infrastructures can fail to contain outbreaks of Ebola or SARS in their early stages. Also, health care systems themselves are weak so that there are insufficient doctors, nurses, and hospitals and clinics to help those who are in need.

Globalization, then, is a powerful force, propelling people, pathogens, goods, and even cultures to far away places, and the only effective response is global cooperation. The question is whether or not that will happen.

The description I have just given you about the spread of disease across countries and continents should lead to the conclusion that global health is in every nation's interest. Indeed, a compelling case can be made that large-scale health hazards have such catastrophic consequences for the health of the populace, the economy, and national security that international cooperation is a matter of vital state interest. The relationship between extremely poor health and dire economic and political consequences is far too complex to express in simple cause-and-effect terms, but instead it can be explained by how poor health contributes to state instability and how state instability in turn creates the conditions for poor health.

Democratic theory holds that the common defense, security, and welfare of the population are among the state's primary obligations, goods that can be achieved only through collective action. The first thing that public officials owe to their constituents is protection against natural and man-made diseases. And if governments have an obligation to assure at least reasonable conditions for health, they have no choice but to pay close attention to health hazards beyond their borders. DNA finger printing, for example, has provided conclusive evidence of migration of pathogens from less to more developed

countries, and, in fact, more than thirty infectious diseases have newly emerged over the last two to three decades, including HIV/AIDS, SARS, hemorrhagic fevers, Legionnaires, lyme disease, hanta virus, and the like.

Not only do emerging and re-emerging diseases increasingly affect the wealthiest countries, but these countries are also less able to ameliorate these harms through technology such as vaccines and pharmaceuticals. Resurgent diseases such as TB, malaria, and HIV have developed extreme resistance to frontline medication. The social and political costs of major epidemics also show why it would be in our national interest to be concerned about health problems. It is difficult to exaggerate the dread and the destabilizing effects on communities caused by disease epidemics. A pestilence is a scourge, decimating the population and presenting a threat to common security as momentous as war, and history demonstrates that society through its own institutions will take whatever means it can to defend itself.

The state's response to disease epidemics, therefore, has profound health costs and social costs. Even in the most powerful countries the question arises whether they have a deeper enlightened interest in redressing extremely high rates of disease and premature death throughout the world's populations. There is a strong case that a forward-looking foreign policy would seek to reduce enduring intractable diseases in developing countries, such as AIDS, cholera, dengue fever, guinea worm, and the like.

States should care about epidemic diseases because of their potentially major economic consequences. Epidemic disease dampens tourism, trade, and commerce. We could see this from the SARS outbreaks, for example, and we can also see it from the global predictions of what would happen if there were a pandemic influenza. Depending upon the severity of that outbreak, it could involve something like two percent of the global GDP.

But even if diseases don't directly threaten developed countries, the economic effects on both developed and developing countries are apparent. In regions with extremely poor health and low life expectancy, economic decline is almost inevitable, and it is only reasonable to consider the effects of HIV/AIDS on the social fabric and economy, for example, in sub-Saharan Africa, which accounts for seventy-two percent of the global AIDS death burden. Average life expectancy in this region is now forty-seven years when it would have been sixty-two years without AIDS.

For some of the worst affected countries, such as Botswana, life expectancy has declined from seventy-six years to thirty-four years. Most of the excess mortality is among young adults, leaving the country without entrepreneurs, a skilled work force, parents, and political leaders. The economic effects are felt among families, where breadwinners fall ill and die and children become orphaned; the private sector, where there is markedly lower creativity and productivity and increased medical and death-related benefits; and the public sector, where political leadership, public services, and government finances precipitously decline.

Endemic disease in poor regions poses potentially significant threats to trade and commerce. Countries with poor health become unreliable trading partners, without the capacity to develop and export food, products, and natural resources, and impoverished consumers cannot afford Western imports. They cannot pay for essential vaccines and medicines, cannot repay debt affecting global financial institutions, and they require humanitarian assistance affecting non-governmental and philanthropic organizations. So, in short, a foreign policy that seeks to ameliorate health threats in poor countries can benefit both the public and private sectors in developed as well as developing countries.

There is also the national security interest, for extremely poor health in one part of the world can affect the security of the United States and its allies. The reasons are that extremely poor health undermines the viability of governments and their ability to prevent and control humanitarian crises and war, affects military peace keeping and humanitarian operations in those regions, and destabilizes strategically important countries, shifting the balance of political, economic, and military power.

Research shows a strong correlation between health and the effective functioning of government and civil society. The Central Intelligence Agency, for example, finds that infant mortality is one of the leading predictors of state failure. Poor health can affect competency, capacity, and integrity of government, as well as the public's trust in its political leaders. States with exceptionally unhealthy populations are often in crisis, fragmented, and poorly governed. At the most extreme, weak or failed states are prone to committing or allowing gross human rights abuses, such as torture, trafficking of young girls for sex, enlisting child soldiers, and even genocide. In these states, there is more opportunity to harbor terrorists and recruit disaffected people to join in armed struggles. Politically unstable states require a heightened diplomacy, create political entanglements, and sometimes provoke military responses.

The burden of HIV/AIDS and other infectious diseases is overwhelmingly concentrated, as I have said, in sub-Saharan Africa, and it is no surprise that many of these political and military entanglements occur in that region. The rest of the world, however, has largely been insulated from the devastation wrought by these endemic diseases, and the explanation for this awful dissonance may lie in the region's marginal strategic importance. Sub-Saharan Africa has weak political, military, and economic power, and it is perhaps for this reason that wealthy nations have resisted seeing health in national security terms.

But the same cannot be said about the burgeoning health crises emerging in pivotal countries in Eurasia such as China, India, and Russia. These countries are in the midst of a second wave of HIV/AIDS, with as many as twelve million infections collectively. The alarming growth of HIV/AIDS in Eurasia mirrors the earlier explosion in sub-Saharan Africa. HIV prevalence rates in the Ukraine and the Russian Federation, for example, have risen twenty fold in less than a decade. In the decades ahead, the center of global HIV/AIDS pandemic is projected to shift from Africa to Eurasia.

Nevertheless, Eurasian states have not been the focus of international attention. For example, they are not among the fifteen countries targeted by PEPFAR [President's Emergency Plan for AIDS Relief]. The Eurasian region, of course, is of high strategic importance in terms of its population, economic and military prowess, and political influence. It has more than sixty percent of the world's inhabitants, one of the highest combined GNPs, and at least four massive armed forces with nuclear capabilities. The geostrategic importance of the region is clear, as it spans Asia and Europe with ten new member states from Eastern Europe joining the European Union.

Do states therefore have powerful reasons based upon narrow or enlightened self-interest to alleviate extreme health hazards beyond their borders? There are good reasons to believe so, but political leaders often do not acknowledge or act upon the evidence that I have just given because they don't, in truth, believe that global health is necessarily in their national interest, even though they may declare it so. The United States Government, for example, has said that AIDS is a national security issue, but it does not act that way. The answer may be that there are, in fact, reasons why it does not believe this to be the case, for rather than a general commitment to global health, states often prefer targeted engagements to prevent only those hazards deemed most

likely to affect their own citizens, as is evidenced by recent international cooperation in SARS and pandemic influenza.

National security assessments and international agreements offer relatively narrow justifications for state action on global health. Governments frame the problem as one of averting direct health threats of infectious diseases reaching their borders, and even when international law, such as that embodied in the International Health Regulations, focuses on helping states reach capacity, it has weak enforcement and no clear targets.

Many scholars would argue that states are incorrect in their assessment and that, in fact, global health does affect their national interest. I would like to be here to tell you that that was the case, and I think I've presented as strong an argument as I could to make that case, but the truth is that developed countries will always have significant and dramatic relative health advantages over poor countries. They have that because of their technological capacity in relation to vaccine and pharmaceuticals, and they also have that simply because it is a clear epidemiological understanding that those who have greatest wealth and social status have strong, enduring, and persistent relative health advantages over their poorer counterparts.

So perhaps the answer is not world health is in the national interests of any given country, but that there is simply an ethical imperative to help, and this ethical imperative simply cannot be ignored. It is well known that the poor suffer, and they suffer more than the rich. Unfortunately, this is doubly true with respect to health. What is less often known is the degree to which the poor suffer unnecessarily and why this occurs.

With respect to health, the global disease burden is not just shouldered by the poor but profoundly disproportionately so, such that health disparities across continents render a person's likelihood for survival dramatically different based upon where she is born. These inequalities have become so extreme and the resultant effects on the poor so dire that they have captured the attention of social epidemiologists, social justice theorists, and economists, an issue no less important than global warming or the other defining problems of our time.

Now, I don't have a lot of time to describe to you these global health disparities, and I think they are well known to you. Disparities in life expectancy, for example, among the rich and poor are vast, with the highest rates of early death in sub-Saharan Africa. Life expectancy in Africa is thirty

years less than in the Americas or Europe. A person born in Zimbabwe can hope to live only thirty-four healthy years, whereas a person born in Japan lives more than twice that many years of healthy life.

While life expectancy in the developed world increased dramatically during the twentieth century, it actually decreased in the least developed countries and in transitional states in the last couple of decades. Infectious disease epidemics, particularly HIV/AIDS, and increased chronic disease have erased hard-won gains in life expectancy that took years to achieve. The diseases of poverty are endemic to the world's poorest regions, but they barely get noticed among the wealthy. Diseases such as diarrhea, elephantiasis, guinea worm, malaria, measles, river blindness, and trachoma are leading causes of death in poor countries, but they're largely unheard of here. For example, diseases of poverty accounted for fifty-four percent in high mortality poor countries compared with only six percent of the deaths in high-income countries. These are also leading causes of child mortality in these countries.

Beyond morbidity and mortality, the diseases of poverty cause physical anguish. For example, when a two-foot long guinea worm parasite emerges from the genitals, extremities, and torso with excruciating pain, or filarial worms cause disfiguring enlargement of the arms, breasts, and genitals, or river blindness leads to unbearable itching and loss of eyesight, these diseases can also cause mental anguish, essentially the suffering that is often involved in these socially stigmatizing diseases. The diseases of poverty facilitate the cycle of poverty in that they decrease earning ability and economic productivity.

I have already mentioned to you, and time won't allow me to go into the problems involving health and social status, that while there is a very strong correlation between health and social status in North America, Europe, and other developed countries, this is also true in poorer countries, and it is doubly true for the focus of this conference, which is women who suffer vastly disproportionately in poor countries relating to maternal health. For example, gender-based violence and sexual violence are all reasons to demonstrate that even within the poorest countries, those with the least control, the least resources, the least political and economic power suffer the most.

So a core insight of health disparities theorists is that there are multiple causal pathways to numerous dimensions of disadvantage. The causal pathways to disadvantage include poverty, poor education, unhygienic and polluted environments, and social disintegration. These and many other causal

agents lead to systematic disadvantage, not only in health, but also in nearly every aspect of social, economic, and political life. Inequalities of one kind beget other inequalities. Taken in their totality, multiple disadvantages add up to markedly unequal life prospects for people in the poorest regions of the world.

As I mentioned earlier, it would appear self-evident that these profoundly different life circumstances between the rich and the poor are unjust, and who would not agree that vast inequalities in health and other life circumstances simply by dint of birth are ethically troubling? Even if there were a consensus, that consensus might quickly break down, and it does once we ask a number of hard questions. Why are these inequalities ethically wrong? Who is responsible for ameliorating the high rates of illness and death, and what level of assistance is ethically warranted?

I am going to, if I may, fast forward to a couple of concluding remarks. One is to develop the idea very briefly about basic survival needs, and the other is to look at international law and its role.

So there are, as I have tried to indicate, intractable problems in global health, the inexorable spread of disease, the disinterest of government, and the widening disparities, but what we do know is how to solve these problems, or at least we have a pretty good idea how to ameliorate much of the suffering and death, and the answer is alarmingly simple if only it could rise on the agenda of the world's most powerful countries, and the cost would be very low compared to the costs that we spend on military confrontations and even low compared to what we give to farm subsidies.

The current focus, however, on high-technology dramatic rescue for high visibility health hazards is not likely to succeed. Instead, we need to meet basic survival needs, things like sanitation, sewage, pest control, clean air and water, diet and nutrition, tobacco reduction, essential vaccines and medicines, and functioning of health systems, both public health systems and health care systems. The public health community recognizes this intuitively in its focus on determinants and health, and even the international community recognizes this, as evidenced by the Millennium Development Goals. Many of these Millennium Development Goals, by the way, go directly to problems of health.

So if meeting basic survival needs is the answer, how could international law play a role? As I indicated before, I think at present there are deep structural faults with international law, the question of "is international law

law?,” and that question, I think, becomes particularly acute when we talk about social and economic rights and particularly the right to health. We have spent many, many decades and maybe centuries, if you go back to ethical thinkers, addressing the importance of civil and political rights, but we have done comparatively very little in advancing the idea of what social and economic rights are. Special Rapporteur Paul Hunt’s work on the right to health has taken great leaps, but even so, questions of monitoring and enforcement of these economic and social rights don’t begin to deal with the problem.

Secondly, international law principally, at least historically, as David Fidler has said so eloquently in so much of his scholarship, that it governs traditionally relations among states. One example of that would be international economic law or trade law, or it might try to hold states accountable for the treatment of its own citizens. We just heard about the International Criminal Court, and we also know about international human rights in that vein, but what international law has been badly structured to do is reach beyond states to civil society. There’s been a great deal of recent scholarship, for example, that has shown the profound effect on health of non-state actors, the media, international corporations, community-based organizations, major philanthropic organizations like the Gates Foundation or the Clinton Initiative or The Carter Center.

What is needed, I think, is an international regime that would facilitate a high level of aid, in particular facilitate a high level of aid to a particular purpose, basic survival needs, with continuous monitoring and enforcement. One possible solution to that might be a framework convention on global health. The advantage of that is that it could set goals for spending, for example, to meet the seven percent of GNP or higher that the global community has said was necessary but is rarely met. It could help build sustainable health systems, particularly addressing the migration of health care workers, and developing strong surveillance laboratory and other capacities. It could create incentives for affordable medicines and vaccines, and it has the advantages of being based upon states consenting to it, binding themselves to these ideas. It can go through gradual development because we’re not in a position to have some grand global treaty just now. It can create international governmental organizations or use existing ones that recognize what is needed, monitor, evaluate, and enforce.

This is not a panacea. It will require states to bind themselves, and that will not be easy. As Gordon Brown, Chancellor of the Exchequer in the United Kingdom, soon to be Prime Minister, probably,[†] said in announcing the international finance facility, “We,” referring to rich nations, “simply do not care enough.” And so whether we try to deal with this question by appeals to the national interests of richer countries, or whether we make appeals based upon ethics or humanitarian concern, or whether we use law by creating new structural means to try to harness the world’s community and govern as best as we can, whatever way we choose, we are facing, in my judgment, an issue that is so important to the future of our planet, so important to our civilizations and how we view ourselves as human beings.

This is, as I said earlier, a problem no less important than any of the great problems of our time, whether it be global warming or the war on terrorism. Nothing is more important for fairness, justice, and our own self-preservation than global health, particularly among the world’s least healthy people.

[†] [Editor’s Note: Following the conference, on June 27, 2007, Gordon Brown became the United Kingdom’s Prime Minister.]

