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*Redressing the Unconscionable Health Gap: A Proposal for a Global Plan of Justice*

Good afternoon. Thank you all for coming. I know it's late in the day. I wanted to add my thanks to Dr. Philip Margolis for being such a gracious host and really being the inspiration behind this series. It's wonderful. And I welcome the Waggoner family who are delights and I've really been privileged to meet you. Ray Waggoner was somebody that I feel honored to represent here because he believed in at least two things that I believe in passionately which are mental health, humanity and ethics. And that really is very important to me. I gave a talk at Grand Rounds this morning on mental health and human rights. Mental health was my first love other than my wife. And I've moved from mental health to AIDS and then public health and now global health. It's very hard to get my hands around the global health area.

I'm going to be talking about a topic of global health governance and what the grand challenges are. I'm not going to per se talk about my global plan for justice but actually even a bolder proposal, the framework invention on global health. The global plan for justice idea is going to come out in the *Lancet* in the next month. The longer version will be coming out in the *Harvard Journal of Law and Policy.*

I want to apologize for two things. One, I'm a lawyer so I just talk - no PowerPoints. And normally I wander around the audience, but I was really tethered to the microphone so I'm just going to be a good boy and sit at the podium nicely. And secondly, I don't normally do this and I haven't in any of the other lectures, but I'm going to read my lecture because I have so much to cover that I want to be able to cover it in a way that's efficient.

This lecture searches for solutions to the most perplexing problems in global health. Problems so important that they affect the fate of millions of people with economic, political and security ramifications for the world's population. No state acting alone can insulate itself from major health hazards. The determinants of health: pathogens, air, food, water and even lifestyle choices do not originate solely within national borders. Health threats inexorably spread to neighboring countries, regions and even continents. 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 the future is demoralizing. The states that bare 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 it is more often out of a narrow self interest or humanitarian instinct, as in Haiti, then 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.

This lecture first inquires why governments should care about serious health threats outside their borders. And I explore the alternative rationales of direct self interest and lightened self interest and national security. Second, I examine the compelling issue of global health equity and ask whether it is fair that people in poor countries suffer such a disproportionate burden of illness and death. Here I will briefly explore a theory that I call a theory of human functioning to support a more robust understanding of the transcending value of health. Third, I describe how the international community focuses on a few high profile, heart rendering issues while largely ignoring the deeper, systemic problems in global health. By focusing on what I call basic survival needs the international community could fundamentally improve prospects for the world's population. And finally, I explore the value of international law itself and propose an innovative

mechanism for global health reform, a framework invention on global health.

My proposal in a nutshell is to establish fair terms of international cooperation with agreed upon mutually binding obligations to create enduring health system capacities, meet basic survival needs and reduce the unconscionable inequalities that exist in global health. I'm quite torn about this proposal because on the one hand most of the people I've talked to, and I've talked Bob Zoellick, head of the World Bank, Margaret Chen at WHO and others, support it as an underlying theory. On the other hand the political realities are dim and make me very dispirited at times. Next month I'm going to Oslo because I had one piece of good news, the Norwegian Parliament has adopted the framework. And I'm going to be championing it in the international arena. So all I can say is go Norway.

It's axiomatic that infectious diseases do not respect national borders, but this simple truth does not convey the degree to which pathogens migrate great distances and pose health hazards everywhere. Human beings congregate in travel, live in close proximity to animals, pollute the environment and rely on overtaxed health systems. The constant cycle of congregation, consumption and movement allows infectious diseases to mutate and spread across populations and boundaries. These human activities and many more have profound health

consequences for people throughout the world and no country can insulate itself from its effects. The world's community is interdependent and reliant on one another for health security.

Powerful reasons therefore exist for governments to pay close attention to global health, not only for the sake of people in faraway places but to prevent potentially catastrophic social, economic and political consequences for their own citizens. But beyond narrow self interests are the broader and lightened interests in redressing extremely high rates of disease and premature death in the world's poorest regions. There is a strong case that a forward looking foreign policy would seek to reduce the enduring intractable diseases in developing countries and it's my profound hope that president Obama's Global Health Initiative, which I hope he will talk about tonight, may redress some of these.

Epidemic disease dampens tourism, trade and commerce as the 2003 sores outbreaks demonstrated. Animal diseases such as foot and mouth, BCS and pandemic influence, whether H1N1 or avian influenza, also had severe economic repercussions. In the avian case it included mass culling of flocks and herds, trade bans on beef , lamb or poultry. And it's predicted that massive economic destruction would ensue from a pandemic of human influenza, one that was more

pathogenic than the current H1N1 with a projected loss of up to six percent in global GDP.

In regions with extremely poor health economic decline is almost inevitable. AIDS in sub-Saharan Africa accounts for 72 percent of global AIDS deaths. Average life expectancy in the region is now 47 years, when it would have been 62 without AIDS. And for some of the worse affective countries such as Botswana life expectancy has declined from 76 to 34 years of age. Most of the excess mortalities among young adults age 15 to 49, leaving the countries without entrepreneurs, skilled work force, parents, teachers, political leaders. The World Bank estimates that AIDS has reduced GDP by nearly 20 percent in the hardest hit countries. And AIDS, of course, is only one disease in countries experiencing multiple epidemics of starvation and massive poverty and regional conflicts that devastate the population. Countries with extremely poor health become unreliable trading partners without the capacity to develop and export products and natural resources, pay for essential medicines and vaccines or pay debt, and require increased financial aid and humanitarian assistance. In short, a foreign policy that seeks to ameliorate health threats in poor countries can benefit public and private countries in developed as well as developing countries.

Extremely poor health in other parts of the world can also affect the security of the United States and its allies. Research shows a correlation between health and the effective functioning of government and civil society. The CIA for example finds that high infant mortality is a leading predictor of state failure. And the state department called AIDS a national security threat. States with exceptionally unhealthy populations are often in crisis, fragmented and poorly governed. In the most extreme form poor health can contribute to political instability, civil unrest, mass migrations and human rights abuses. In these states there is greater opportunity to harbor terrorists or recruit disinfected people to join in armed struggles. Politically unstable states require heightened diplomacy, create political entanglements and sometimes provoke military responses.

Diseases of poverty are overwhelmingly concentrated in sub-Saharan Africa so it's no surprise that many of these political and military entanglements occur in that region. But it's also true that Africa has weak political military and economic power so it can too easily be ignored. The same cannot be said about the burgeoning health crisis emerging in pivotal countries in Eurasia, such as China, India and Russia. These countries are in the midst of a second wave of AIDS with prevalence rates rising twentyfold in less than a decade. In the

decades ahead the center of global AIDS is projected to shift from Africa to Eurasia. And recall that infant mortality is a prime predictor of state instability. Russia's official infant mortality rate which is thought to be vastly undercounted is three to four times higher than in North America and Western Europe. Nearly two-thirds of children born in Russia will be unhealthy, many suffering life-long illness and disability. Yet Eurasia has more than 60 percent of the world's inhabitants, one of the highest combined GNPs and at least four massive armed forces with nuclear capabilities. But due to extreme health hazards Eurasia will suffer economic, political and military decline. Political instability in a region with such geostrategic importance will have major international ramifications.

Governments, therefore, have powerful reasons based upon narrow or enlightened self interest to ameliorate extreme health hazards beyond their borders. But do political leaders acknowledge and act on this evidence? The answer is that political engagement in global health is relatively limited. As UK now Prime Minister, then Chancellor of the Exchequer, Gordon Brown said when launching the International Finance Facility for Global Health, "Rich countries just don't care enough." Well, it's no surprise and we saw this with the Haiti telethon the other night that rich countries, philanthropists and even celebrities have announced with great fanfare breathtaking gifts to the poor,

unprecedented. OECD countries increased global health assistance, rising from two billion in 1990 to twelve billion in 2005. The Gates Foundational Loan will donate up to three billion dollars per year. And this development assistance for health may appear substantial but it actually sits modestly beside the one trillion dollars spent on military expenditures annually and three hundred billion on agricultural subsidies. If you were to ask me, for example, what is the most destructive thing the United States does for international health my answer, and even here in the Midwest, it would still be my answer would be the Farm Bill.

The increase in development assistance, moreover, is largely attributable to extensive resources devoted to a few high profile problems: the AIDS pandemic certainly with the Global Fund and PEPFAR, pandemic influenza, the Asian tsunami, the Haitian earthquake. But even factoring in these new investments most OECD countries have not come close to fulfilling their pledges of giving 0.7 percent of GNI per annum. OECD countries would have to invest in an additional one billion dollars by 2015 to close the investment gap. And with these additional dollars WHO projects tens of millions of lives would be saved every year. And although I know we consider ourselves a very generous people in America and we are, nonetheless we do fall near the bottom even with PEPFAR in terms of our global

health assistance as a percentage of GDP. Notably and thankfully I noticed that President Obama has announced that in the spending cuts for discretionary spending the global health initiatives are going to be exempt.

Well, perhaps it does not or should not matter if global health serves the interests of the richest countries. After all there are powerful humanitarian reasons to help the world's least healthy people. But even ethical arguments have failed to capture the full attention of political leaders and the public. The global burden of disease is not just shouldered by the poor but disproportionately so, such that health disparities across continents render a person's likelihood of survival drastically different depending upon where she is born. These inequalities have become so extreme and the resultant effects on the poor so dire that health disparities have become an issue no less important than global warming or the other defining issues of our time. The current global distribution of disease has led to radically different health outcomes. Disparities in life expectancy among the rich and poor are vast. Average life expectancy in Africa is 30 years less than the Americas or Europe. Life expectancy in Zimbabwe or Swaziland is less than half that of Japan. A child born in Angola is 73 times more likely to die in the first years of life than a child born in Norway. And a woman giving birth in Africa is a hundred times more

likely to die in labor than a woman here in America. While life expectancy in the developed world has increased throughout the twentieth century it actually decreased in the least developed countries and in transitional states such as Russia. And as little as one concrete example offers a sense of proportion about the global health gap. In one year alone 14 million of the world's poorest people died while only 4 million would have died if this population had the same death rate as the global rich, ten million avoidable deaths a year.

The diseases of poverty are endemic but barely get noticed among the wealthy. Diseases such as elephantiasis, Guinea worm, Malaria, River blindness, schistosomiasis and trachoma are common in poor countries but many are virtually unheard of here. Beyond morbidity and premature mortality the diseases of poverty cause physical and mental suffering. For example, when a two-foot Guinea worm parasite emerges from the genitals, breasts, extremities and torso with excruciating pain. Alfilaria worms cause disfiguring enlargement of arms, legs, breasts and genitals. Or River blindness leads to unbearable itching and loss of eyesight, all preventable.

Well, human instinct tells us that it is unjust for large populations to have such poor prospects for good health and long life simply by happenstance of where they live. And although almost everyone believes that it is unfair that the poor live miserable and short lives,

there's little consensus about whether there is an ethical let alone a legal obligation to help the downtrodden. What do wealthier societies owe as a matter of justice to the poor in other parts of the world? Well, perhaps the strongest claim that health disparities aren't equal is based upon what I call a theory of human functioning.

Health has special meaning and importance to individuals and communities as a whole. Health is necessary for much of the joy, creativity and productivity that a person derives from life. Individuals with physical and mental health recreate, socialize, work and engage in family and social activities that bring meaning and happiness to their lives. Perhaps not as obvious health also is essential for the functioning of populations. Without minimal levels of health people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art and provide for the common security. Amartya Sen famously theorized that the capability to avoid starvation, preventable morbidity and early mortality is a substant to freedom that enriches human life. Depriving people of this capability strips them of the freedom to do what they want to do and to be who they want to be and have a reason to value. Under a theory of human functioning health deprivations are unethical because they unnecessarily reduce one's ability to function and their capacity for human agency. Health among all other forms of

disadvantage is special and foundational and that its effects on human capabilities impact one's opportunities in the world. And I can think of no place other than the University of Michigan and its medical and public health research and dedicated people who live by that motto.

But unfortunately Amartya Sen's theory does not answer the harder question about who has the corresponding obligation to do something about global inequalities. Even the most liberal egalitarians that believe in just distribution such as Nagel, Rawls and Rotzler frame their claims narrowly and rarely extend them to international obligations of justice. Their theories of justice are relational and apply to fundamental social contracts. But positing such as relationship among different countries and regions is much more difficult.

Well, suppose that states were convinced of my arguments so far that amelioration of global health hazards was in their national interests or they otherwise accepted the claim that they have an ethical responsibility to act. Would the consequent funding and efforts make a genuine difference? Well, if past history is any guide the answer is 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, hurricane or famine or an enduring crisis such as AIDS. Or even worse yet, and America is really bad at this, we lurch from one frightening disease to the next irrespective of the

level of risk ranging from anthrax to smallpox to SARS to influenza H5N1, to influenza H1N1, to bioterrorism.

What is truly needed, and this is what I believe most passionately, and what rich countries like America do instinctively, maybe not adequately as Peter Jacobsen and Harold Markel will know, they do for their own citizens what I call basic survival needs. By focusing on the major determinants of health the international community could dramatically improve prospects for good health. Basic survival needs include sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines and well functioning health systems. Meeting every day survival needs 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 determinants of common disease and disabilities across the globe. Mobilizing the public and private sectors to meet basic survival needs comparable to a Marshall Plan could radically transform prospects for good health among the world's poorest people. And meeting basic survival needs can be disarmingly simple and inexpensive if only it could rise on the agenda of the world's most powerful countries. It does not take advanced biomedical research, huge financial investments or complex programs.

Consequently what poor countries need is not foreign aid workers power shooting in to rescue them. Nor do they need foreign run state of the art facilities. Rather what they need is to gain the capacity to provide basic health systems and services themselves. Well, if meeting basic survival needs can truly make a difference and if this solution is preferable to other paths then can international law structure legal obligations accordingly? The answer is that extant health governance has been lamentingly deficient. Everyone agrees with this. And a fresh approach is badly needed.

The WHO was founded in 1948 as an incredibly powerful normative institution. But its potential has never been realized. The WHO constitution empowers the agency to adopt conventions which unlike normal treaties affirmatively require states to take action. And despite WHO's impressive normative powers modern international health law is remarkably thin with only one significant regulation and one treaty in 60 years of existence. The international health regulations which were revised in 2005 in light of SARS originally applied only to cholera, plague and yellow fever. The same diseases originally discussed at the first International Sanitary Conference in Paris in 1851. The WHO did not create a treaty until it adopted the Framework Convention on Tobacco Control in 2003. And although a laudable achievement, the FCTC is almost generous because it regulates a

vilified industry that had denied for years and decades scientific realities about health, engineered tobacco to create dependence and targeted youth women and minorities. And it still does in developing countries.

Although norms created by the WHO are sparse there is a much larger body of international law that affects global health ranging from food safety, arms control and the environment to trade in human rights. I'm currently finishing up a book on global health law for Harvard University Press so I've been really steeped in it. The WHO should be a leader in creating or at least influencing many of these norms, but that has not happened. The agency has shied away from the high politics of international law because it sees itself principally as a scientific technical agency. Thus WHO is comfortable developing technical standards for food safety but it has not ventured into the harder terrain of WTO rule making and dispute resolution. It ought to have a great deal to contribute and sway over the traded goods and services, sanitary and fido-sanitary measures and intellectual property rights, all of which clearly affect global health. Yet its influence is nowhere to be found. As a result social activists have increasingly turned to the language of human rights to articulate their fondest hopes and dreams for global health.

But recasting the problem of extremely poor health as a human rights problem, which I actually heartily support, isn't good enough either for a number of reasons. First, the legal obligation for the right to health falls primarily on each state to protect its own population. Although the international covenant of economic, social and cultural rights, which by the way the United States hasn't ratified, posits that all states have duties to cooperate in achieving economic and social rights. The obligation to assist states cannot become primary. Secondly, the right to health itself is expressed as progressively realizable so there is little agreement as to when a state has reached an obligation to its people let alone reached an obligation to people in faraway places. And finally, even if some obligation to offer financial and technical assistance could be read in to human rights documents there's no systematic method of implementation and enforceability. In short, human rights don't do what we need which is to obtain scalability and sustainability of health systems.

This leaves us with the very problem that I have posited throughout this lecture. That the duty to improve the health of the world's most disadvantaged falls primarily on those who lack the means to do so. This is undoubtedly an untenable position if global health is to be taken as a solemn issue of international concern. If the law is to play a constructive role then innovative models are essential. And here I

make the case for a framework convention on global health. I am proposing a global health governing system incorporating a bottom up strategy that strives to build health system capacity, set priorities, meet basic survival needs, engage stakeholders to bring to bear their resources and expertise, harmonize the activities among proliminating a proliferating number of actors operating around the world in a fragmented way and to evaluate and monitor progress so that goals are met and promises are kept. The framework convention approach is becoming an essential strategy of powerful transnational social movements to safeguard the environment and, of course, with tobacco control.

A framework convention on global health would represent an historical shift with a broadly imagined global governance regime. The initial framework would establish the key modalities with a strategy for subsequent protocols on the most important governance principles. This would include the framework's mission, objectives, its engagement and coordination, state parties and stakeholder's obligations, institutional structures, empirical monitoring, enforcement, ongoing scientific analysis and guidance for subsequent law making processes. I detail these in quite specific ways in an article in the *Georgetown Law Journal* and in a shorter way in a two-part series in *JAMA*.

The framework convention approach has a number of advantages based on its incremental nature and its ability to evolve over a long period of time and to engage stakeholders. The process of creating international norms and institutions also provides an ongoing and structured forum for states and stakeholders to develop a shared humanitarian instinct on global health. A high profile forum for normative discussion can help educate and persuade states and influence public opinion in favor of decisive action. A framework convention, however, will not be a panacea and it cannot easily circumvent many of the seemingly intractable problems of global health governance: the dominance of economically and politically powerful countries, the deep resistance to creating obligations to expend or transfer wealth, the lack of trust in international legal regimes like the UN, and the vocal concerns about the integrity and competency of countries and governance in the world's poorest regions.

But given the dismal nature of global health governance I believe that a framework convention on global health is a risk work taking. It will at a minimum identify the genuinely important problems in global health. It will target the major determinants of health. It will prioritize and coordinate currently fragmented activities. And it will engage a broad range of stakeholders from business, media, foundations and

states. It will also provide a needed forum to raise visibly for one of the most pressing problems facing humankind.

So this evening what I have sought to demonstrate is why politically and economically powerful countries should care about the world's least healthy people. It may be a matter of national interest so that helping the poor makes everyone safer and more secure. Or global health assistance simply may be ethically the right thing to do to avert an unfolding humanitarian catastrophe. Or there may be a growing sense of legal obligation whether through WHO treaties and regulations or the international human right to health. Although no single argument may be definitive in itself the cumulative weight of evidence is now overwhelmingly persuasive.

Whatever the reasons perhaps we're coming to a tipping point when the status quo is no longer acceptable and it is time to take bold action. Global health like global climate change may soon become a matter so important to the world's future that it demands international attention and no state can escape the responsibility to act. And if that were the case states and stakeholders would need an innovative international mechanism to bind themselves and others to take an effective course of action. Amelioration of the enduring and complex problems of global health is virtually impossible without a collective response. No state or stakeholder acting alone can avert the ubiquitous

threats of pathogens as they rapidly spread and change forms. And if all states and stakeholders voluntarily accepted fair terms of cooperation through a framework convention or another mechanism then it could dramatically improve life's prospects for millions of people.

But it would do more than that. Cooperative action for global health like global warming benefits everyone by diminishing our collective vulnerabilities. And think about this, the alternative to fair terms of cooperation is that everyone would be worse off and particularly those who suffer from compounding disadvantages. Absent a binding commitment to help, rich states might find it politically or economically easier to withhold their fair share of global health assistance hoping that others will take up the slack. Major outbreaks of infectious disease including extensively drug resistant forms would become increasingly more likely. And even if the economically empowerful escaped major health hazards themselves as the rich often can do we would all still have to avert our eyes from the mounting suffering among the poor. And we will have to live with our consciences knowing that much of this physical and mental anguish is preventable. What is more important is that if the global community does not accept fair terms of cooperation on global health soon there's every reason to believe that affluent states, philanthropists and

celebrities simply will move on to another cause. And when they do the vicious cycle of poverty and endemic disease among the world's least healthy people will continue unabated. And that is a consequence that none of should be willing to tolerate. Thank you very much for inviting me.