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Global Health

An Introduction

Michael Freeman

The concern of Global Health is with the improvement of health worldwide, the reduction (and ultimately the elimination) of disparities, and protection against global threats that disregard national borders.¹ It has been defined as the area of study, research, and practice that places priority on improving health and achieving health equity for all people worldwide.² The roots of global health are in public health.³

Public health envisages a philosophy of interventions, the object of which is the protection and promotion of the health of a population.⁴

Efforts to promote health and prevent disease were undertaken by some of the earliest civilisations.⁵ Religion shared a common ground with medicine.⁶ There is also archaeological evidence that ancient civilisations, for example the Egyptians and the Incas, appreciated the significance of sanitation and urban planning.⁷ There were further developments with the Greeks: Hippocrates tried to explain ill-health and offer recommendations for avoiding disease.⁸ The Romans, too, were aware of the health implications of the environment and developed methods of purifying water supplies.⁹

With the decline of the Roman Empire and the decay of its system of public health, the knowledge accumulated by the classical civilisation was lost. Thus, when the Black Death struck in 1347–51,¹⁰ killing a third of Europe's population,¹¹ interpretations as to its causes were diverse, speculative, and also rooted in prejudice. Thus, a common belief was that Jews were to blame—they had poisoned the wells.¹² Physicians put the emphasis on individual treatment. They had no power to effect public health measures.

¹ See J.P. Koplan, T.C. Bond, M.H. Merson et al, 'Towards A Common Definition of Global Health' (2009) 373 *Lancet* 193.

² See S.B. Macfarlane, M. Jacobs, and E.E. Kaaya, 'In The Name of Global Health: Trends in Academic Instruction' (2008) 29(4) *Journal of Public Health Policy* 383.

³ On public health see J. Coggon, *What Makes Health Public?* (Cambridge: CUP, 2012). See also M. Verweij and A. Dawson, 'The Meaning of "Public" in "Public Health"' in A. Dawson and M. Verweij (eds), *Ethics, Prevention and Public Health* (Oxford: OUP, 2008).

⁴ See C.E.A. Winslow, 'The Untilled Fields of Public Health' (1920) 31 *Science* 23.

⁵ G. Rosen, *A History of Public Health* (Baltimore, MD: Johns Hopkins University Press, 1993).

⁶ See as an example *Deuteronomy* 18: 15, 21–2.

⁷ See B. Inglis, *A History of Medicine* (London: Weidenfeld and Nicolson, 1965).

⁸ See E.D. Phillips, *Greek Medicine* (London: Thames and Hudson, 1993).

⁹ See R. Porter, *The Greatest Benefit to Mankind* (London: Harper Collins, 1977).

¹⁰ A good account of which is P. Ziegler, *The Black Death* (New York: Harper Torchbooks, 1969).

¹¹ See J. Kelly, *The Great Mortality* (London: Perennial, 2006); O.J. Benedictow, *The Black Death 1346–1353* (Woodbridge: Boydell Press, 2004).

¹² See N. Cantor, *In The Wake of the Plague* (New York: NYU Press, 2001).

This was the province of the magistrate. Venice tried quarantine methods. Milan sealed in the occupants of affected houses, leaving them to die.¹³ In Florence, a committee of eight was given dictatorial power: they ordered the culling of cats and dogs—they did not know the disease was being carried by rats. Throughout Italy, leper houses beyond the city limits were established.

In the centuries following the Black Death there was rarely any systematic response to disease. Only gradually were the causes of diseases examined, and this led to, or at least coincided with, public health interventions. James Lind (1716–91), a Scottish naval surgeon, noted that armies lost more men by sickness than ‘by the sword’. He demonstrated, using the world’s first controlled clinical trial, that scurvy was caused by an inadequate diet and could be prevented by issuing fresh fruit rations.¹⁴

By the close of the eighteenth century (in England) public health was being taken more seriously. Some municipal corporations began to tackle problems like polluted water supplies. Manchester even established a Board of Health (in 1796). The prison reform movement also awakened public health concerns.¹⁵ The stage was set for the Victorian Revolution. The public health movement became a moral crusade to eliminate the visible signs of filth, since physical cleanliness and good health were viewed as a precondition for both social and spiritual progress.

The medical profession was not in the vanguard of public health reform. The medical colleges never gave an impetus, and the organized medical profession played a ‘surprisingly secondary and desultory role in the vast expansion of Victorian state provision’.¹⁶ And vested interests, business generally and water companies, were often resistant to public health reform. A key figure in the Victorian Sanitary revolution was Edwin Chadwick (1800–90).¹⁷ It was his view that much poverty was due not to fecklessness, but to disease. The social costs of sickness converted Chadwick to the ‘sanitary idea’—to prevention. Poverty could not be abolished but poverty which was the result of preventable disease could be. Chadwick used Poor Law medical officers’ reports as data for his ‘Report on the Sanitary Condition of the Labouring Population of Great Britain’ of 1842.¹⁸ This charts the prevalence of disease and poverty through maps, vital statistics, and descriptions of streets, dwellings, refuse, privies, sewers, drainage, and odours. His work led to Britain’s first Public Health Act in 1848. This created the General Board of Health. Within five years, 103 towns had adopted the Act. But there was resistance from vested interests championing ‘local autonomy’. *The Times* supported the opposition: it had described cholera as the ‘best of all sanitary reforms’.¹⁹

The General Board ceased to operate in 1854. Chadwick’s bureaucratic model was replaced by one based on medicine and run by a doctor. John Snow’s cholera investigations in 1849²⁰ were a watershed: he argued that cholera was linked to contaminated drinking water. Better drainage and sewerage systems were gradually installed. There was significant new legislation. This included the Sanitary Act 1866 (which gave local authorities new powers to provide clean water supplies) and the

¹³ Porter, *The Greatest Benefit to Mankind* (n 9) 125.

¹⁴ S.R. Brown, *Scurvy: How a Surgeon, a Mariner, and a Gentleman Solved the Greatest Medical Mystery of the Age of Sail* (New York: St Martin’s Press, 2003).

¹⁵ Most influential was John Howard, *The State of the Prisons* (1777).

¹⁶ R. Porter, *Disease, Medicine and Society in England 1550–1860* (Cambridge: CUP, 1993) 59.

¹⁷ On Chadwick, see S.E. Finer, *The Life and Times of Sir Edwin Chadwick* (London: Methuen, 1952). Chadwick had been Jeremy Bentham’s secretary.

¹⁸ The circulation of this was enormous: 20,000 copies were sold within two weeks.

¹⁹ Quoted in Porter, *The Greatest Benefit to Mankind* (n 9) 412.

²⁰ See M. Pelling, *Cholera, Fever and English Medicine 1825–1865*. (Oxford: OUP, 1978) 132–40.

Vaccination Act 1867 (which increased penalties for failure to vaccinate infants).²¹ Vaccinations were opposed on civil liberties grounds.²² This opposition was successful, and compulsory vaccination was rescinded in 1909.²³

Similar battles were fought over communicable diseases. Sexually transmitted diseases began to attract attention in the second half of the nineteenth century: the impact on the army at the time of the Crimean War stirred concern. The first Contagious Diseases Act in 1864 targeted prostitutes working in the ports and garrison towns.²⁴ Prostitutes were required to undergo a physical examination: if found to be infected, they would be detained for up to three months and compulsorily treated. There was also legislation providing for the regular inspection of 'known prostitutes'. There was opposition from civil libertarians and feminists, as well as from the medical profession, and the legislation was short-lived.²⁵

Tuberculosis also attracted public health legislation.²⁶ Bacteriology demonstrated that it was an airborne disease. There were campaigns to stop spitting in public places, and in Britain and France²⁷ in the 1890s there were demands for the compulsory detention of contagious cases. This did not happen, but the sanatoria which the poor were 'encouraged' to enter were custodial institutions in all but name. By 1910 there were forty-one public sanatoria in England, mostly run through the Poor Law. The sanatoria were 'nominally preventive or therapeutic',²⁸ but in reality they were 'dustbins', where the dying would never again infect family or workmates. The sanatorium functioned as a 'segregative' institution, protecting society from the 'degenerates' within it.²⁹

It is not surprising that medicine can expand its category of 'degenerates'. Nor was it long before the dangers of allowing such people to reproduce were perceived. The eugenics movement was a misguided product of the nineteenth-century initiative to improve public health. It led to policies of forced sterilization in a number of countries, and not just in Nazi Germany, the country with which it is particularly associated.³⁰

The US developed medically-based immigration controls.³¹ The target, initially at least, was the infectious disease, but mental abnormality assumed increasing importance as eugenics established itself. The US Supreme Court was prepared to legitimate this movement and its practices, including forced sterilization. Mr Justice Holmes famously proclaimed that 'three generations of imbeciles were enough'.³² Carrie Buck, the victim of sterilization in this case, was subsequently shown to have above average intelligence.³³

²¹ Compulsory vaccination against smallpox had been introduced in 1853.

²² The Anti-Compulsory Vaccination League was founded in 1874.

²³ The debate continues. See M. Verweij, 'Individual and Collective Considerations in Public Health Influence Vaccination' (2001) 15 *Bioethics* 536.

²⁴ See J. Walkowitz, *Prostitution and Victorian Society* (Cambridge: CUP, 1982).

²⁵ It was repealed in 1886. See F. Mort, *Dangerous Sexualities* (London: RKP, 1987).

²⁶ See F.B. Smith, *The Retreat of Tuberculosis* (London: Croom Helm, 1988).

²⁷ See D.S. Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth Century France* (Berkeley, CA: University of California Press, 1995).

²⁸ Porter, *The Greatest Benefit to Mankind* (n 9) 423.

²⁹ Porter, *The Greatest Benefit to Mankind* (n 9).

³⁰ In relation to England, see S. Trombley, *The Right To Reproduce* (London: Weidenfeld and Nicolson, 1988). See also M. Freeman, 'Sterilising The Mentally Handicapped' in M. Freeman, *Medicine, Ethics and Law* (London: Stevens, 1988) 55.

³¹ Between 1892 and 1934 over 12 million immigrants were medically inspected. Only 2% were denied entry.

³² In *Buck v Bell* 274 US 200 (1927). And see D. Kevles, *In The Name of Eugenics* (Cambridge, MA: Harvard University Press, 1995).

³³ See S.J. Gould, *The Mismeasure of Man* (Harmondsworth: Penguin, 1974) 323–36.

Until the twentieth century, the health problems of the industrialized world and those of the rest of the world (much of which it had colonized) could be split. Colonization had not been good for the health of the 'Third World'.³⁴ Roy Porter explained why:

Epidemiological link-ups between previously isolated regions, the movement of fleets and armies, of millions of slaves and indentured labourers, the spread of diseases by ecological change and social dislocation, the misery bred by shanty-towns—all have been implicated in the hail of death that European rule brought. The good that western medicine did was marginal and incidental.³⁵

The twentieth century brought new problems. One of the early effects of globalization was to bring health problems from different parts of the world together. This was seen dramatically in 1918 when the most lethal and mobile pandemic ever to strike the world—not even rivalled by HIV/AIDS—killed over 25 million people in six months, to be followed by an epidemic of encephalitis lethargica; and a further wave of killer influenza two years later. A side-effect of the First World War, it killed about three times the number who died in the war.³⁶

The flu pandemic was the worst pestilence since the Black Death, nearly 600 years earlier. Nothing of its intensity has happened since, though it may be feared that HIV/AIDS might kill as many. Whether this is pure chance or because of better medicine and better health measures is uncertain. Better international structures had been put in place after the cholera pandemic in the middle of the nineteenth century, and International Sanitary Conferences were held.³⁷ It was at the seventh of these—in Venice in 1891—that agreement was reached on the quarantining of westbound ships with cholera on board. In fact, by then, cholera had virtually disappeared.

In 1907, twenty-three European countries set up the Office International d'Hygiène Publique. This collected and disseminated information on a variety of diseases: cholera, plague, yellow fever, malaria, typhoid. It acted as a forum to discuss issues such as sanitation, immunization, and isolation. The League of Nations, established after the First World War, set up its own health body, the Health Organisation of the League of Nations. The United Nations was established after the Second World War. The World Health Organization (the WHO) was set up and, unlike its predecessor, was given a status independent of its parent body. The WHO's goal was a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The WHO initiates programmes of immunization for the world's children—targeting diphtheria, polio, tuberculosis, tetanus, whooping cough, and measles. It has also promoted the training of para-health personnel, such as China's barefoot doctors.

The world health movement had some outstanding successes, notably the worldwide eradication of smallpox.³⁸ When Bangladesh became free of this disease in 1974, the world's press was able to proclaim the end of smallpox, though ironically a British photographer caught and died of the disease in Birmingham four years later. Today, the virus only exists (at least officially) in two laboratories. There is, however, concern that it may constitute one of the biological weapons held in reserve by one or more of the irresponsible so-called 'rogue states'. The WHO has been less successful with other

³⁴ See S. Watts, *Epidemics and History: Disease, Power and Imperialism* (New Haven, CT: Yale University Press, 1997).

³⁵ Porter, *The Greatest Benefit to Mankind* (n 9) 482.

³⁶ See G. Kolata, *Flu* (Basingstoke: Macmillan, 2000).

³⁷ The first was in Paris in 1851.

³⁸ See I. Glynn and J. Glynn, *The Life and Death of Smallpox* (London: Profile Books, 2004).

major childhood diseases. India manages to immunize only half of its children born each year against measles and polio, and immunization rates in Central Africa are even lower. It is also now recognized that diseases unknown in the richer, developed world have been neglected or targeted inappropriately. An example is diphtheria, which went virtually unnoticed in the West until US personnel succumbed to it in the Philippines during the Second World War. Bilharzia is the second most socio-economically devastating parasitic disease after malaria, and it particularly affects children.

This was of little concern in the West. It was many years before war, poverty, famine, and population displacement were recognized as aggravating features in this developing world. For too long the pharmaceutical industry ('Big Pharma') were more concerned with erectile dysfunction in Western men than killer diseases in the developing world. Malaria has not been eradicated: indeed; more people are infected by it today than in 1960. And anyway, as Roy Porter pointed out, 'the parasite changes its genetic makeup more rapidly than the pharmaceutical industry can produce new and tested drugs'.³⁹ In addition, diseases once in retreat are returning, and not just in poor nations. Tuberculosis is becoming more common. It is on the increase in the US and in Europe, but the increase in prevalence in parts of Africa is much greater. More than 3 million people a year die from TB, 95 per cent of them in low and middle income countries. Cholera has also returned. It broke out in Indonesia in 1961, and spread through Asia and Africa, attacking twenty-nine countries in two years. In 1993 a new strain erupted in India and Bangladesh, and spread to South East Asia.

Old diseases re-emerge—diphtheria in the former Soviet Union and its empire is one example and cholera is another—and new ones emerge. AIDS was first noticed in 1981 and the HIV virus was discovered in 1983. It was HIV/AIDS, more than any other disease, which stimulated thinking about the ethics of Public (Global) Health. In the early 1980s, before the causes of AIDS were fathomed, we were able to hear pronouncements reminiscent of Biblical times—it was the wrath of God wreaked upon the gay. Even today there are some—the former President of South Africa is a prominent example⁴⁰—who deny the causal role of HIV. Conflict rages, if a little more muted, over the policies of many companies, particularly the impact of these in the developing world. It is in sub-Saharan Africa where HIV/AIDS is most prevalent.⁴¹

Concern that there would be a worldwide AIDS pandemic forced governments to take sexual health more seriously (and more positively). In Britain it was the Thatcher era. Family values were pushed by the government, even if members of her government did not always practise this.⁴²

There was a reluctance to promote sexual health. In the UK it was 1988 before the dangers of AIDS were proclaimed in a national advertising campaign. Things did improve: a Cabinet committee on AIDS was created. The medical profession and public health experts were given the task of devising a strategy.⁴³ The successor to Thatcher, John Major, heading the government for two-thirds of the 1990s, did not have a coherent policy on sexual health, but HIV/AIDS was proclaimed as one of the government's target areas. However, this did not stop it from instigating legislation to

³⁹ Porter, *The Greatest Benefit to Mankind* (n 9) 488.

⁴⁰ Thabo Mbeki. His Health Minister recommended beetroot! There were other dissenting voices.

⁴¹ 69% of HIV sufferers and 70% of AIDS deaths are in Sub-Saharan Africa. See 'UNAIDS Report on Global AIDS Epidemic' (2012).

⁴² On family values, see M. Freeman, 'Family Values and Family Justice' (2000) 56 *Current Legal Problems* 136.

⁴³ See M. Durham, *Sex and Politics: The Family and Morality in the Thatcher Years* (Basingstoke: Macmillan, 1991).

permit parents to withdraw their children from sex education classes.⁴⁴ Major's Health Minister ordered the withdrawal of a booklet on sexual health, and at the end of its thirteen years in government, the party stopped the AIDS awareness campaign, which cost all of £6.2 million a year. A later Conservative government (in 1996) cut funding for AIDS prevention and treatment.

During this period (and thereafter), HIV infection has continued to rise, though at a rate much less than was predicted in the early 1980s.⁴⁵ It is estimated that there are 33.4 million people living with HIV today, 3.4 million of whom are children under 15. Ninety-one per cent of these live in Sub-Saharan Africa.⁴⁶ The majority are women.⁴⁷ In 2011, about 1.1 million people in the world died of AIDS: about one-sixth of them were children under 15.⁴⁸ There are large numbers of AIDS orphans.⁴⁹ In the years since the pandemic was discovered, more than 25 million people have died as a result of AIDS. Most people in developing countries who could benefit from AIDS drugs have no access to these drugs. We were warned in 2008 that we may never find a vaccine for AIDS;⁵⁰ questions have therefore been raised as to whether it might be better to focus spending on prevention, for example on safe-sex campaigns, and on testing rather than on treatment.⁵¹ The WHO designated 2006 the 'Year of Acceleration of HIV Prevention in the African Region', and made HIV testing its priority.⁵² There is mandatory pre-marital HIV testing in Nigeria, Botswana, and the Democratic Republic of Congo.⁵³ In the US, two states, Illinois and Louisiana, imposed such a requirement but soon abolished it when couples moved to neighbouring states to marry.⁵⁴ The requirement is also on Missouri's statute book. In Europe, the only country to contemplate mandatory pre-marital testing (and prohibit marriage for those with HIV or AIDS) was Albania,⁵⁵ but it capitulated when many organizations, including international ones, voiced serious objections. There are problems with treatment too: high percentages of patients do not comply with their treatment regime.⁵⁶

There was very little discussion of the ethical issues involved in global health questions until the emergence of AIDS,⁵⁷ but ethical issues in relation to HIV/AIDS began to be debated almost as soon as this pandemic was recognized.⁵⁸ Only more

⁴⁴ Education Act 1993.

⁴⁵ The number of AIDS-related deaths in Sub-Saharan Africa was 33% less in 2011 than in 2005. See further J. Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Currey, 2006).

⁴⁶ Most acquire HIV from mothers during pregnancy, birth, or breastfeeding. Early intervention can bring the infection rate down to 2%, but the drugs needed may not be available in most resource-limited countries where the burden of HIV is highest.

⁴⁷ Women make up 60%. The population of women living with HIV has been increasing in the last 10 years or so. See further WHO, 'Women and Health: Today's Evidence, Tomorrow's Agenda' (2009).

⁴⁸ A total of 3.4 million children have HIV/AIDS; 91% per cent of them live in Sub-Saharan Africa.

⁴⁹ On the problems of orphans see J. Todres, 'Rights, Relationships and the Experience of Children Orphaned by AIDS' (2007) 41 *UC Davis Law Review* 417.

⁵⁰ By David Baltimore: see *The Guardian*, 15 February 2008.

⁵¹ See E. Pisani, *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS* (London: Granta, 2008).

⁵² See K. De Cock, 'Unfinished Business—Expanding HIV Testing in Developing Countries' (2006). 354 *New England Journal of Medicine* 440.

⁵³ See S. Rennie and B. Mupenda (2008) 8 *Developing World Bioethics* 126.

⁵⁴ See M. Closen, R. Gamath, and D. Hopkins, 'Mandatory Premarital HIV Testing: Political Explanation of the AIDS Epidemic' (1994) 69 *Tulane Law Review* 71.

⁵⁵ See Amnesty International, 'Albania: Disability and the Right to Marry' (2004).

⁵⁶ According to S.C. Kalichman and D. Rompa: see 'HIV Treatment Adherence and Unprotected Sex Practices in People Receiving Antiretroviral Therapy' (2003) 79 *Sexually Transmitted Infections* 59.

⁵⁷ See U. Schüklenk, *AIDS: Society, Ethics and the Law* (Aldershot: Ashgate, 2001).

⁵⁸ eg R.D. Mohr, 'AIDS, Gays and State Coercion' (1987) 1 *Bioethics* 35; M. O'Brien, 'Mandatory HIV Testing Policies: An Ethical Analysis' (1989) 3 *Bioethics* 273.

recently, with the publication of the journal *Developing World Bioethics* in particular (but also other periodical literature), have the ethical issues come sharply into focus. And this has coincided with an appreciation of the impact of globalization on the world, and also with the rise of human rights.⁵⁹ Alison Brysk has pointed out that ‘assaults on fundamental human dignity continue and the very blurring of borders and rise of transnational sectors that facilitates the development of a global human rights regime may also be generating new sources of human rights abuse’.⁶⁰ This may shock. After all, as Brysk also points out, a ‘more cosmopolitan and open international system should free individuals to pursue their rights, but large numbers of people seem to be suffering from both long-standing state repression and new denials of rights linked to transnational forces’.⁶¹

The concept of global health only began to be discussed relatively recently.⁶² It is uncertain when the expression was first used. John Rawls wrote of the ‘law of peoples’ in 1999.⁶³ But it had no egalitarian distributive principle of any kind. He was committed to a laissez-faire global economic order. In this international context Rawls’ concept of justice is little different from that of Robert Nozick.⁶⁴ Why should representatives prefer an egalitarian law of peoples over more egalitarian alternatives? He may have been right to believe that the ‘great social evils in poorer societies are likely to be oppressive governments and corrupt elites’.⁶⁵ But, as Thomas Pogge has responded, ‘relative poverty breeds corruptibility and corruption’, and it is ‘by no means entirely home-grown’.⁶⁶

Despite Rawls, global health was about to ignite the public imagination. Explaining why is not easy. McInnes and Lee suggest the following.⁶⁷ It was a response to real world change: ‘as the world has become more globalised, so too has health’.⁶⁸ A second explanation can be found in the call for a ‘paradigm shift’⁶⁹ in response to how human health is affected in many new ways by ‘global interconnectedness’,⁷⁰ such as the emergence of novel infections, increased drug resistance, new geographical distributions of disease vectors. They argue that the emergence of global health was presented as a ‘natural response to changes in the material world’.⁷¹

Reference is often made to Laurie Garrett’s book *The Coming Plague*.⁷² Writing in 1994, she predicted ‘recurrent eruptions of newly discovered diseases’,⁷³ epidemics of diseases migrating to new areas, among others. The WHO was similarly alarmist—we were on the ‘brink of a global crisis in infectious diseases’ and could no longer afford to

⁵⁹ On which see K. Sellars, *The Rise and Rise of Human Rights* (Stroud: Sutton Publishing, 2002).

⁶⁰ A. Brysk, ‘Introduction’ in, *Globalisation and Human Rights* (Berkeley, CA: University of California Press, 2002) 1.

⁶¹ Brysk, ‘Introduction’ (n 60) 1–2.

⁶² See J. Youde, *Global Health Governance* (Cambridge: Polity Press, 2012).

⁶³ J. Rawls, *The Law of Peoples* (Cambridge, MA: Harvard University Press, 1999). And see G. Brock, *Global Justice* (New York: OUP, 2009) ch 2.

⁶⁴ R. Nozick, *Anarchy, State and Utopia* (New York: Basic Books, 1974).

⁶⁵ Rawls, *The Law of Peoples* (n 63) 77.

⁶⁶ T. Pogge, ‘An Egalitarian Law of Peoples’ (1994) 23 *Philosophy and Public Affairs* 195, 213, 214.

⁶⁷ C. McInnes and K. Lee, *Global Health and International Relations* (Cambridge: Polity Press, 2012).

⁶⁸ McInnes and Lee, *Global Health* (n 67) 7.

⁶⁹ See T. Kuhn, *The Structure of Scientific Revolutions* (Chicago: University of Chicago Press, 1970).

⁷⁰ McInnes and Lee, *Global Health* (n 67) 8.

⁷¹ McInnes and Lee, *Global Health* (n 67) 9–10.

⁷² L. Garrett, *The Coming Plague: Newly Emerging Diseases in a World out of Balance* (New York: Farrar, Straus and Giroux, 1994).

⁷³ Garrett, *The Coming Plague* (n 72) 12.

ignore their threats. The WHO's Director-General warned in 1996 that no country was safe.⁷⁴

The media played a role too. But what the media perceives to be the highest risk to health contrasts sharply with what actually poses the greatest risk. Harrabin, Coote, and Allen wrote: 'The news media tend to focus on stories about health services. Only rarely do they publish stories about public health—that is measures to improve health, prevent illness or reduce health inequalities.'⁷⁵ Rather than discussing obesity⁷⁶ or smoking⁷⁷ or alcohol,⁷⁸ unusual hazards such as SARS⁷⁹ can dominate headlines for weeks.⁸⁰

This leads to the obvious question: what is global health? It is concerned with the health of the population in a global context. It transcends the perspectives of individual nations. It has been defined as 'an area for study, research and practice that places a priority on improving health and achieving health equity for all people worldwide'.⁸¹ It is about the worldwide improvement of health, the reduction of disparities, and protection against global threats that disregard national boundaries.

At a UN Summit in 2000, member states declared eight Millennium Development Goals, reflecting major challenges which confronted human development globally. These goals were to be met by 2015. Three of the goals focus explicitly on health. Across all goals there are eighteen targets, supported by forty-eight health indicators. In 2012 the United Nations reported that several of the targets have been met ahead of the 2015 timeline.

The main diseases and health conditions prioritized by global health initiatives are often grouped under the term 'diseases of poverty' and 'diseases of affluence'. However, the impacts of globalization increasingly blur such a distinction.

Many low-cost, evidence-based healthcare interventions for improved health and survival are now known. For example, priority global targets for improving maternal health include increasing coverage of deliveries with a skilled birth attendant.⁸² Interventions for improved child health and survival include the promotion of breastfeeding and vaccination. In malaria-endemic regions, the use of insecticide-treated bedmats and intermittent pharmacological treatment can reduce mortality.

Based on such studies, lists of treatments and intervention measures have been drawn up that could potentially save several million lives each year.⁸³

⁷⁴ World Health Report 1996, 'Fighting Disease, Fostering Development' (Geneva: WHO, 1997) Introduction by Hiroshi Nakajima.

⁷⁵ R. Harrabin, A. Coote, and J. Allen, *Health in the News: Risk, Reporting and Media Influence* (London: King's Fund, 2003) 1.

⁷⁶ On childhood obesity see T. Lobstein, 'Child Obesity and the Junk Food Marketeers' in J. Wild (ed), *Exploiting Childhood* (London: Jessica Kingsley, 2013) 49.

⁷⁷ On the slow progress towards control see E.K. Ong and S.A. Glantz (2000) 355 *Lancet* 1253. But there is now a Framework Convention on Tobacco Control (2003).

⁷⁸ Anon, 'Let's be Straight Up About the Alcohol Industry' (2011) 8(3) *PLoS Medicine*.

⁷⁹ On SARS see F. Fleck, 'How SARS Changed the World in Less than 6 Months' (2003) 81(8) *Bulletin of the World Health Organization*, 625.

⁸⁰ See Macfarlane, Jacobs, and Kaaya, 'In The Name of Global Health' (n 2).

⁸¹ Namely, reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria, and other major diseases.

⁸² According to the World Health Organization's 'World Health Report 2005', poor maternal conditions are the fourth leading cause of death for women worldwide, after HIV/AIDS, malaria, and tuberculosis.

⁸³ Z.A. Bhutta, T. Ahmed, R.E. Black, et al, 'What works? Interventions for maternal and child undernutrition and survival' (2008) 371 *Lancet* 417.

It is recognized that, to be most effective, interventions need to be sensitive to the local context, as well as timely and equitable. They must also achieve maximum coverage of the target population. Thus, for example, immunization programmes with partial coverage often fail to reach those at greatest risk of disease.

Even though there are health intervention programmes in place, they may not make a difference. There is a 'critical group': some populations have access to medical treatment and others do not. This may be the result of the absence of a sustainable infrastructure. Many external factors can influence how effective a programme can be.

There are many funds available. But funds do not always translate into positive outcomes. Focus on one particular disease—perhaps because of the interest of the donors—can lead to ignoring other children's diseases.

Investments have increased substantially in recent years. Attention is also being paid to imbalances in health systems and in health workforces. In 2006, the WHO estimated a shortage of almost 4.3 million doctors, midwives, nurses, and support staff worldwide, but mainly in Sub-Saharan Africa. Fifty-seven countries face severe shortages, partly because their doctors, etc are employed on higher salaries in the richer, developed world.⁸⁴

When global health is discussed there is a tendency to focus on HIV/AIDS, malaria, TB, malnutrition, etc. But the range of issues is now expanding to embrace tobacco control,⁸⁵ obesity,⁸⁶ terrorism,⁸⁷ and global warming.⁸⁸ The latest health question to fire the global imagination is violence against women. It is easy to forget that it was only in the 1970s that domestic violence was recognized as a social problem.⁸⁹ Since one in five women worldwide are the victims of domestic violence, and its health consequences are manifest, it is surprising that initiatives to tackle its health implications have been so slow in coming. Within 'domestic violence' is embraced not just battering, but the sexual abuse of children, rape including marital rape, forced marriage, female genital mutilation,⁹⁰ and other traditional practices harmful to women, drug-induced violence, sexual harassment, inside the domestic setting and in the public space, for example at work, forcing a woman into prostitution, etc. The health issues include more than just physical injury, for example depression, and drug and alcohol abuse.

With many of the Millennium Development Goals having been met, and real progress achieved in several of the others, focus has shifted to the realization of 'sustainable development'.⁹¹ This is defined as 'development that meets the needs of the present without compromising the ability of future generations to meet their own needs'. Human health is thus embodied within an ecological context of sustainable

⁸⁴ The World Health Assembly adopted a Global Code of Practice in 2010 to facilitate the strengthening of health workforces with skills relevant to population needs.

⁸⁵ See now the Framework Convention on Tobacco Control (2003). It is estimated that 200,000 children die each year as a result of exposure to secondhand smoke. See J. Heymann and K. McNeill, *Children's Chances* (Harvard University Press, 2013) 105.

⁸⁶ Obesity is associated with numerous chronic diseases including cardiovascular conditions, diabetes, stroke, cancers, and respiratory diseases. About 16% of the global burden of disease, measured as DALYs, has been accounted for by obesity. In low-income countries the number of individuals with diabetes is expected to increase from 84 million to 228 million by 2030.

⁸⁷ See J. Moreno, *In The Wake of Terror: Medicine and Morality in a Time of Crisis* (Cambridge, MA: MIT Press, 2003).

⁸⁸ P. Haggett, *The Geographical Structure of Epidemics* (Oxford: OUP, 2000) is an early discussion of the association.

⁸⁹ See E. Pizzey, *Scream Quietly or the Neighbours Will Hear* (Harmondsworth: Penguin, 1974).

⁹⁰ See E. Dorkenoo and S. Elworthy, *Female Genital Mutilation* (London: Minority Rights Group, 1992).

⁹¹ 'Our Common Future—Report of the World Commission on Environment and Development' (United Nations, 1987) (the Brundtland Report).

development: all aspects of human ecology fundamentally dependent on the quality of the natural environment, such as clean water, clean air, wholesome nutrition, and recreation.⁹² This duly recognized, the challenges encountered in sustainable development for health not only include environmental and social determinants but are also substantively influenced as well by organizational and technological systems.⁹³

For example, major reductions in the burden of malaria have been achieved by improved prevention and treatment. Yet, such success cannot be taken for granted: tuberculosis control is now threatened by the emergence of multiple antibiotic-resistant strains. While this disease has social and environmental determinants, it is a health systems and technological challenge as well. Similarly, whilst health promotion and primary prevention are critical in combating the non-communicable disease (NCD) pandemic,⁹⁴ they are much less than 100% effective: hundreds of millions of people are developing NCDs, most of them poor. Affordable technologies must be made accessible to assist in their management. The world must respond to this challenge as well, this is now being addressed by the WHO, in a new Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–20.⁹⁵

⁹² 'Bringing human health and wellbeing back into sustainable development' in, *IISD Annual Report 2011–12*.

⁹³ F. White, L. Stallones, and J.M. Last, *Global Public Health: Ecological Foundations* (Oxford: OUP, 2013).

⁹⁴ Non-communicable diseases are caused by different factors such as environment, heredity, or nutrition and lifestyle habits. According to the WHO, non-communicable diseases account for 60% of deaths worldwide.

⁹⁵ World Health Organization, *Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–2020* (Updated revised draft, 15 March 2013).