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The Quest for Global Justice in Health: A Review of Global Health Law by Lawrence 0. Gostin

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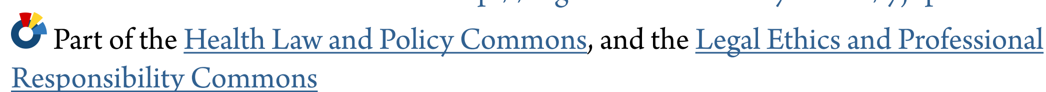

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The Quest for Global Justice in Health: A Review of *Global Health Law* by Lawrence O. Gostin

Octavio Gómez-Dantés* & Julio Frenk**

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INTRODUCTION

We are witnessing the emergence of a new world health order. Health occupies an increasingly relevant place in the global agenda. An unprecedented health transition is leading to a new model characterized by expanded international and national funding for health and the involvement of a growing pluralism of actors.

During the twentieth century, the life expectancy of the world population increased more than it had in all previous centuries combined. In 1900, global life expectancy averaged just over a mere thirty years.[1] By 1990, it had more than doubled to sixty-four years, and now may surpass seventy years.[2] Of course, there are huge disparities among countries: life expectancy at birth in Japan is eighty-three years, while in Sierra Leone it is forty-five.[3]

We have also seen a major shift in the dominant patterns of disease. Chronic non-communicable disorders (NCDs) in adults have replaced acute infections in children as a relatively dominant cause of death globally. The increasing importance of chronic diseases explains another salient characteristic of the health transition: the rising role of disability in the global health profile. "Health problems," according to a recent Global Burden of Disease Report, "are increasingly defined not by what kills us, but what ails us."[4]

The prominence of health in the global agenda has changed as well. Health issues have moved from the realm of "low politics," commonly associated with development concerns, to that of "high politics," usually associated with national and global security issues."[5] Health issues increasingly contribute to economic

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1. *Health, History and Hard Choices: Funding Dilemmas in a Fast-Changing World*, WORLD HEALTH ORG. 7 (2006), http://www.who.int/global_health_histories/seminars/presentation07.pdf.

2. *World Health Statistics 2014: A Wealth of Information on Global Public Health*, WORLD HEALTH ORG. 68 (2014), apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf.

3. *Life Expectancy at Birth, Total (Years)*, WORLD BANK, http://data.worldbank.org/indicator/SP.DYN.LE00.IN (last visited Apr. 22, 2015) (listing country-by-country life expectancy data through 2012).

4. *The Global Burden of Disease: Generating Evidence, Guiding Policy*, UNIV. OF WASH. INST. FOR HEALTH METRICS & EVALUATION 44 (2013), http://www.healthdata.org/sites/default/files/files/policy_report/2013/GBD_GeneratingEvidence/IHME_GBD_GeneratingEvidence_FullReport.pdf.

5. David P. Fidler, *Health as Foreign Policy: Between Principle and Power*, 7 WHITEHEAD J. DIPL. & INT'L REL. 179, 180 (2005).

growth and development, national and global security, and human rights promotion.

The growing perceived importance of health explains the unparalleled sums of international and national funds that are flowing into this sector. International assistance for health grew from $5 billion (in U.S. dollars) in 1990 to almost $30 billion in 2012, while government health expenditures in developing countries increased from $128 billion in 1995 to over $400 billion in 2010.[6]

There has also been a recent proliferation of actors in the global health arena: the World Health Organization (WHO) and other United Nations (U.N.) agencies, development banks, bilateral agencies, global health initiatives, philanthropic organizations, global nongovernmental organizations (NGOs), professional associations, transnational corporations, research funders, and academic institutions.

Given this complex context, it is critically important to use novel perspectives when discussing the nature and scope of global health. This is exactly what Lawrence O. Gostin achieves in his recent book, *Global Health Law*. This outstanding volume views global health through the lens of international law. However, its vast breadth and innovative approach allow it to transcend a strictly legal framework. It appeals not only to legal and public health specialists, but also to "the informed public that cares about global health with justice."[7] The book's launching is particularly timely since negotiations around the post-2015 Development Agenda are reaching their final stage. These negotiations intend to define a new development framework that will succeed the Millennium Development Goals.[8]

The topic of this book is in good hands. Gostin is one of the pioneers and leading figures in the field of global health law.[9] His credentials are impeccable. He has published some of the most influential papers on global health law.[10] At Georgetown University, he holds the highest academic rank of University Professor and serves as the Founding O'Neill Chair in Global Health Law. In

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6. *Financing Global Health 2012: The End of the Golden Age?*, UNIV. OF WASH. INST. FOR HEALTH METRICS & EVALUATION 56 tbl.B1 (2012), http://www.healthdata.org/sites/default/files/files/policy_report/2012/FGH/IHME_FGH2012_FullReportHighResolution.pdf.

7. LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW xvi (2014).

8. *See Millennium Development Goals and Post-2015 Development Agenda*, UNITED NATIONS ECON. & SOC. COUNCIL, http://www.un.org/en/ecosoc/about/mdg.shtml (last visited Mar. 13, 2015).

9. Global health law should be distinguished from international law. *See infra* Part II.

10. *See, e.g.*, Lawrence O. Gostin, *World Health Law: Toward a New Conception of Global Health Governance for the 21st Century*, 5 YALE J. HEALTH POL'Y L. & ETHICS 413 (2005); Lawrence O. Gostin & Devi Sridhar, *Global Health and the Law*, 370 NEW ENG. J. MED. 1732 (2014); Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53 (2008).

addition, he is professor of Law and Public Health at the Johns Hopkins Bloomberg School of Public Health. He is also the Faculty Director of the O'Neill Institute for National and Global Health Law and Director of the WHO Collaborating Center on Public Health Law and Human Rights. In recent years, Gostin has been leading a call for a Framework Convention on Global Health modeled on the successful design and implementation of the Framework Convention on Tobacco Control (FCTC).

Global Health Law has a clear guiding question: How can international law contribute to improve global governance in order to offer equal opportunities to live healthy and productive lives everywhere? The book has three explicit goals: (i) to define global health law within the field of global governance for health; (ii) to describe and analyze the major sources of global health law and their institutional frameworks; and (iii) to discuss several themes—health equity, global solidarity, health in all policies, multiple regimes, good governance, health-promoting priorities, and right to health—that are critical for global health in the twenty-first century. Using a critical approach and a thoughtful style, Gostin addresses this guiding question and these goals in the book's four parts.

I. THE MAIN CHALLENGE OF GLOBAL JUSTICE AND THE DEFINITION OF GLOBAL HEALTH LAW

This ambitious book opens with a discussion of the main challenges of global justice in health and the core concepts of global health law. For Gostin, the main challenge of global justice in health is the global recognition and effective exercise of the right to health. Recognition of such a right could help reduce the existing health gap between the rich and the poor, which according to Gostin, has seen negligible signs of improvement. "Despite unprecedented engagement," he says, "the international community has not fundamentally changed the reality for the world's least advantaged people."[11] Realistic as this appraisal may sound, the health conditions of the global poor deserve a more balanced discussion. The most recent global health initiatives have rendered important, but still insufficient, achievements that have benefited primarily the poor and vulnerable. A few examples:

- The expansion of the global coverage of immunizations produced a seventy-five percent decrease in measles deaths (from an estimated 544,200 to 145,700 annually) between 2000 and 2013.[12]

11. GOSTIN, *supra* note 7, at 14.
12. *Measles: Fact Sheet No. 286*, WORLD HEALTH ORG., http://www.who.int/mediacentre/factsheets/fs286/en (last updated Feb. 2015).

- The number of global deaths due to malaria declined from almost one million in 2000 to 584,000 in 2012 thanks to increased use of insecticide-treated bed nets, earlier diagnoses, and expanded access to more effective drugs.[13]
- The number of AIDS-related deaths has diminished from 2.3 million globally in 2001 to 1.6 million in 2012 due to a significant increase in access to preventive services and antiretroviral therapy.[14]

A discussion of how global health conditions have evolved requires reliable metrics and information systems to measure improvements. It also demands a clear understanding of what would constitute a "fundamental change" in the lives of the world's poorest people. Interestingly, a recent *Lancet* Commission Report discussed the possibility of reducing the burden of common infections, nutritional deficiencies, and maternal and child disorders in most high-mortality developing countries by 2035. The Commission articulated a goal of reaching current morbidity rates in the best performing middle-income nations, such as Chile, Costa Rica, and Cuba.[15] Gostin may consider this to be a reasonable timeframe and achievement.

To meet the major challenges of global justice in health, Gostin argues that we need to define: (i) the goods and services that the right to health should guarantee; (ii) a state's duty to meet the health needs of its population; (iii) the responsibilities of a wealthy state to promote the health of poor people beyond its borders; and (iv) the governance strategies necessary to improve the performance of global health institutions and the health conditions of the global population. It is only through law, he adds, that we can define the entitlements to health services that individuals and populations may claim. Legal instruments will also be needed to establish and enforce corresponding state obligations and transform the prospects for good health—especially for the poor and vulnerable.

"Health aid" is key in answering these questions. This concept is usually associated with the idea of charity provided by rich countries to poor nations in order to meet problems supposedly characteristic of the developing world. The convergence of world population health needs with increasing global interdependence is forcing us to move beyond this reductionist idea of charity. Instead, health aid should be conceived as collaborative, where the international

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13. *10 Facts on Malaria*, WORLD HEALTH ORG. 2, http://www.who.int/features/factfiles/malaria/malaria_facts/en (last updated Dec. 2014).

14. *Fact Sheet*, UNAIDS, http://www.unaids.org/en/resources/campaigns/globalreport2013/factsheet (last visited Apr. 11, 2015).

15. Dean T. Jamison et al., *Global Health 2035: A World Converging Within a Generation*, 382 LANCET 1898, 1900-01 (2013).

community builds capacity to collectively respond to common threats.[16] "Conceptualizing international assistance as 'aid,'" says Gostin, "masks the deeper truth that human health is a globally shared responsibility, reflecting common risks and vulnerabilities–an obligation of health justice that demands a fair contribution from everyone."[17] The recent Ebola crisis evinces the extent to which a global response is a shared moral imperative. The global response sought to protect the populations not only of Guinea, Liberia, Sierra Leone and neighboring African countries, but also the population of the Western world.

After discussing the framework of joint responsibility under which the challenge of global health justice should be addressed, Gostin analyzes the global health profile, or "globalized health hazards." This term encompasses the transnational spread of infectious diseases, the increasing prevalence of NCDs, and the global expansion of disability. "Globalized health hazards" also include the underlying processes that explain these phenomena (travel, trade, migration, aging, urbanization, motorization, environmental degradation). This conventional classification of global health needs and their determinants focuses only on health losses and risks. However, the conventional classification Gostin supports fails to discuss the "globalized health opportunities" that global law should help promote. These opportunities include the spread of health-related knowledge and practices that enhance health and wellbeing.

In chapter three, Gostin discusses the first of the book's three central goals: defining global health law within the field of global governance for health. His definition is comprehensive: "The study and practice of international law–both hard law (e.g., treaties that bind states) and soft instruments (e.g., codes of practice negotiated by states)–that shapes norms, processes, and institutions to attain the highest attainable standard of physical and mental health for the world's population."[18] Gostin's conception of global health law assumes health to be a fundamental human entitlement. He modifies the definition of health put forth by WHO: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[19] Gostin echoes a growing consensus that healthcare is a right. However, he goes on to insist that global heath law should help guarantee equal opportunities to live a healthy life. This notion includes access not only to personal and public health services, but also to

16. Julio Frenk et al., *From Sovereignty to Solidarity: A Renewed Concept of Global Health for an Era of Complex Interdependence*, 383 LANCET 94, 94 (2014).

17. GOSTIN, *supra* note 7, at 19.

18. GOSTIN, *supra* note 7, at 59.

19. *WHO Definition of Health*, WORLD HEALTH ORG., http://www.who.int/about/definition/en/print.html (last visited Mar. 13, 2015).

clean water, sanitary services, adequate nutrition, and other determinants of health.

Notably, Gostin avoids the use of three terms that are included in the WHO definition of health: "state," "complete," and "social wellbeing." In a paper published in the *Journal of Public Health Policy* in 2014, we objected to the use of these terms for at least three reasons.[20] First, the word "state" conveys the idea of permanence or immovability. Critics tend to view health more as a dynamic condition with continuous adjustments to the changing demands of the physical and social environment.[21] A second important objection is the use of the term "complete" when referring to wellbeing. At a time when chronic illness increasingly dominates the epidemiologic landscape, the emphasis on total "physical, mental and social wellbeing" seems unrealistic. Finally, we object to the WHO's expanded definition of health, which includes not only physical and mental health, but also social wellbeing. This impractically broadens the scope of responsibility of healthcare providers.

An important topic that Gostin touches only briefly in discussing his definition of "global health law" is the difference between the concept and the theory of "international health law." The Health Law and Justice Program of American University's Washington College of Law states that global health law not only encompasses international health law, but also extends beyond it in three ways. First, international health law focuses on health-specific agreements while global health law examines a broader collection of laws that affect but are not necessarily focused on health. Second, international law focuses on agreements among nation-states that attempt to influence governmental behavior, while global health law also addresses the rights and obligations of nongovernmental actors. Third, international health law focuses mostly on international agreements, while global health law also considers the impact of national and local laws on global health.[22] This distinction is implicit in part two of *Global Health Law*.

II. INSTITUTIONAL FRAMEWORKS OF GLOBAL HEALTH LAW

According to Gostin, international law applies mainly to states and has three main sources: (i) treaties, which are international agreements between states; (ii) customary international law, which refers to legal norms that have been

20. Julio Frenk & Octavio Gómez-Dantés, *Designing a Framework for the Concept of Health*, 35 J. PUB. HEALTH POL'Y 401 (2014).

21. RENÉ DUBOS, MAN ADAPTING xvii (11th prtg. 1975).

22. Health Law & Justice Program, *What Is Health Law?*, AM. UNIV. WASH. COLL. OF LAW, http://www.wcl.american.edu/health/health_law_info.cfm (last visited Apr. 11, 2015).

established by general and consistent state practice; and (iii) general principles of law, a vague body of law that emphasizes broad principles of domestic or municipal law that are recognized in the legal systems of civilized nations.

Rich as international law may be, it has two serious limitations related to its state-centric orientation. One, as mentioned above, is its narrow potential to govern non-state actors, including individuals, NGOs, foundations, and private enterprises, some of which have a dominating presence in the global health arena. The second limitation is its mostly voluntary nature. As Gostin says, "In signing and ratifying treaties, which are the primary source of health law, states establish international legal rules by consenting to them. There is often no supranational authority to monitor, adjudicate, and enforce international law against states."[23]

Conceptually, Gostin places global health law not, as expected, within "global health governance" but within "global governance for health." At the beginning of his book he states the following: "The former principally describes the norms and institutions within the health sector, while the latter is more encompassing, extending beyond the health sector."[24] This allows him to establish a platform for the promotion of "healthy policies" or "health in all policies" through international law, something he considers critical for global health.

In terms of institutions, global health has become, as Gostin attests, increasingly pluralistic. Traditionally, the vehicles for mobilizing international collective action had been the U.N. health agencies—most notably the WHO. However, in recent years the range of actors involved in global health has expanded to include development banks, international NGOs, academic institutions, and philanthropic organizations. This institutional diversification has generated novel public-private alliances among the traditional agencies of the U.N. system and other important global actors, including multinational private corporations. The result is a diversity of what could be called "quasi-multilateral" organizations. Salient among them are the Global Alliance for Vaccines and Immunization and the Global Fund to Fight Aids, Tuberculosis and Malaria.

Such pluralism positively reflects the growing importance of health in the global agenda. Until now, the broad variety of actors had not been able to develop an effective global health system with a capacity for concerted action. To deal effectively with the challenges posed by globalization, global health actors must solve what has been described as a sovereignty paradox.[25] Paradoxically, in a world of sovereign nation-states, health continues to be

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23. GOSTIN, *supra* note 7, at 64.
24. *Id.* at xii.
25. Dean T. Jamison et al., *International Collective Action in Health: Objectives, Functions and Rationale*, 351 LANCET 514, 515 (1998).

primarily a national responsibility. Yet, the determinants of health and the means to fulfill that responsibility are increasingly global. Because of the international transfer of health risks, so too are the consequences of failing to fulfill that responsibility. No individual country, no matter how powerful, can unilaterally generate an effective response to most global challenges. The 2009 Swine Flu pandemic demonstrated the importance of international cooperation in avoiding the reintroduction of this disease into America once the outbreak in the United States was under control.

The way to solve this paradox is not for nation-states to give up, but rather to *share* their sovereignty in order to mobilize international collective action in a way that engages all actors. This, in turn, requires a transformation of the institutional architecture for global health. The basis for this transformation should be a clear allocation of functions to the multiplicity of actors concerned with global health that preserves some sort of global coordination through the main multilateral health agencies.

According to Gostin, these institutions should be guided by five values of good governance. It would be difficult to disagree with his list of values: honesty, transparency, deliberative decision-making, effective performance, and accountability.

The WHO's importance in the institutional framework of global health merits a full chapter. "There is no substitute for the WHO, with its incomparable normative powers and influence," Gostin states.[26] However, he also argues that this institution is facing a crisis of leadership, expressed above all in its decreasing capacity to respond to global emergencies. This crisis demands reform, which should include at least the following eight very reasonable proposals. The WHO should: (i) encourage members to become shareholders, "foregoing a measure of sovereignty for the global common good";[27] (ii) transform the Organization's internal culture from technical excellence to global leadership; (iii) give voice to stakeholders and harness the creativity of non-state actors; (iv) improve its governance through transparency, performance, and accountability; (v) exert its institutional authority as a normative organization; (vi) increase organizational coherence to ensure a unified voice and policy across headquarters, regions, and countries; (vii) ensure funding that is predictable, sustainable, and scalable to needs; and (viii) exercise leadership in global governance for health by exerting influence within and beyond the health sector.

Gostin discusses four other global actors in detail: the World Bank, the Global Fund, the GAVI Alliance, and the Bill & Melinda Gates Foundation. According to him, these institutions "bring a host of benefits–more funding, an

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26. GOSTIN, *supra* note 7, at 89.
27. *Id.* at 115.

enhanced voice for civil society, and innovative ideas–but also a mismatch between health needs and available funds, a fractured approach to health planning and financing, and inadequate leadership and accountability."[28] The arguments presented in this part of the book are somewhat lopsided, especially in regard to the World Bank and the Gates Foundation. The World Bank and its *World Development Report 1993: Investing in Health* are depicted as paradigmatic sources of the neoliberal health policies of the 1990s, which had "a devastating impact on public health."[29] Little praise is offered for the conceptual and methodological contributions that this Report, qualified by *The Lancet* as a landmark document, brought to the health arena.[30] Gostin criticizes the Gates Foundation's passion for technical innovations and points to the problems of governance and accountability that such a powerful actor creates. Fair as these criticisms may sound, this unbalanced discussion unjustly minimizes the impact this philanthropic organization has had on the health conditions of the poor, particularly through its support of efforts such as global immunization and research on diseases of the poor.

III. INTERNATIONAL LAW AND GLOBAL HEALTH

Part three of *Global Health Law* starts with a discussion of the core sources of law in global health–the two major WHO normative treaties (the International Health Regulations (IHR) and the FCTC) and the international human rights law regime–and ends with a thorough analysis of the relationship between trade and health.

The IHR, which govern global health security and remain one of the world's most widely adopted treaties, date back to the nineteenth century and were last revised in 2005. The IHR aim primarily "to prevent, protect against, control and provide a public health response to the international spread of disease."[31] They also deal with the relationship between health, international trade, and human rights. Salient in the discussion of the IHR are the lessons learned from the Swine Flu pandemic, which offered what until recently was the only significant test of

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28. *Id.* at 129.
29. *Id.* at 140.
30. Richard Horton & Selina Lo, *Investing in Health: Why, What, and Three Reflections*, 382 LANCET 1859 (2013).
31. *International Health Regulations (2005)*, WORLD HEALTH ORG. 10 (2008), whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

the IHR's effectiveness. Gostin concludes that this global emergency showed improvements in global governance, but also revealed important fault lines. For example, many nations failed to adopt certain WHO science-based recommendations regarding trade sanctions, travel restrictions, and coercive public health powers. The recent Ebola outbreak also tested the IHR. The Ebola crisis exposed the inability of global governance arrangements to build the health system envisioned by these regulations. Such a system would require countries "to develop capabilities to detect, assess, report, and respond to global health emergencies."[32]

The WHO's most recent treaty is the FCTC. Gostin discusses the damaging effects of tobacco; the strategies of the tobacco industry to promote tobacco consumption; the response of the medical establishment and civil society to "Big Tobacco's dishonesty and deceit"; and, finally, the FCTC itself, "the most innovative international health treaty ever adopted by the World Health Assembly."[33] The chapter ends with a fascinating examination of the strategies for a "tobacco-free world," including a ban on the commercial sale of cigarettes reminiscent of the alcohol prohibition in the United States in the 1920s.

While Gostin analyzes the human rights law regime with a dual focus on civil/political and economic/social rights, his discussion centers on the right to health, which "encompasses health care, public health, and the underlying determinants of health."[34] This discussion includes an additional appraisal of the definition of the right to health, as well as its appearance in national constitutions and in litigation. Gostin addresses the debate over the legal interpretation of this right, which was once dismissed by a U.S. Court of Appeals as being part of a group of rights that are "devoid of articulable or discernible standards and regulations"[35] Gostin argues that "national litigation demonstrates the justiciability of health rights despite their progressive nature and budgetary implications," and mentions that the most successful cases have involved access to essential services and medicines.[36] Regrettably, the budgetary impacts of some of these cases, especially in Brazil and Colombia, are not sufficiently documented. No mention is made of the increasing participation of the pharmaceutical industry in financing some of these lawsuits, especially those in which access to extremely costly medication for uncommon diseases is involved.

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32. Lawrence O. Gostin, *Ebola: Towards an International Health Systems Fund,* 384 LANCET e49 (2014).

33. GOSTIN, *supra* note 7, at 209.

34. *Id.* at 259.

35. Flores v. S. Peru Copper Corp., 414 F.3d 233, 255 (2d Cir. 2005) (quoting Beanal v. Freeport-McMoran, Inc., 197 F.3d 161, 167 (5th Cir. 1999)).

36. GOSTIN, *supra* note 7, at 264.

The third part of the book ends with an analysis of the effects of international trade on health and a description of the trade in health services. Emphasis is put on the impacts of trade liberalization on health and the reasonable concern that in this process, the interests of rich countries and multinational corporations may be prioritized over the health and lives of the people of the Global South. Gostin highlights the need for accessible essential vaccines and medicines, and advocates for the inclusion of domestic public health as a priority for the World Trade Organization. Indeed, he concludes that the global discussion should strike a balance between trade and health. "A fair and vibrant trade system would raise everyone's standard of living, which would benefit global health and development," he says.[37] "At the same time," he adds, "a healthy population is more creative and productive, which bodes well for trade and investment."[38]

IV. THE QUEST FOR GLOBAL SOCIAL JUSTICE

The final part of this book is devoted to four crucial topics of global health—the HIV/AIDS pandemic, international migration of health workers, pandemic influenza, and the 'silent' pandemic of NCDs—and to an exciting and comprehensive reflection on the road to a world with global health justice.

The chapter "Imagining Global Health with Justice" attempts to respond to three strategic questions: (i) To what level of health should we aspire and with what provision of health-related services? (ii) What would global health justice look like? and (iii) What would it take to achieve global health with justice?

Gostin wisely states that no government or institution can guarantee complete physical and mental wellbeing. What governments can guarantee–and that should be the goal of global health–are the conditions in which people can be healthy. This requires public health or community services, essential personal health services accessible to all, and interventions that address the socioeconomic determinants of health.

In trying to answer the second question, Gostin brings up a topic also raised by the WHO framework for assessing health system performance: the need to improve not only the general level of population health but also its distribution.[39] Gostin states that health institutions have focused on the general level of major health indicators, such as life expectancy and infant and maternal mortality. He

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37. *Id.* at 301.
38. *Id.*
39. Christopher J.L. Murray & Julio Frenk, *A Framework for Assessing the Performance of Health Systems*, 78 BULL. WORLD HEALTH ORG. 717 (2000).

rightly argues that we should move beyond this approach to close the gaps that exist in health conditions between the well-off and the poor. "Global health with justice," he says, "demands that society embed fairness into the environment in which people live and equitably allocate services, with particular attention to the needs of the most disadvantaged."[40] Gwatkin and Ergo captured this idea when they coined the concept of "progressive universalism," which refers to the expansion of comprehensive health services through the implementation of measures that benefit the poor first.[41] According to these two authors, the Family Health Program in Brazil and *Seguro Popular* in Mexico were both designed to increase coverage first among disadvantaged groups instead of taking the traditional approach of serving the rich, who are easier to reach.

Finally, in answering the third question, Gostin states that good governance is critical to achieving global health with justice. Good governance includes establishing clear and rigorous targets, monitoring progress, and ensuring accountability for results.

Global Health Law ends with a discussion of Gostin's ambitious proposal for a Framework Convention on Global Health. The design of this framework could draw upon the much-praised FCTC. The goal of this novel Convention would be gradually to create the conditions to guarantee the effective exercise of the right to health and to reduce health inequities. Gostin's framework would represent a "New Deal" for global health.

In sum, *Global Health Law* is a book that will likely become a classic. It provides an ordered, thoughtful, and comprehensive approach to a nascent field of scholarship and practice. In this regard it will be particularly useful for education. It affords useful insights into global governance challenges. Most importantly, it offers reasonable policy and legal answers to the practical dilemmas faced by those interested in improving global health with a special focus on the timeless aspiration for social justice.

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40. GOSTIN, *supra* note 7, at 413.

41. Davidson R. Gwatkin & Alex Ergo, *Universal Health Coverage: Friend or Foe of Health Equity?*, 377 LANCET 2160, 2161 (2011).