

Global Health Governance

The Scholarly Journal For The New
Health Security Paradigm

Special Symposium Issue 2021: Global Health Justice and Governance

Guest Editor: Benjamin Mason Meier

Global Health Justice as a Foundation for the Future of Global Health Governance
Benjamin Mason Meier

Health Injustice:
The Dominant Global Narrative of Our Time
Lawrence Gostin

What Regulators Can Learn from Global Health Governance
Cary Coglianese

The Links of Global Health Governance, Knowledge and Premature Mortality
Prabhat Jha

The Urgency of Mutual Collective Accountability in Global Health Governance
Jillian Clare Kohler

Global Health Justice:
Reflections on Prah Ruger
Kok-Chor Tan

Of Inequalities and Values:
The Confusion and Hope in Global Health Governance
Justice Nonvignon

Global Health Justice and Governance:
A Response
Jennifer Prah Ruger

GLOBAL



HEALTH GOVERNANCE

**THE SCHOLARLY JOURNAL FOR THE NEW HEALTH SECURITY PARADIGM
PEER REVIEWED, OPEN ACCESS JOURNAL**

ISSN 1939-2389

GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

PUBLISHER

THE SCHOOL OF DIPLOMACY AND INTERNATIONAL RELATIONS,
SETON HALL UNIVERSITY

EDITOR

YANZHONG HUANG

GUEST EDITOR

BENJAMIN MASON MEIER

MANAGING EDITOR

COURTNEY PAGE-TAN

ASSOCIATE EDITORS

ISAAC LEVINE

SUMMER MARION

KRYSTAL MARTINEZ

GRANT WEN

MARY YANG

GLOBAL



HEALTH GOVERNANCE

EDITORIAL BOARD

OBIJIOFOR AGINAM
UNITED NATIONS UNIVERSITY

MELY CABALLERO-ANTHONY
NANYANG TECHNOLOGICAL UNIVERSITY

JOSHUA BUSBY
UNIVERSITY OF TEXAS

JEAN-PAUL CHRETIEN
*US NAVY, DEPARTMENT OF
DEFENSE/ARMED FORCES HEALTH
SURVEILLANCE CENTER*

SARA DAVIES
QUEENSLAND UNIVERSITY OF TECHNOLOGY

SARA GORMAN
JANSSEN GLOBAL PUBLIC HEALTH

KAREN A. GRÉPIN
WILFRID LAURIER UNIVERSITY

EDUARDO J. GOMEZ
LEHIGH UNIVERSITY

GIGI KWIK GRONVALL
UNIVERSITY OF PITTSBURGH

SUSAN HUBBARD
*JAPAN CENTER FOR INTERNATIONAL
EXCHANGE*

YANZHONG HUANG
SETON HALL UNIVERSITY

KERMIT JONES
PERMANENTE MEDICINE

ADAM KAMRADT-SCOTT
*CENTRE FOR INTERNATIONAL SECURITY
STUDIES, UNIVERSITY OF SYDNEY*

TIM K. MACKEY
*UNIVERSITY OF CALIFORNIA SAN DIEGO,
SCHOOL OF MEDICINE*

ROBERT MARTEN
LSHTM

SUERIE MOON
*GRADUATE INSTITUTE OF INTERNATIONAL
AND DEVELOPMENT STUDIES*

PETER NAVARIO
*NEW YORK UNIVERSITY'S COLLEGE OF
GLOBAL PUBLIC HEALTH*

ROBERT L. OSTERGARD, JR.
UNIVERSITY OF NEVADA, RENO

SIMON RUSHTON
UNIVERSITY OF SHEFFIELD

DEVI SRIDHAR
THE UNIVERSITY OF EDINBURGH

JOHN P. TUMAN
UNIVERSITY OF NEVADA

JEREMY YOUDE
UNIVERSITY OF MINNESOTA DULUTH

GLOBAL HEALTH GOVERNANCE

VOLUME XVI, No. 1
SPECIAL SYMPOSIUM ISSUE 2021

GLOBAL HEALTH JUSTICE AND GOVERNANCE

TABLE OF CONTENTS

GLOBAL HEALTH JUSTICE AS A FOUNDATION FOR THE FUTURE OF GLOBAL HEALTH GOVERNANCE <i>Benjamin Mason Meier</i>	4
HEALTH INJUSTICE: THE DOMINANT GLOBAL NARRATIVE OF OUR TIME <i>Lawrence Gostin</i>	10
WHAT REGULATORS CAN LEARN FROM GLOBAL HEALTH GOVERNANCE <i>Cary Coglianese</i>	14
THE LINKS OF GLOBAL HEALTH GOVERNANCE, KNOWLEDGE AND PREMATURE MORTALITY <i>Prabhat Jha</i>	34
THE URGENCY OF MUTUAL COLLECTIVE ACCOUNTABILITY IN GLOBAL HEALTH GOVERNANCE <i>Jillian Clare Kohler</i>	38
GLOBAL HEALTH JUSTICE: REFLECTIONS ON PRAH RUGER <i>Kok-Chor Tan</i>	42
OF INEQUALITIES AND VALUES: THE CONFUSION AND HOPE IN GLOBAL HEALTH GOVERNANCE <i>Justice Nonvignon</i>	50
GLOBAL HEALTH JUSTICE AND GOVERNANCE: A RESPONSE <i>Jennifer Prah Ruger</i>	57

GLOBAL HEALTH JUSTICE AS A FOUNDATION FOR THE FUTURE OF GLOBAL HEALTH GOVERNANCE

Benjamin Mason Meier

New understandings of global health justice will be necessary to reform global health governance in facing future challenges. In responding to the unprecedented global health challenges of COVID-19, a pandemic requiring collective action to address a common threat, institutions of global health governance have faltered in their repeated efforts to unite nations in global solidarity. In the absence of intergovernmental leadership, this era of global health is reliant upon a proliferating set of non-state actors and unsteady support from foreign financial aid, neoliberal trade agreements, and public-private partnerships, leading to increasing fragmentation among actors, undue political influence for donors, and rising inequities within and between nations. Our world's increasing interconnectedness has revealed the pitfalls of the current global health governance framework, requiring global health actors to ask questions anew about their moral obligations to prevent disease and promote health.

*Global Health Justice and Governance*¹ offers a theory of shared health governance that calls for a universal vision of health through the merging of common values among global, national, and local actors. Jennifer Prah Ruger contends that global and national responses to health governance must be grounded in moral and ethical claims about health. These claims build upon her previous work, *Health and Social Justice*, which submits a theory of "health capability" that centers the right to health and the necessary means to achieve health by focusing on issues at the intersection of economics, ethics, and politics.² From the deeply theoretical to the highly practical, Prah Ruger's new vision of global health justice analyzes the current public health problems of a globalized world, frames the norms by which global health policy should be structured, examines the current global health architecture, and proposes novel institutions to reconceptualize global health governance. This ethics-based focus on governance will not only allow global health actors to design solutions rooted in respect for public health, but will help realize accountability for achieving global justice. In confronting a cataclysmic pandemic in the absence of global leadership, such a vision of shared health governance is crucially necessary in charting a path forward global health governance.

This special issue of *Global Health Governance* seeks to evaluate the global health governance implications and applications of *Global Health Justice and Governance*. Introducing the special issue, this editorial describes the central importance of this work as a foundation of global governance for health. The editorial begins by briefly reviewing Professor Prah Ruger's seminal work, examining how it contributes necessary normative frameworks for global health and, in the process, reframes global health governance. With this special issue arising out of a 2019 colloquium at the University of Pennsylvania, the editorial then describes the themes and discussions of that meeting, bringing together the contributing authors to discuss the interdisciplinary implications of this book. Summarizing the resulting articles that came out of this workshop, it becomes possible to recognize the sweeping application of this work for the future of global health governance. *Global Health Justice and Governance* will prove central to the evolution of the field, with

this special issue attesting to the continuing importance of normative analysis in global health.

SITUATING *GLOBAL HEALTH JUSTICE AND GOVERNANCE*

Global Health Justice & Governance analyzes the current public health problems of a globalized world, justifying the norms that should structure global health policy, examining the limitations of the global health architecture, and proposing novel institutions to reconceptualize global health governance.

As a normative framework for global health governance, *Global Health Justice and Governance* recognizes that health justice requires health capabilities, with health capabilities in a globalizing world requiring provincial globalism. While a variety of moral and ethical theories offer foundations for global health justice, it remains difficult to apply these theories of responsibility to global health governance. Prah Ruger notes that no actor in the current system of governance has taken leadership to narrow global health inequities, with governance grounded in power rather than justice, denying accountability in global health and raising an imperative for new moral theories. She presents a moral foundation for global health through health capability, the ability to live a healthy life, examining these capabilities as directly impacted by social and political decisions. To realize health capabilities for all, Prah Ruger looks to “provincial globalism,” a theory grounded in the idea of equal dignity, to provide a framework to secure health agency, an individual or group’s ability to pursue health goals. Provincial globalism thus looks outward to examine local and national environments and determine the necessary conditions to allow all persons to achieve good health. Unlike other relational moral theories defined by procedural components, provincial globalism outlines the substantive ends for achieving justice along with the means to realize them. By allocating primary responsibility for creating functioning health care systems to states—with the responsibilities for norm setting, leadership, and knowledge sharing to global health actors—provincial globalism incorporates both individual and shared obligations in a framework for attaining global health justice.

Prah Ruger analyzes the ways in which realizing provincial globalism requires “shared health governance.” Conceptualizing a structure designed to foster global health citizenship, and thus the promotion of health capabilities for all people, Prah Ruger looks to shared health governance to guide the development of a renewed global health system. Where the global health governance system lacks a general theory grounded in global justice, provincial globalism provides a normative framework for reconceptualizing the global health architecture based on the right to health, requiring both new and existing actors to unite under shared health governance. Shared health governance offers a unique theory of justice that acknowledges the shortfalls of the current global health system, grounding obligations to correct that system in a universal moral duty to achieve global health equity. Incorporating shared health governance as a foundation of global health governance, however, poses several challenges, including determining roles and responsibilities, inspiring social motivation, creating legitimacy and accountability, and ensuring effective implementation of governance for health.³ The alleviation of these challenges draws from provincial globalism to demand voluntary cooperation among global health actors and the assumption of duties required to fulfill global health equity

as a basis to ensure health capabilities. Shared health governance thereby assigns roles and responsibilities to voluntary participants through the determination of functions and needs of individual, local, state, and global actors. Yet, harnessing shared health governance to redesign the global health architecture remains daunting, requiring Prah Ruger to propose a new governance regime for global health through global health law.

Codifying specific obligations for realizing provincial globalism through shared health governance, global health law provides a legal framework for securing health capabilities. Prah Ruger notes that, in the absence of enforcement mechanisms under international law, the emerging field of global health law must draw from a normative theory to facilitate the redistribution of resources, implementation of related legislation and policy, development of public regulation and oversight, and fulfillment of public goods. By promoting treaty regimes that build capacity, provide technical and economic support, and identify barriers, global health law can advance health capabilities – but this vision of global health law requires a moral foundation in justice. To ensure compliance with these regimes, stakeholders must draw upon the ideals of shared health governance to bring a moral purpose for international relations to achieve global health equity. It is these same ideals that support the implementation of human rights law in global health governance, defining the legal responsibilities of duty-bearers to meet the needs of rights-holders.⁴ Providing a path to link provincial globalism with human rights, a health and human rights approach can support obligations and facilitate accountability for upholding health capability. By demanding that global health actors recognize a human right to health, Prah Ruger’s approach to global health governance reinforces the shared health governance framework by declaring a universal moral duty to achieve health equity, and thus realize human rights as a normative framework and political catalyst for universal health coverage.

CONSIDERING THE GLOBAL HEALTH GOVERNANCE IMPLICATIONS

Conceptualizing shared health governance as a basis to realize human rights law and redress global health inequities, *Global Health Justice and Governance* was launched at the University of Pennsylvania in May 2019, followed by a two-day symposium to consider its relevance to global health governance. The initial launch allowed Prah Ruger to examine the genesis of the book and the path from her previous book. Through a structured conversation with LaShawn Jefferson, Prah Ruger reflected on the importance of theories of justice to redressing global health inequities, shifting the global governance landscape from one driven by power politics and free markets to one seeking human flourishing through health capability. This shared health governance, Prah Ruger argued, would provide a basis to strengthen the World Health Organization (WHO) to realize health equity. Examining the notion of common humanity in a globalizing world, Prah Ruger concluded that a focus on equity can reform global health institutions to ensure accountability for securing health for all through a new global health constitution.

The symposium that followed brought together 10 interdisciplinary scholars from across the world at the Perry World House at the University of Pennsylvania. The discussion covered a range of disciplinary perspectives. Beginning with a focus on “global public health,” Mary Bassett opened the discussion by addressing the values that frame the work of health departments and the contemporary threats to those values that underlie public health, with Prabhat Jha examining the role of governance in framing

shared goals to reduce child mortality but necessitating new knowledge through global health governance. From global health to “global health justice,” Kok-Chor Tan sought to distinguish the legal concept of human rights from the moral concept of health capability, examining the importance of provincial globalism as a basis for reducing health inequality. The session on “global health governance,” led by Yanzhong Huang, recognized the need for a new global health governance architecture that reflects universal values, with health capability providing an effective value structure. Cary Coglianese led the session on “global and domestic regulation,” examining the rise of narrow self-interest in policy and necessitating regulation to incentivize steps toward equity. Applying these themes to “global health law,” Lawrence Gostin provided an examination of the links between global health ethics and human rights obligations and the need for develop new treaties through WHO to facilitate governance. The substantive sessions ended with Justice Nonvignon addressing rising income inequality, evolving development models, and public-private partnerships, raising a need for transparency through regulation. With Jennifer Prah Ruger responding at the end of each session, she concluded the workshop by reflecting on the ways in which *Global Health Justice & Governance* draws from multiple disciplines to further ethical analysis in global health governance.



DEVELOPING A SPECIAL ISSUE OF *GLOBAL HEALTH GOVERNANCE*

This special issue of *Global Health Governance* arises out of the discussions in this workshop, drawing from the interdisciplinary dialogue at the University of Pennsylvania and examining discrete perspectives on the themes of Global Health Justice and Governance. It opens with Lawrence Gostin’s commentary, which analyzes the importance of Prah Ruger’s theoretical lens in the COVID-19 response, emphasizing the injustice exposed through disproportionate mortality rates and laying out WHO

governance as a basis for human flourishing. Looking to legal regulation as health governance, Cary Coglianese captures one of Prah Ruger's core insights—governance is local, national, and global—with regulatory harmonization necessary to prevent disease and promote health. Given the crucial importance of global governance, Prabhat Jha reflects on the governance underlying global efforts to reduce premature mortality, looking to the collective aspirations, shared health governance, and public financing that have come together to improve child survival but failed to control malaria. Jillian Kohler draws from these governance frameworks to examine the necessary institutional mechanisms for mutual collective accountability as a foundation of solidarity and cooperation in global health governance. Looking to the philosophical contributions of Prah Ruger's analysis of global justice, Kok-Chor Tan considers the role of human rights as a basis for human flourishing, analyzing whether global health justice requires health equality. Justice Nonvignon examines the specific role of organizations in redressing health inequality, noting the challenges in establishing universal values in an elitist global health architecture. Prah Ruger closes out the special issue by detailing the importance of each contribution, to the workshop and this issue, while analyzing each contributor's unique application of Global Health Justice and Governance across disciplines.

The lessons in this special issue of *Global Health Governance* will have crucial application in confronting pervasive health injustices amidst the current pandemic response. Notwithstanding a global health imperative to respond to this public health threat through global solidarity, nationalist governments have sought to isolate themselves from our globalizing world.⁵ The limitations facing global governance, with states neglecting moral obligations for international cooperation, have posed cataclysmic setbacks for vaccine access and human flourishing. Drawing from *Global Health Justice and Governance*, it becomes clear that principles of health capability can provide a moral path to respond to global health threats through shared health governance.⁶ Where global health governance has been unable to coordinate the world in realizing our common global interest in infectious disease prevention, it will be necessary to reestablish shared health governance in building back better, translating principles of provincial globalism into global health law to strengthen national health systems and WHO governance. *Global Health Justice & Governance* can provide a moral foundation for the future of global health governance, with Prah Ruger already applying the theoretical frameworks of her analysis in assessing moral obligations to prevent, contain, and respond to the COVID-19 pandemic.⁷ Extending the theoretical framework of her earlier work to a global level of analysis, Prah Ruger's complete vision of global health justice can reimagine global health governance in preparing for future threats.

Benjamin Mason Meier is a Professor of Global Health Policy at the University of North Carolina at Chapel Hill, a Scholar at Georgetown Law School's O'Neill Institute for National and Global Health Law, and a consultant to international organizations, national governments, and nongovernmental organizations. Dr. Meier's interdisciplinary research — at the intersection of public health, international law, and global governance — examines the advancement of human rights to promote global health.

Acknowledgments *In editing the contributions to this special issue of Global Health Governance and developing this editorial, the author is grateful for the research assistance of Hannah Rice and Savannah Faircloth and the editorial guidance of Yanzhong Huang.*

¹ Jennifer Prah Ruger. 2018. *Global Health Justice and Governance*. Oxford University Press.

² Jennifer Prah Ruger. 2009. *Health and Social Justice*. Oxford University Press.

³ Jennifer Prah Ruger. 2012. Global health governance as shared health governance. *Journal of Epidemiology and Community Health*; 66: 653-61.

⁴ Benjamin Mason Meier & Lawrence O. Gostin. 2018. *Human Rights in Global Health: Rights-Based Governance for a Globalizing World*. Oxford University Press.

⁵ Caitlin R. Williams et al. 2020. Populist Nationalism Threatens Health & Human Rights in the COVID-19 Response. *American Journal of Public Health*. 110(12).

⁶ Jennifer Prah Ruger and Kara Zhang. 2019. Addiction as Capabilities Failure, University of Pennsylvania *Journal of Law and Public Affairs* 5(1): 25-61.

⁷ Jennifer Prah Ruger. 2020. The injustice of COVID-19: we need a moral constitution for our planet's health, *Lancet Planetary Health* 4:264-265.

HEALTH INJUSTICE: THE DOMINANT GLOBAL NARRATIVE OF OUR TIME

Lawrence O. Gostin

Jennifer Prah Ruger's seminal scholarship has demonstrated that she is perhaps the world's most insightful thinker and innovator in tackling the unconscionable health inequities that pervade societies, within and among nations. In her pivotal book, *Global Health Justice and Governance*, Prof. Prah Ruger foresees that a deadly contagion could circle a globalized planet in days. But she couldn't have imagined that just two years later, the world would experience a once-in-a-lifetime pandemic. Indeed, the COVID-19 pandemic rapidly circumnavigated the globe in a matter of months, with profound health, social, and economic consequences for humanity.

But it isn't only all the death and suffering of the coronavirus pandemic that captures the world's attention. It is also the deep health and economic injustices the pandemic has so vividly revealed. The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) should be blind to social, economic, and racial circumstance. Yet, like so many viruses, SARS-CoV-2 is anything but equal in its impact. In the United States, for example, it has disproportionately killed African Americans, Hispanics, and American Indians. The virus has struck essential workers and the most vulnerable among us, including people with underlying disease and the elderly.

And even now that science has given us astoundingly effective vaccines, the benefits have been cruelly reserved primarily for the well-off, both within and among nations. "Vaccine nationalism" is a new term of art to mean that richer countries have hoarded the vast supply of vaccine doses, leaving low- and middle-income without this life-saving medical resource. Even the COVID-19 Vaccine Global Access (COVAX) Facility, designed to more equitably allocate global vaccine supplies, has been starved of doses and dollars.

Prof. Prah Ruger would regard COVID-19 vaccines as global public goods. What does that mean? It means that no one should "own" the vaccine. No company should profit from it. No scientist should hold the intellectual property. No country should hoard it. And that safe and effective vaccines are equitably and affordably distributed to the world's population, irrespective of power and riches. Imagine the breakdown of international diplomacy and global solidarity if populations in China, Europe or North America were largely spared the devastation of COVID-19, while those in lower-income countries died in their hundreds of thousands. And that is exactly what is happening.

The World Health Organization should be at the center of global governance in ensuring equitable access to vaccines and other vital medical resources. But the Organization has been unable to gain global cooperation, with its largest funder, the United States, blaming WHO for the pandemic under President Trump. President Biden has strongly supported WHO and COVAX but has continued hoarding vaccine doses and raw materials for use domestically. With the United States largely on the sidelines, it has fallen to two relatively new global public/private partnerships (CEPI and Gavi, the Vaccine Alliance), working with WHO, to fill the leadership void. The COVAX Facility is fighting headwinds of nations that are active in procuring vaccines for their own populations. Global solidarity is strained at best. And at worst, it is an utter failure, as the

WHO's own Independent Panel of Pandemic Preparedness and Respond (IPPR) recently reported.

It may not be a coincidence that another type of injustice has been superimposed in the public's psyche alongside COVID. The global outrage over the police killing of George Floyd has spilled over into the streets with a cry of "Black Lives Matter." Even with the conviction of Derek Chauvin on charges of second-degree murder has not ameliorated the hurt of injustice. Racial stereotypes and discrimination have permeated all of our social institutions, from the health system to law enforcement, and beyond. The public seems unwilling, as they should, to tolerate injustice so deep, and of so many kinds.

Even before the COVID-19 pandemic, social and economic injustice had become the prevailing global narrative of our time. The world has achieved astounding success in reducing disease and poverty. Many key indicators show how far we have come, including greater longevity and reductions in maternal mortality and childhood deaths. We've massively expanded access to treatments like antiretroviral therapy for HIV/AIDS. And the number of people living in absolute poverty has been steadily falling. Yet, these vast improvements in overall population health mask cavernous and deepening inequities. Core inequalities in income and in health have persisted. In many ways, injustice is graver than it has been in generations.

And this is exactly where Prof. Prah Ruger's scholarship is so consequential. Her book predicted that the way countries and the world are governed would not be fit for purpose in tackling health and social injustice. Prof. Prah Ruger's book speaks about a bewildering confusion of health actors and systems, arguing that humankind needs a new vision, a new architecture, and new coordination to ensure health capabilities for all. Indeed, many of our global institutions have themselves been embroiled in controversy, not least of which is the World Health Organization. The spectacle of Donald Trump, American president, a populist and nationalist, announcing America's withdrawal from WHO showed the utter dysfunction of extant global health governance.

Prof Prah Ruger's life's work has shown with sharp clarity the fundamental responsibility of governments, international institutions, and all of society to promote human flourishing. The central role that health plays in flourishing places a unique claim on our public institutions and resources, to safeguard the public's health and safety—and to do so with particular attention to the most vulnerable and marginalized. Faced with staggering inequalities, imperiling epidemics, and weak governance, the world desperately needs a new global health architecture. *Global Health Justice and Governance* lays out this vision.

This symposium issue of *Global Health Governance*, capably edited by Benjamin Mason Meir and Yanzhong Huang, is a fitting tribute to Prof. Prah Ruger's stunning career, where she has exhibited deep compassion for those left behind. All symposium authors embrace, as they should, Prah Ruger's seminal theory of capabilities, recognizing that nothing is more important than enhancing human flourishing, which is the foundation for so much of what we all value. But symposium authors actively engage on the best ways to achieve Prah Ruger's goal.

Kok-Chor Tan, for example, is more prepared to use a lens of human rights than is Prah Ruger. Could the legal doctrine and language of human rights help promote human flourishing? He further asks whether global health justice requires only securing some defined level of health sufficiency, or whether it should be equal. For me, and I suspect

Prof. Prah Ruger, justice requires more than a sufficient level, but rather that our institutions should continually strive for greater equity.

Prof. Prah Ruger's deep commitment to good governance is certainly captured in the ideals of transparency, accountability, and stewardship (non-corruption). Jillian Kohler explores whether these values are embedded in the work of international organizations themselves, focusing on WHO, UNDP, and the Global Fund. Each of these organizations would profess to be dedicated to good governance, and they often give voice to the ideals of transparency and accountability, less so anti-corruption. But the institutional governance of these global actors does not create robust mechanisms for full transparency and accountability—and that remains a core problem in global governance for health.

Beyond transparency and accountability, Justice Nonvignon asks whether the governance of global institutions sufficiently focuses on inequalities in health, which is Prah Ruger's major project. He claims that international institutions have not paid nearly enough attention to health inequalities. Certainly, arising from the United Nations Sustainable Development Goals, the rhetoric of "leaving no one behind" is salient. But there are too few mechanisms to close cavernous health gaps. Even the SDGs fail to measure inequalities through detailed disaggregated data. And data systems both of national governments and of international institutions rarely track indicators of inequity, like socioeconomic status, race, gender, and disability.

Finally, Cary Coglianese explores a more direct form of governance, the role of legal regulation. He brings us back to the glaring gaps in law and regulation seen during the Great Coronavirus Pandemic of 2020. Even a cursory description of how SARS-CoV-2 was unleashed, most probably at the Wuhan seafood market, shows how local and national sanitation and food regulations play a major role in pandemic preparedness. Prof. Coglianese captures one of Prah Ruger's core insights—governance is both local and national, as well as global. Think of the pivotal role (either functional or dysfunctional) played by the Centers for Disease Control and Prevention (CDC) around the world, including in China, South Korea, and the United States. As the COVID-19 response turns to innovative therapies and vaccines, drug regulatory agencies (e.g., FDA and European Medicines Agency) become pivotal. And regulatory harmonization among a myriad of national agencies must be at the forefront of pandemic planning.

The Great Coronavirus Pandemic of 2020 teaches many lessons about equity, governance, and global solidarity. National and global responses have failed systematically. A pandemic should bring us together, but COVID-19 has too often pulled us apart. In a populist age, populist governments have taken a "nation first" approach. And in a world with increasing institutional fragmentation, there has not been a clear global leader. If only our blueprint for this pandemic had embraced Jennifer Prah Ruger's theory of health justice and borrowed richly from her solutions. Health inequities have become the prevailing narrative of our age, and Prah Ruger's insights ought to be at the center of our response.

Lawrence O. Gostin is University Professor, Georgetown University's highest academic rank, and Founding O'Neill Chair in Global Health Law. He directs the World Health Organization Center on National and Global Health Law. Professor Gostin

served on two global commissions on the Ebola epidemic, and was senior advisor to the UN Secretary General's post-Ebola Commission. He served on the drafting committee for the G-7 Summit on global health security. A Member of the National Academy of Medicine, he also serves on the Academy's Global Health Board. The National Academy and American Public Health Association awarded him their Distinguished Achievement Award. He's a fellow of the Royal Society of Public Health and Faculty of Public Health (UK). President Obama appointed Gostin to the President's National Cancer Advisory Board. The National Consumer Council (UK) bestowed the Rosemary Delbridge Memorial Award for the person "who has most influenced Parliament and government to act for the welfare of society."

WHAT REGULATORS CAN LEARN FROM GLOBAL HEALTH GOVERNANCE

Cary Coglianese

The Great Pandemic of 2020 shows how much public health around the world depends on effective global and domestic governance. Yet for too long, global health governance and domestic regulatory governance have remained largely separate fields of scholarship and practice. In her book, Global Health Justice and Governance, Jennifer Prah Ruger offers scholars and practitioners of regulatory governance an excellent opportunity to see how domestic regulation shares many of the same problems, strategies, and challenges as global health governance. These commonalities reinforce how much national and subnational regulators can learn from global health governance. Drawing on insights from Prah Ruger's impressive book, I offer seven lessons for domestic regulators around the world to use to improve their performance, arguing that it is vital for regulators to see themselves as operating in a larger social environment in which they must remain agile, vigilant, and responsive to other actors and to changing circumstances.

INTRODUCTION

Scientists and scholars will be studying for decades the causes and implications of the COVID-19 pandemic that overwhelmed the world in 2020. For now, as the pandemic continues to rage and fatalities mount in the millions worldwide, the final extent of mortality and morbidity effects from the viral outbreak cannot be known, nor can we yet gauge the full losses from the resulting global economic dislocation. But even from the earliest days of the rampage caused by the SARS-CoV-2 virus, it has been evident how much public health effectiveness around the world depends not only on the quality of global health governance but also on the performance of domestic regulatory institutions.

The fact that the earliest cases of SARS-CoV-2 infection appeared among workers at the Huanan Seafood Wholesale Market in Wuhan, China¹ has brought renewed attention to the ways that viral transmission can occur when people and animals, domestic and wild, all closely come in certain food markets, particularly those in Asia.² Even if SARS-CoV-2 did not actually originate at the food market itself, its early identification there serves as a reminder of how improved local sanitation and food regulations, including those controlling trade in wild and exotic animals, can help prevent or slow the spread of pathogenic outbreaks.³

Another principal way that domestic regulation clearly affects global health stems from how nations are able to respond in the face of a virulent pathogen's transnational spread. Once the transmission of SARS-CoV-2 crossed national borders, actions by domestic regulators proved pivotal to the virus's ability to gain a foothold and spread further. Although both South Korea and the United States announced their first cases of the novel coronavirus on the same day in January 2020, the contrasting domestic regulatory responses in each country has led to vastly different patterns in viral spread.

The rate of infections in Korea began to decline within about six weeks' time, while infections skyrocketed in the United States over that same period.⁴ Regulatory officials in South Korea immediately recognized the need for expansive testing to isolate the virus

and quickly brought together private companies to develop and administer coronavirus tests throughout the nation.⁵ That testing allowed government authorities to isolate infected and exposed individuals, effectively containing the virus's early spread.

By contrast, officials of the U.S. Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) spent weeks following a business-as-usual plan that wasted crucial time and allowed the virus to take root in major cities across the country.⁶ By the time the FDA finally exercised its authority to waive regulations that apply to testing in less dire circumstances, a containment strategy was too late. The spread of the virus across the United States has not only resulted in massive levels of premature mortality and other profound public health and economic effects within U.S. borders, but it also has complicated the overall battle against the global pandemic and contributed to an economic downturn around the world.

The contrasting paths taken early by South Korea and the United States—a contrast sustained even more than a year later—make evident how much global health outcomes can vitally depend on high-quality domestic regulatory responses. And yet, despite the clear connection between global health and domestic regulatory governance, the scholarship and practice of domestic regulation has remained too disconnected from the scholarship and practice of global health governance. This disconnect exists notwithstanding important similarities between governance at both the global and domestic levels—and notwithstanding the lessons that practitioners and scholars of both regulation and global governance can learn from one another.

Fortunately for regulatory scholars, the publication of Jennifer Prah Ruger's recent book, *Global Health Justice and Governance*,⁷ provides an excellent basis for understanding the challenges of both global and domestic public health governance, and it offers an illuminating normative framework for the pursuit of global health justice. Global health governance and domestic regulatory governance share a common set of problems and common strategies for solving those problems. The common problems—chiefly, externalities, coordination challenges, and distributional inequities—often exist on different planes, with regulatory problems primarily existing within the confines of individual jurisdictions, whereas global health problems inherently transcend national boundaries. But the different planes intersect with each other, as the current COVID-19 pandemic makes plain.⁸ Moreover, some of the same underlying issues and challenges—as well as an overall need for solutions of hard and soft power—cut across both policy planes and both fields of research.

By drawing out these connections, I seek in this essay to show what the vision of global health governance offered in Prah Ruger's remarkable book has to offer scholars and practitioners of domestic regulatory governance. Prah Ruger argues that meaningful progress in securing global health justice ultimately depends on widely accepted norms and on the coordinated efforts of a diverse array of actors and institutions—or on what she calls “shared” health governance. I suggest that much the same is needed for domestic regulatory governance to be successful. Rather than seeing regulation as just a set of rules on the books, it is more useful to view domestic regulatory governance as a social enterprise involving the interaction of a diverse range of individuals and organizations. I conclude with seven lessons that domestic regulators can learn from Prah Ruger's model of shared health governance.

COMMON PROBLEMS

Prah Ruger begins her book presciently with accounts of previous deadly viral outbreaks: the 2013 Ebola epidemic that spread largely in Africa, and the 2003 SARS outbreak in Asia.⁹ The international spread of contagious pathogens presents a paradigmatic example of a global health problem. Prah Ruger acknowledges that contagion is also exactly the same kind of problem that is typically used to justify domestic regulation: a negative externality. Of course, when used to justify domestic regulation, externalities are treated as failures of the private market, because the terms of individual, private transactions do not fully account for the social costs of their spillovers.¹⁰ This is classically the case with pollution, and it provides the underlying justification for environmental regulation.

With respect to global pandemics, the underlying failure is only partly one of the private marketplace. Private markets are no match for a viral spread, as the prevention, management, and elimination of that spread essentially constitutes a public good. The full costs of addressing contagion vastly exceed the individual benefits to any single actor, but if positive global health outcomes are achieved, their enjoyment cannot be denied to those who fail to contribute to them.¹¹ Moreover, some of the measures needed to respond to pandemics—for example, quarantines—depend on the exercise of the kind of force which only domestic governments possess.¹² This is why, as Prah Ruger points out, transnational pathogenic outbreaks are *governance* problems. A global pandemic represents the failure of national governments and international organizations to coordinate and function effectively to keep a viral outbreak contained. As she puts it, “[t]he international spread of pathogenic health risks reflects global health governance failures to respond effectively and to prevent local health harms from becoming worldwide risks.”¹³

But externalities are not the only kind of global health problems that need attention—nor the only kind with direct parallels within the domain of regulation. Prah Ruger highlights another global health problem: the need for cross-border coordination—or what regulatory scholars sometimes call regulatory cooperation or harmonization. Such cross-border problems arise, for example, when health care institutions are integrated across nations, as in Europe. Such integration demands basically either a common set of institutional standards and rules about costs and capacities, or a system of mutual recognition of different countries’ standards.¹⁴ In addition to the need to coordinate on health care delivery, a host of other problems also call for interjurisdictional cooperation, such as “counterfeit drugs,” “organ allocation and transplantation,” “overuse of antibiotics,” “medical tourism,” and “health worker migration.”¹⁵ When such cross-border regulatory problems hold implications for global health, solving them necessitates both domestic regulatory responses and transnational regulatory coordination. This challenge is little different than other cross-border regulatory problems, such as those related to terrorism and money-laundering, refugees and immigration, and the safety of food, consumer, and pharmaceutical products in international trade.¹⁶

A similar type of coordination problem arises inside nations themselves. This is especially the case in countries with federal systems of government. In the United States, for example, much attention has been paid to the coordination of medical licensing schemes so that health professionals initially licensed in one state can take advantage of changes in demographics or labor market conditions and relocate to other states.¹⁷ The

need for professional licensing coordination in the United States came into starker relief in response to the COVID-19 crisis. To prepare for a spike in patients and the prospect of health care workers getting sick at a time when hospitals were overwhelmed, New York City took steps in 2020 to welcome nurses and doctors from other states to fill its hospitals' staffing needs.¹⁸

A third and final type of global health problem figures prominently throughout Prah Ruger's book: inequality. This problem, too, has clear parallels within the domain of regulation.

Prah Ruger assembles empirical findings from her own research and that of others which demonstrate troubling disparities that persist in health and access to health care, both across and within countries. For example, Prah Ruger observes that:

While there has been much progress toward improving global health outcomes over the past several decades, global inequalities in adult and child mortality remain extreme; the gap is far from being closed, and the distribution of health burdens and benefits is drastically unequal. Mortality gaps between the richest and poorest countries are wide. Worldwide 99 percent of maternal deaths occur in developing countries.¹⁹

Even within developed countries such as the United States, differences in health outcomes and standards of living can be extreme. Life expectancy, Prah Ruger reports, is twenty years greater on average in urban areas of Colorado than in North and South Dakota.²⁰ Residents in downtown Chicago live an average of sixteen years longer than their principally Black and Hispanic neighbors in the city's south side.²¹

Despite the existence of such health disparities within a single country's borders, it may be at first glance unclear the extent to which this inequality is fully a *regulatory* problem. Regulation has not been typically viewed as the principal domestic policy tool used to respond to societal inequality; taxation and social services tend to handle most of the distributional work from the standpoint of domestic policy.²² But laws and rules do make up an essential part of the policy toolkit that makes any tax or spending program work. Moreover, concerns about inequality do directly undergird many areas of regulation. Employment discrimination regulation and other civil rights laws expressly aim at social inequities produced by racial and gender biases.²³ Environmental regulators are aware that pollution patterns contribute to disparate health outcomes along racial and socioeconomic lines, and, as a result, these regulators have sometimes developed programs or set enforcement priorities in an attempt to address environmental injustices.²⁴ In these and other ways, the problem of inequality remains a matter of great concern in the realm of both global health governance and domestic regulation.

COMMON SOLUTIONS

Despite sharing a common set of problems with global health governance (externalities, cross-border coordination, and distributional inequities), regulatory governance might seem otherwise unrelated to global health governance. After all, regulation is associated with governmental entities that issue rules and rely on hard sanctions to enforce them—a model of power more compatible with the state-dominated world of what Prah Ruger calls *international* health governance. Prah Ruger makes clear

that international health governance, sometimes labeled “Westphalian” after the 1648 Peace of Westphalia treaties, centered around nation-states and their sovereignty.²⁵ That model of governance might have applied in the past, but it contrasts with what has become a system of *global* health governance since around the middle of the Twentieth Century.²⁶

This newer system of global health governance still accommodates the older Westphalian system—indeed, Prah Ruger acknowledges the continued “primacy of states”²⁷ even today—but global health governance is not exclusively dominated by state actors. Instead, it reflects the reality that a multiplicity of non-state actors also shapes health outcomes and patterns around the world. Prah Ruger observes that the behaviors of these various actors are “uncoordinated,”²⁸ “diffuse[, and] non-hierarchical.”²⁹ They “lack any clear structure” because global health governance “does not clearly delineate roles for states, UN organizations, international organizations, civil society organizations, and public-private partnerships.”³⁰ The chaotic state of affairs makes global governance something closer to a Hobbesian state of nature: “Fierce competition among actors and priorities results in end runs around national governments and the UN system.”³¹ As a result, it is more accurate to describe global health governance as “increasingly political and decreasingly technical and scientific.”³²

Perhaps surprisingly, much the same can be said of domestic regulatory governance. Over the last several decades, both the practice and the study of regulation has shifted toward recognition of its more highly fragmented and contested state of affairs, replete with multiple public and private actors. No longer is regulation viewed as merely a formalistic application of binding rules imposed by government on private industry. Today, governments around the world deploy a mix of tools, and binding rules are only one of many.³³ The work of regulators encompasses extensive use of public outreach efforts, information campaigns, guidance statements, and technical assistance. Voluntary recognition or rewards programs are now quite common,³⁴ and public regulators take great interest in developing public-private partnerships in an effort to achieve regulatory goals.³⁵

Government regulators’ blending of binding legal rules with a variety of non-binding strategies is possible due to the diverse nongovernmental actors that make up the social environment within which domestic regulatory governance operates. Nongovernmental forms of regulatory governance include self-regulatory schemes, such as the chemical industry’s Responsible Care program³⁶ and the nuclear power industry’s Institute of Nuclear Power Operations.³⁷ An extensive array of nongovernmental standards today are produced by industry groups and national and international standard-setting bodies, such as Underwriter’s Laboratories, the ASTM International, and the International Organization of Standardization.³⁸ Regulators rely on these nongovernmental standards either to substitute for or complement binding governmental rules. And, not infrequently, these nongovernmental standards become adopted as binding governmental rules through a process known as incorporation by reference.³⁹

Just as global health governance is more than just a Westphalian world of nation-states, so too is regulatory governance about much more than a narrow realm of rules. Regulators, after all, are seeking to shape individual and organizational behavior in ways that solve problems or improve social or economic conditions. Both regulators and regulatory scholars thus understand that formal regulatory law is only one factor affecting relevant behavior. Other forces also can be used to achieve regulatory goals.⁴⁰ Indeed, a widely accepted framework views the behavior of regulated businesses as shaped by

“three ‘licenses’”—a regulatory license (the formal law and its enforcement), an economic license (business imperatives), and a social license (community pressures and social norms).⁴¹ Both regulators and the businesses they oversee recognize the power of the so-called social license in shaping firms’ behavior. The social license can be more demanding than either of the other licenses—even to the point that, within certain sectors and with respect to certain regulations, businesses will go beyond merely complying with their regulatory licenses and invest in costly measures that demonstrate their commitment to various environmental and social values, or what is sometimes referred to as corporate social responsibility.⁴²

In the end, domestic regulatory governance has much more in common with global health governance than it might first seem, even though these commonalities operate at different scales and within a different geographic scope. The types of problems that motivate global health governance also motivate regulatory governance. And just as global health governance comprises a broad, even eclectic, “set of standards, institutions, rules, norms, and regulations,”⁴³ so too does regulatory governance comprise a pluralistic and intersecting set of internal and external behavioral drivers, as well as governmental and nongovernmental standards. As Prah Ruger shows, “[b]oth state and non-state actors are important instruments in achieving global health justice,”⁴⁴ and so too are both state and non-state actors pivotal to the efficacy of regulatory governance in delivering public health within the confines of a particular national or subnational jurisdiction.

COMMON CHALLENGES

As a result of these similarities in both problems and solutions, it should come as little surprise that many of the challenges that “vex” global health governance also often vex regulatory governance. Prah Ruger describes an array of challenges at the global level: “hyperpluralism and fragmentation”; “incoherence, disorder, and inefficiency”; “blurred lines of responsibility”; “actors with divergent interests”; controversial “normative principles and processes”; policy uncertainties and shortage of data and “analysis of ... problems”; power imbalances that lead some actors to exert “excessive political influence” of self-interested actors; and a lack of “credible compliance and dispute resolution mechanisms.”⁴⁵

This list describes astonishingly well the challenges that confront domestic regulators in advanced pluralist societies. Regulators in the United States and Europe, for example, find themselves increasingly operating in an environment of growing inequality, polarization, and adversarialism.⁴⁶ The U.S. governing system in particular is said to lack “socially desirable incentives; rational selection of ends and means; accurate, unbiased, up-to-date information; the capacity to adapt promptly and flexibly to a changing policy environment; credibility to those actors whose expectations and responses will ultimately determine policy success or failure; and a bureaucracy that can manage and implement policies effectively in the real world.”⁴⁷ The rise of the internet and social media has made sleepy backwaters of regulatory policy-making much more contentious, and the emergence of populism and still uglier forms of nationalism only add to today’s challenges.⁴⁸ One need only look to ethnic conflicts, civil strife, and social movements as varied as Brexit, the Tea Party, Yellow Vests, and the Arab Spring to see the disruptive politics confronting domestic governance.

When Prah Ruger observes that *shared* health governance—her aspirational but also positive or descriptive account of global health governance—depends largely on voluntary acceptance of norms, she could be writing about domestic regulatory governance as well. As she puts it, governance at the global level depends on an “overarching principle [of] voluntary compliance rising from common values, shared norms, and both substantive and procedural legitimacy.”⁴⁹ Shared health governance, she writes, “relies on persuasion, education, and social movements to shape positive moral norms.”⁵⁰ This is not qualitatively distinct from domestic regulatory governance. Admittedly, domestic regulation does afford the possibility of inducing behavioral compliance by way of punitive sanctions that transnational institutions cannot mete out to enforce international norms. Even though the importance of such enforcement power should not be discounted, regulators also aspire to solve problems rather than just impose penalties for their own sake.⁵¹ It marks success if regulators reach a point where threats and sanctions are no longer needed.

At the domestic level, much regulatory compliance is effectively voluntary. This fact probably cannot be overstated. Domestic regulators rarely have oversight officers physically present at regulated industrial operations to observe them on a continuous basis. The number of inspectors needed to visit each regulated entity in any country’s economy, even just on annual basis, would likely well exceed available public resources. As a result, most regulated businesses, most of the time, escape any direct oversight of their compliance with regulation. And yet, compliance still occurs. Regulatory authorities depend on widely shared norms about the legitimacy of the law to induce compliance.⁵² As Peter Schuck has written, “the mass compliance necessary for effective policy implementation depends far less upon episodic agency enforcement than upon a fragile condition: citizens’ internal sense of the rectitude, competence, and legitimacy of the law and of the officials who administer it.”⁵³

In the end, the differences between global governance challenges and domestic governance challenges are much less profound than they might first seem—at least as would seem apparent from the much too separated worlds that global governance scholars and regulatory governance scholars tend to inhabit. These differences between levels of governance are more a matter of degree than of kind. They are differences also in the units of analysis emphasized: individuals and firms for regulatory governance; nation-states and international actors for global governance. But they are not so different in terms of their basic underlying problems, solutions, and challenges.

At any level, governance is about securing order, changing behavior, and managing disputes—all in an ever-changing world of competing interests and ideas. As such, governance is never easy, nor has it yet proven entirely satisfactory on any level.⁵⁴ Still, once a greater number of scholars and policy actors recognize the commonalities between the realms of global and domestic governance, it should then become easier to learn lessons from each realm.

LESSONS FOR REGULATORY GOVERNANCE

A number of leading regulatory scholars—John Braithwaite, Susan Rose-Ackerman, Charles Sabel, and Richard Stewart, to name a few—already have recognized commonalities between the domestic and global realms of governance and made important contributions to understanding governance of both kinds. But too many other

regulatory scholars tend toward a more limited focus solely on governance at the domestic level, passing up opportunities to learn from research on global governance. In addition to the much-too-separate realms inhabited by scholars, regulatory decision-makers could also learn much from those who study global governance. For anyone who tills mainly in domestic regulatory fields, Prah Ruger's *Global Health Justice and Governance* inspires valuable lessons about the priorities and principles of high-quality domestic regulation.

At least seven lessons for national and subnational regulators can be gleaned from Prah Ruger's account of global health governance and especially from her case for a "shared" governance system grounded ultimately in a commonly accepted set of values and norms which intrinsically motivate the action needed to deliver global health justice.⁵⁵ Given the necessary interdependence that Prah Ruger rightly recognizes exists between global health governance and domestic regulatory governance, domestic regulators have much they can learn from her illumination of the governance challenges associated with the quest for global health justice. Greater consideration of the following lessons could help promote not only improved health conditions at the national level, but also an improved health justice at the global level.⁵⁶

1. *Pay attention to the distribution of regulatory outcomes and not merely their aggregate levels.*

Prah Ruger argues throughout her book for improvements in global health justice in distributional terms. She is rightly troubled by today's gross disparities in both health outcomes and available health care resources. Using the level of health needed to sustain human flourishing as a benchmark, she emphasizes how people in different parts of the world lack even this basic floor.⁵⁷ Public health officials around the world thus need to reduce shortfalls or gaps between that optimal floor and present-day reality.⁵⁸ As she explains, "the health goals of a just society are to ensure all individuals have the ability to be healthy."⁵⁹ This approach does not demand that everyone in fact achieve identical levels of health. Nor does it deny the importance of efficiency and other aggregate measures of human welfare and development. After all, economic development provides an important pathway toward health justice. But justice does necessitate global movement toward minimizing what Prah Ruger terms "shortfall inequality"—that gap between needs and reality.⁶⁰ It means reducing the number of people who lack basic health resources and acceptably safe conditions in which to work and live.

Domestic regulators and regulatory scholars have an obvious role to play making progress toward health justice. Building codes, environmental regulations, and workplace health and safety standards all purport to deliver benefits that promote healthy conditions for the overall public, including those with the least resources. Yet regulators too seldom see themselves as in the business of promoting equality—whether of health or of any other regulatory goal. The principal metric for both regulatory design and evaluation has long tended to focus on aggregate effects—whether benefits overall justify costs overall.⁶¹ Under the Kaldor-Hicks efficiency framework, as long as benefits exceed costs, a regulatory policy will be deemed successful. Seldom do regulators concern themselves with explicitly assessing how regulations' benefits and costs are distributed across different segments of society. Even when regulatory agencies are supposed to consider the "distributive impacts" of their regulations,⁶² in practice they rarely conduct any systematic analysis of the distribution of regulatory costs and benefits.⁶³

This lack of attention may stem, at least in part, from some uncertainty about exactly how to factor the distribution of impacts into any specific regulatory decision. How much regressivity in the distribution of regulatory impacts ought to be tolerated? Does the tolerable level depend on the size of the overall net benefits of the regulation? Perhaps if a new regulation results in benefits vastly outweighing its costs, then it should not matter if those with greater income or wealth in society are shown to benefit to a somewhat greater degree. To date, though, no common professional agreement has yet to be reached over what might constitute a tolerable level of regressivity in regulatory impacts nor over how tradeoffs between overall welfare and equity should be made.⁶⁴ Certainly nothing like the clear benchmark offered by the Kaldor-Hicks framework for efficiency exists for assessing the distribution of regulatory impacts.

Even if such a benchmark did exist, there would still be a question of whether regulation is the appropriate policy arena within which to pursue distributional justice. Perhaps if a market failure exists and regulation fixes it, then that should be the end of the analysis and any resulting inequities created by the regulation would be better addressed through other programs and policies specifically aimed at redistribution.⁶⁵ But even if that is so, the need for distributional analyses of regulatory impacts would still remain important. For one thing, even if regulators should mainly focus on aggregate net benefits, the possibility that a particular regulation or regulatory program might on occasion result in highly skewed regulatory impacts that severely harm already disadvantaged individuals in society should at least lead regulators to adjust their policy actions in those instances to reduce those harms. Furthermore, the mere step of identifying the distribution of regulatory effects could influence support for other social policies to offset the inequities. If regulators do little to estimate and disclose publicly the distribution of impacts, then tax or spending policies to offset regulations' distributional inequities may be less likely ever to be pursued.⁶⁶ It would be valuable for domestic regulators to heed the message in Prah Ruger's book by doing more to emphasize equality concerns in regulatory governance.

2. *Use hard law strategically to reinforce soft law.*

Prah Ruger's vision for "shared health governance" driven by widely accepted norms seems the apotheosis of soft power.⁶⁷ Still, Prah Ruger recognizes that the full attainment of shared health governance cannot magically arise on its own accord. It depends on an iterated set of interactions between global health institutions and nation-states. In this regard, she acknowledges that "sanctions, incentives, and punishments can be helpful."⁶⁸ Global actors can provide incentives for state action, and states in turn can then build up their own capacities to deliver on the promise health justice. Ideally, in the end, such iteration and progression lead to an equilibrium in which global and national actors follow shared norms to carry out responsibilities in ways that rely on their respective comparative advantages.⁶⁹

This model of shared health governance for the achievement of global health justice mirrors an excellent strategy for domestic regulation. Regulators will rarely, if ever, possess the resources needed to oversee all the actions of all the individuals and entities whose behavior regulation seeks to affect. As a result, regulatory organizations need to deploy their scarce resources strategically, trying to maximize public value from the steps that they are able to take.⁷⁰ That means recognizing that punitive action is

costly—both in what it takes to document and enforce violations, but also in the potential for making regulation seem unreasonable and sparking resistance by regulated actors.⁷¹ Regulators must use their limited enforcement resources wisely, such as by targeting actors that pose the greatest risks to society.

When they approach regulatory encounters in a responsive fashion—that is, by first seeking to treat legal violations as problems to solve, and only later escalating punitively in response to regulated entities’ recalcitrance and resistance—regulators often seek to reinforce social norms, even if they do not necessarily substitute completely for them.⁷² They frequently see their role not as a lone sheriff in town, but rather as an integral part of a larger social system shaping private behavior.⁷³ Especially in the face of limited capacities for monitoring and oversight, they need to use their resources to complement, reinforce, and leverage private motivations and non-legal norms that can support socially optimal behavior.⁷⁴

3. Preserve and strengthen institutional trust and legitimacy.

Social norms also affect the levels of public support, trust, and legitimacy that surround both domestic and international governing institutions. Prah Ruger acknowledges a set of process-oriented norms, such as those calling for institutions to exhibit neutral decision-making, transparency, and public participation.⁷⁵ She also importantly recognizes a relationship between legitimacy and the substantive performance of any governing institution. This relationship manifests itself in two ways.⁷⁶ First, an institution’s substantive performance improves the degree of trust and legitimacy it earns from the public. Institutions that fail to deliver on the promise of improved health outcomes and equity will hardly engender much confidence, while those that deliver consistently high levels of substantive success will gain greater trust. Second, by adhering to fair, open, and accountable procedures, institutions build and maintain trust and legitimacy that in turn strengthens their ability to achieve substantive success. As Prah Ruger explains, global health governance “needs impartial institutions that engender trust and legitimacy” because “[o]nly this kind of institution can inspire acceptance and adherence.”⁷⁷

This is also true for domestic regulators. At the same time that these national and subnational institutions exist to deliver substantive regulatory outcomes, their leaders also will do well to attend to “perceptual outcomes,” such as public confidence, trust, and legitimacy.⁷⁸ These perceptual outcomes amount to resources that are perhaps even more valuable than fiscal resources in terms of a regulatory body’s ability to achieve its mission. Trust and legitimacy can affect the level of voluntary compliance with regulations. They also help make it more likely that the regulatory body will receive the political support and budgetary outlays essential for substantive success.

Perhaps nowhere has the importance of perceptual resources been better documented than with Dan Carpenter’s detailed history of the U.S. FDA.⁷⁹ Carpenter demonstrates how the agency benefited for many decades from its ability to inculcate a reputation for scientific rigor and regulatory integrity. Of course, in more recent years, the FDA has struggled at times to live up to the stellar regulatory reputation it once held, encountering criticism over delays in its drug approval process and controversies over perceived regulatory oversteps, such as with respect to its assertion of authority to regulate tobacco in the 1990s. Most recently, the agency’s perceived initial slowness to

respond to the CoV-2 outbreak has put a critical spotlight on the FDA, and it continues to struggle to find an appropriate balance with respect to regulatory oversight of coronavirus testing, treatment, and vaccines.

In fairness, of course, the current pandemic puts an enormous strain on nearly every institution. But the pandemic also demonstrates how vital it is, in times of crisis, for pivotal domestic regulators to be able to draw upon a reservoir of legitimacy and trust. In the end, the path toward the restoration of the economy following the Great Pandemic of 2020 will likely depend on whether members of the public have confidence that their governmental institutions will adequately ensure their health and safety if they return to normal life.⁸⁰ Pandemics make crystal clear what is also true in normal times: effective governance depends on trust—and the best regulators always seek to earn that trust, both through how they act and by what they achieve.⁸¹

4. *Be vigilant and dynamic in the face of changing behavior and conditions.*

The world is constantly changing, with many moving parts interacting in different ways over time. As a result, to be effective, governance must remain a continuously active undertaking. Prah Ruger wisely warns against “indecisiveness”⁸² and a “fail[ure] to act.”⁸³ She urges a shared health governance that “is dynamic, addressing current and future challenges.”⁸⁴

In addition, Prah Ruger illustrates the dire consequences that can arise from inaction by recounting the 2007 fiasco involving Atlanta lawyer Andrew Speaker, who tested positive for a highly resistant strain of tuberculosis. Due to feeble efforts by public health officials in the state of Georgia, Speaker managed to take multiple international flights after having been diagnosed with tuberculosis and warned not to travel. Prah Ruger places much of the fault for the resulting public health dangers on the shoulders of the state of Georgia (ironically, where the U.S. CDC is headquartered) due to the state’s failure to provide “adequate surveillance, reporting, intervention, and personnel training.”⁸⁵

Prah Ruger’s example shows what can happen when domestic regulators succumb to “dithering” in the face of new risks or changing circumstances.⁸⁶ More generally, the example provides a still broader lesson for regulators of all kinds never to treat the world as static. Economic and social conditions are constantly in flux; new technologies and new risks are regularly emerging. Regulation will not succeed if it is viewed a matter of just putting rules on the books. It must be agile and responsive.

Effective regulation requires active “obligation management”—adding new requirements, modifying or lifting existing ones, monitoring conditions and overseeing compliance, and variously cajoling and threatening as needed.⁸⁷ Regulatory effectiveness requires staying vigilant as to how regulated entities adapt in response to regulatory requirements. Even after a regulation is adopted, regulated entities are still likely to have interests at odds with the purposes of the regulation and therefore they will still have self-interested reasons to try to defeat or circumvent those purposes.⁸⁸ “Agility” and “adaptability” may not be the kinds of adjectives that most people immediately associate with regulation, but many regulatory problems could be avoided with greater responsiveness by the leaders of regulatory organizations in the face of new problems or changes in industry behavior.⁸⁹

5. *Coordinate with other actors and institutions.*

At the global level, cooperation and coordination is essential. As Prah Ruger notes, “[m]ost observers agree that improving global health in the twenty-first century will require coordination and cooperation among states, using both legal and non-legal mechanisms.”⁹⁰ Global health justice also requires coordination with various international institutions and non-state actors. It makes sense that Prah Ruger labels her aspirational model as one of *shared* health governance:

No one (or set of) institution(s) or actor(s) on its own is able to perform [the] core functions and meet [the] fundamental needs [of global health justice]. As such, [shared health governance] parcels out respective roles and responsibilities at the global, state, local, and individual levels based on functional requirements and needs, identifying actors and institutions, their obligations, and how they are held accountable.

In short, global health governance is a team sport. One might even say that it takes a village to govern the global village.

The same applies with domestic regulatory governance. No regulatory organization on its own can gather all needed information, observe all possible regulated conduct, or change everyone’s behavior.⁹¹ To activate the behavioral change needed to solve problems, domestic regulatory bodies often work best if they fulfill a role akin to the conductor of an orchestra—that is, by directing and steering others and leveraging businesses’ own capacities to fulfill regulatory functions.⁹²

In the end, “[a] regulator’s performance depends on other institutions and entities in the overarching nexus of relationships within which it is embedded.”⁹³ The initial creation of a regulatory organization necessarily depends on others—e.g., members of a legislature—who give the regulatory body its authority, define its mandate and its legal constraints, and determine its funding and staffing levels. The regulatory organization is also embedded in a larger governmental system comprising other administrative agencies and bodies at different levels of government that interact with and affect the regulatory organization’s ability to carry out its mandate. The degree of public trust and legitimacy that the regulator enjoys will also be partly affected by the overall political environment within which it is situated. Because “[t]he regulator is just part of an overall ‘system’ that includes both other governmental entities as well as the industry that it regulates,” it must learn to act strategically and in coordination with these various other moving parts of the governance system.⁹⁴

6. *Draw on a rigorous base of evidence and analysis.*

A domestic regulator, as with any institution involved in global health governance, can only expect to make sound decisions when its leaders are informed by the best available evidence and by carefully considered analysis. This is an obvious but too often neglected lesson that bears repeating.

This lesson follows directly from Prah Ruger’s emphasis on the significant role for “empirical evidence of effectiveness, efficiency, and accountability” in global health governance.⁹⁵ She favors reliance on “evidence-based standards and best practices” for

public health interventions,⁹⁶ and warns appropriately that “[u]nintended consequences are always a danger.”⁹⁷ She proposes a “Global Institute of Health and Medicine” that “would provide the needed scientific knowledge to craft effective policies and inform both domestic and global systems.”⁹⁸

In much the same way, domestic regulatory decision-makers must seek out the best available scientific and economic analysis to inform policy and management decision-making. Yet the systematic development of regulatory analysis remains of relatively recent vintage and to date has been limited to mainly the prospective analysis of new regulations—so-called “RIA” or “regulatory impact assessment.”⁹⁹ Although RIA practices can now be found in all the major economies, the same cannot be said of retrospective evaluation of regulations once adopted.¹⁰⁰ Furthermore, numerous opportunities remain for regulators to strengthen their use of data analytics in enforcement and oversight management.¹⁰¹

With the rise of populism around the world, certain countries are showing signs of devaluing expertise.¹⁰² At various points during the COVID-19 crisis, for example, the heads of state in the United States and Brazil openly flouted recommendations from scientists.¹⁰³ U.S. President Donald Trump even endorsed the use of unproven and potentially dangerous medications, and he planted seeds of doubt about public health data on CoV-2 cases and fatalities.¹⁰⁴ Not only do such actions undermine public trust and legitimacy, they may also encourage risky behavior that only exacerbates a public health crisis. Needless to say, domestic governance still can benefit from greater reliance on empirical evidence and analysis.

7. *Treat regulation as a relational activity rather than a mechanistic structure.*

As vital as it is for regulatory decisions to be informed by evidence and analysis, it is also important not to mistake regulation for little more than a challenging mathematical or engineering problem that can be solved by finding the right answer. As many of the preceding lessons already suggest, domestic regulation—as with governance more generally—is a *relational activity*. It is, at its best, very much “shared” governance in the fullest sense of that term: interactive and iterative, and intersecting with many different actors and sectors. Partly that is because the world is changing, with new regulated entities and restructured existing ones appearing constantly. But mainly regulation is relational because it is ultimately about human behavior and how to shape, direct, and modify that behavior. To regulate well requires actions taken by people in *regulatory* organizations to influence actions taken by people in *regulated* organizations, in the face of incentives and constraints created by other people in still other organizations. Regulation, in other words, is sociological.

Regulation’s sociological or relational character begins with its very origins. The process of initially authorizing regulation of a sector or an activity usually gives regulation the kind of public backing that Prah Ruger argues is needed to make progress toward global health justice.¹⁰⁵ The public backing which leads legislatures to pass regulation-authorizing legislation stems often from either broad social movements or from crises or catastrophes that make the need for regulation more evident to the broader public.¹⁰⁶ Regardless of new legislation’s precise path, the early years of any new regulatory regime tend to enjoy some political and social tailwinds behind it. Those tailwinds, and any new

social norms they engender, help reinforce the same behavioral changes that any new set of regulations will aim to foster.

Regulation does not operate in a social vacuum. It is situated in a social and political context that affects its performance and meaning. This is so despite the fact that many regulators and scholars still seem to treat the most important regulatory questions as being ones of how the rulebook should be written. These drafting and design questions are certainly not unimportant, and I would not suggest for a moment that they should be answered based on hunches instead of sound analysis. But getting the rule's design "right" is only part of the activity of regulating. The rules on the books are only part of the story.

Regulation is not a machine, but instead is an ongoing, and often conflict-ridden, set of relationships between people in and out of government. Recognizing this reality both follows from and reinforces many of the preceding lessons—such as those about wielding hard power to reinforce soft power, remaining vigilant and dynamic, and coordinating with others. Most importantly, such recognition helps to explain why domestic regulatory governance and global health governance have so much in common: they are both about shaping human behavior in ways that will advance societal objectives.

CONCLUSION

The relational and interactive nature of governance may be clearest on the global stage, where actors and institutions from many different cultures and legal systems must cooperate in a non-hierarchical social order. But that same relational, interactive character also describes governance at the domestic level. Global health governance and domestic regulatory governance share much in common, with some of the same general goals, strategies, and challenges. A realization of these commonalities should help facilitate greater cross-learning by scholars and practitioners who too often work within relatively limited domains. It is for this reason that an attentive reading of Jennifer Prah Ruger's recent book, *Global Health Justice and Governance*, can repay students of domestic regulation, offering a set of important lessons about how to approach the task of regulating well.

The Great Pandemic that emerged in 2020 has laid bare a number of harsh realities about inequities of health conditions and economic security around the world, revealing how much work remains to be done to deliver justice for all of humanity. The pandemic has also demonstrated the crucial role for high-quality domestic governance in successfully preventing and responding to global health problems.¹⁰⁷ The pursuit of excellence in domestic regulation will thus be integral to efforts to secure improved health conditions throughout the world. In that pursuit, regulators, policymakers, and members of the public will do well to keep in mind that regulation is not a self-implementing machine that operates separate from society. Regulation does not run on autopilot. Instead, it demands ongoing vigilance, adaptability, and responsiveness to changing circumstances and new risks. It requires adequate leadership, expertise, and resources to engage on an ongoing basis with a host of governmental and nongovernmental actors—not merely to deploy and enforce binding rules, but also to leverage social norms and other private pressures for behavioral change. Prah Ruger's model of shared health governance at the global level offers its readers an important vision for how regulators can best help make the world a better and healthier place.

Cary Coglianese is the Edward B. Shils Professor of Law and Professor of Political Science at the University of Pennsylvania Law School, where he also serves as the founding director of the Penn Program on Regulation. He specializes in the study of administrative law and regulatory processes, with an emphasis on the empirical evaluation of alternative processes and strategies and the role of public participation, technology, and business-government relations in policy-making.

¹ Kristian G. Andersen, Andrew Rambaut, W. Ian Lipkin, Edward C. Holmes, and Robert F. Garry, “The Proximal Origin of SARS-CoV-2,” *Nature Medicine* 26 (2020): 450–452, <https://doi.org/10.1038/s41591-020-0820-9>; Peng Zhou, Xing-Lou Yang, Xian-Guang Wang, Ben Hu, Lei Zhang, Wei Zhang, Hao-Rui Si, et al., “A Pneumonia Outbreak Associated with a New Coronavirus of Probable Bat Origin,” *Nature* 579 (2020), 270–273, <https://doi.org/10.1038/s41586-020-2012-7>.

² Jianjian Wei, Jie Zhou, Kitling Cheng, Jie Wu, Zhifeng Zhong, Yingchao Song, Changwen Ke, Hui-Ling Yen, and Yuguo Li, “Assessing the Risk of Downwind Spread of Avian Influenza Virus via Airborne Particles from an Urban Wholesale Poultry Market,” *Building and Environment* 127 (January 2018): 120–126, <https://doi.org/10.1016/j.buildenv.2017.10.037>; Xin-Lei Gao, Ming-Fei Shao, Yi Luo, Yu-Fang Dong, Feng Ouyang, Wen-Yi Dong, and Ji Li, “Airborne Bacterial Contaminations in Typical Chinese Wet Market with Live Poultry Trade,” *Science of the Total Environment* 572 (2016): 681–687, <https://doi.org/10.1016/j.scitotenv.2016.06.208>; George F Gao, “Influenza and the Live Poultry Trade,” *Science* 344 (2014): 235, <https://doi.org/10.1126/science.1254664>; Bruno B. Chomel, Albino Belotto, and François-Xavier Meslin, “Wildlife, Exotic Pets, and Emerging Zoonoses,” *Emerging Infectious Diseases* 13 no. 1 (2007): 6–11, doi: 10.3201/eid1301.060480; P.C. Woo, S.K. Lau, and K.Y. Yuen, “Infectious Diseases Emerging from Chinese Wet-markets: Zoonotic Origins of Severe Respiratory Viral Infections,” *Current Opinion in Infectious Diseases* 19, no. 5 (2006): 401–407, doi: 10.1097/01.qco.0000244043.08264.fc; Corrie Brown, “Emerging Zoonoses and Pathogens of Public Health Significance – an Overview,” *Revue scientifique et technique (International Office of Epizootics)* 23, no. 2 (2004): 435–442, <https://doi.org/10.20506/rst.23.2.1495>.

³ Research reveals the efficacy of a range of governmental regulatory interventions related to wildlife trade and open food markets, such as government mandated monthly market cleanings, control of the slaughter and sale of live animals, and targeted bans on the sale of wildlife and exotic animals. James Gorman, “China’s Ban on Wildlife Trade a Big Step, but Has Loopholes, Conservationists Say,” *New York Times*, February 27, 2020, <https://www.nytimes.com/2020/02/27/science/coronavirus-pangolin-wildlife-ban-china.html>; Hong Kong Food and Health Bureau, *Study on the Way Forward of Live Poultry Trade in Hong Kong: Final Report*, R9191/07, no. 5 (Hong Kong: BMT Asia Pacific, 2017), https://www.fhb.gov.hk/download/press_and_publications/consultation/170403_f_live_poultry_trade/e_consultancy_report_full.pdf; Y. H. Connie Leung, Eric H. Y. Lau, Li Juan Zhang, Yi Guan, Benjamin J. Cowling, and J. S. Malik Peiris, “Avian Influenza and Ban on Overnight Poultry Storage in Live Poultry Markets, Hong Kong,” *Emerging Infectious Diseases* 18, no. 8 (2012):1339–1341, doi: 10.3201/eid1808.111879; Peng Wu, Hui Jiang, Joseph T. Wu, Enfu Chen, Jianfeng He, Hang Zhou, Lan Wei, et al., “Poultry Market Closures and Human Infection with Influenza A(H7N9) Virus, China, 2013–14,” *Emerging Infectious Diseases* 20, no. 11 (2014): 1891–1894, <https://dx.doi.org/10.3201/eid2011.140556>.

⁴ Chad Terhune, Dan Levine, Hyunjoo Jin, and Jane Lanhee Lee, “Special Report: How Korea Trounced US in race to Test People for Coronavirus,” *Reuters*, March 18, 2020, <https://www.reuters.com/article/us-health-coronavirus-testing-specialrep/special-report-how-korea-trounced-u-s-in-race-to-test-people-for-coronavirus-idUSKBN2153BW>.

⁵ Joohee Cho and Hakyung Kate Lee, “South Korea’s Coronavirus Test Makers in High Demand,” *ABC News*, April 4, 2020, <https://abcnews.go.com/International/south-koreas-coronavirus-test-makers-high-demand/story?id=69958217>; Sean Fleming, “South Korea’s Foreign Minister Explains How the Country Contained COVID-19,” *World Economic Forum*, March 31, 2020, <https://www.weforum.org/agenda/2020/03/south-korea-covid-19-containment-testing/>.

- ⁶ Peter Whoriskey and Neena Satija, “How U.S. Coronavirus Testing Stalled: Flawed Tests, Red Tape and Resistance to Using the Millions of Tests Produced by the WHO,” *Washington Post*, March 16, 2020, <https://www.washingtonpost.com/business/2020/03/16/cdc-who-coronavirus-tests/>; Michael D. Shear, Abby Goodnough, Sheila Kaplan, Sheri Fink, Katie Thomas, and Noah Weiland, “The Lost Month: How a Failure to Test Blinded the U.S. to COVID-19,” *New York Times*, March 28, 2020, <https://www.nytimes.com/2020/03/28/us/testing-coronavirus-pandemic.html>; Joshua M. Sharfstein, Scott J. Becker, and Michelle M. Mello, “Diagnostic Testing for the Novel Coronavirus,” *The Journal of the American Medical Association* 323, no. 15 (2020): 1437–1438, doi: 10.1001/jama.2020.3864.
- ⁷ Jennifer Prah Ruger, *Global Health Justice and Governance* (New York: Oxford University Press, 2018).
- ⁸ Prah Ruger, 243.
- ⁹ Prah Ruger, 3–5, 10–11.
- ¹⁰ Thomas Lambert, *How to Regulate: A Guide for Policymakers* (New York: Cambridge University Press, 2017), 22–28; Stephen Breyer, *Regulation and its Reform* (Cambridge, MA: Harvard University Press, 1982), 23–36.
- ¹¹ Prah Ruger, 371.
- ¹² Prah Ruger, 237.
- ¹³ Prah Ruger, 13.
- ¹⁴ Organization for Economic Co-operation and Development, *International Regulatory Co-Operation: Rules for a Global World* (Paris: OECD Publishing, 2012), [http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=GOV/RPC\(2012\)8/REV1&docLanguage=En](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=GOV/RPC(2012)8/REV1&docLanguage=En); Organization for Economic Co-operation and Development, *International Regulatory Co-Operation: Addressing Global Challenges* (Paris: OECD Publishing, 2013), <https://www.oecd.org/env/international-regulatory-co-operation-9789264200463-en.htm>.
- ¹⁵ Prah Ruger, 15.
- ¹⁶ Cary Coglianese, Adam M. Finkel, and David Zaring, eds., *Import Safety: Regulatory Governance in the Global Economy* (Philadelphia: University of Pennsylvania Press, 2009); Jennifer Daskal, “Privacy and Security Across Borders,” *Yale Law Journal* 128 (2019): 1029-1051.
- ¹⁷ Department of the Treasury Office of Economic Policy, Council of Economic Advisers, Department of Labor, *Occupational Licensing: A Framework for Policymakers* (Washington, D.C.: 2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf; Janna E. Johnson and Morris M. Kleinberg, *Is Occupational Licensing a Barrier to Interstate Migration?*, Staff Report 561 (Minneapolis: Federal Reserve Bank of Minneapolis, 2017), <https://doi.org/10.21034/sr.561>
- ¹⁸ Melanie Grayce West, “Doctors from Across Country Are Volunteering in New York City Hospitals,” *Wall Street Journal*, April 16, 2020, <https://www.wsj.com/articles/doctors-from-across-country-are-volunteering-in-new-york-city-hospitals-11587054224>.
- ¹⁹ Prah Ruger, 6.
- ²⁰ Prah Ruger, 5.
- ²¹ Prah Ruger, 5.
- ²² Aanund Hylland and Richard Zeckhauser, “Distributional Objectives Should Affect Taxes but Not Program Choice or Design,” *The Scandinavian Journal of Economics* 81, no. 2 (1979): 264–284, doi: 10.2307/3439965.
- ²³ Olatunde C.A. Johnson, “Overreach and Innovation in Equality Regulation,” *Duke Law Journal* 66 (2017): 1771-1805.
- ²⁴ Robert D. Bullard, Glenn S. Johnson, and Angel O. Torres, *Environmental Health and Racial Equity in the United States: Building Environmentally Just, Sustainable, and Livable Communities* (Washington, D.C.: American Public Health Association Press, 2011); David M. Konisky, ed., *Failed Promises: Evaluating the Federal Government’s Response to Environmental Justice* (Cambridge, MA: The MIT Press, 2015).
- ²⁵ Prah Ruger, 18, 220.
- ²⁶ Prah Ruger, 17-18.
- ²⁷ Prah Ruger, 29; see also Ruger, ix, xiii, 123, 177, 232, 335-336, 376.
- ²⁸ Prah Ruger, 19.
- ²⁹ Prah Ruger, 19.
- ³⁰ Prah Ruger, 20.
- ³¹ Prah Ruger, 21.
- ³² Prah Ruger, 21.

- ³³ Orly Lobel, “The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought,” *Minnesota Law Review* 89 (November 2004): 262–390.
- ³⁴ Jonathan C. Borck and Cary Coglianese, “Voluntary Environmental Programs: Assessing Their Effectiveness,” *Annual Review of Environment and Resources* 34 (2009): 305–324, <https://doi.org/10.1146/annurev.enviro.032908.091450>.
- ³⁵ Cary Coglianese, “Getting the Blend Right: Public-Private Partnerships in Risk Management,” in *The Future of Risk Management*, eds. Howard Kunreuther, Robert J. Meyer, and Erwann O. Michel-Kerjan (Philadelphia: University of Pennsylvania Press, 2019), 325–343.
- ³⁶ Jennifer Howard, Jennifer Nash, and John Ehrenfeld, “Industry Codes as Agents of Changes: Responsible Care Adoption by US Chemical Companies,” *Business Strategy and the Environment* 8, no. 5 (1999): 281–295, [https://doi.org/10.1002/\(SICI\)1099-0836\(199909/10\)8:5%3C281::AID-BSE213%3E3.O.CO;2-%23](https://doi.org/10.1002/(SICI)1099-0836(199909/10)8:5%3C281::AID-BSE213%3E3.O.CO;2-%23).
- ³⁷ Joseph V. Rees, *Hostages of Each Other: The Transformation of Nuclear Safety Since Three Mile Island* (Chicago: University of Chicago Press, 1994).
- ³⁸ Cary Coglianese, “Private Standards and Public Governance,” *The Regulatory Review*, November 4, 2019, <https://www.theregreview.org/2019/11/04/coglianese-private-standards-public-governance/>; JoAnne Yates and Craig N. Murphy, *Engineering Rules: Global Standard Setting Since 1880* (Baltimore: Johns Hopkins University Press, 2019).
- ³⁹ Emily S. Bremer, “Incorporation by Reference in an Open-Government Age,” *Harvard Journal of Law and Public Policy* 36 (2013): 133–210.
- ⁴⁰ Over a dozen years ago, on the founding of an international peer-reviewed journal on regulatory governance, John Braithwaite, David Levi-Faur and Cary Coglianese noted that “[m]any regulatory scholars will say that they are interested not only in regulation by rules; they ... want to distinguish principles from rules or regulation through social norms from regulation through formal rules.” John Braithwaite, Cary Coglianese, and David Levi-Faur, “Can Regulation and Governance Make a Difference?” *Regulation and Governance* 1, no. 1 (2007): 1–7, <https://doi.org/10.1111/j.1748-5991.2007.00006.x>.
- ⁴¹ Neil Gunningham, Robert A. Kagan, and Dorothy Thornton, “Explaining Corporate Environmental Performance: How Does Regulation Matter?” *Law and Society Review* 37, no. 1 (March 2003): 51–90, <https://doi.org/10.1111/1540-5893.3701002>.
- ⁴² Neil Gunningham, Robert A. Kagan, and Dorothy Thornton, *Shades of Green: Business, Regulation, and Environment* (Stanford: Stanford University Press, 2003).
- ⁴³ Prah Ruger, 161.
- ⁴⁴ Prah Ruger, 161.
- ⁴⁵ Prah Ruger, 48–49.
- ⁴⁶ Thomas Piketty, *The Economics of Inequality*, trans. Arthur Goldhammer (Cambridge, MA: Harvard University Press, 2015); Robert A. Kagan, *Adversarial Legalism: The American Way of Law*, 2nd ed. (Cambridge, MA: Harvard University Press, 2019); Ezra Klein, *Why We’re Polarized* (New York: Avid Reader Press, 2020); Pippa Norris and Ronald Inglehardt, *Cultural Backlash: Trump, Brexit, and Authoritarian Populism* (New York: Cambridge University Press, 2019); R. Daniel Kelemen, *Eurolegalism: The Transformation of Law and Regulation in the European Union* (Cambridge, MA: Harvard University Press, 2011).
- ⁴⁷ Peter H. Schuck, *Why Government Fails So Often: And How It Can Do Better* (Princeton: Princeton University Press, 2014), 409–410. In addition to structural and political barriers to governmental success, it remains the case that the tasks that society entrusts to government are among the most difficult. Cary Coglianese, “Because It’s Hard,” *The Regulatory Review*, January 11, 2016, <https://www.theregreview.org/2016/01/11/coglianese-because-its-hard/>.
- ⁴⁸ Cary Coglianese, “Law as Scapegoat,” in *The Crisis of Confidence in Legislation*, eds. Maria De Benedetto, Nicola Lupo & Nicoletta Rangone (Baden-Baden, Germany: Nomos Verlagsgesellschaft, 2020), 337–365.
- ⁴⁹ Prah Ruger, 210.
- ⁵⁰ Prah Ruger, 212.
- ⁵¹ Malcolm Sparrow, *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance* (Washington, D.C.: Brookings Institution Press, 2000). For a similar perspective on managing compliance but at the international level, see Abram Chayes and Antonia Handler Chayes, *The New Sovereignty: Compliance with International Regulatory Agreements* (Cambridge, MA: Harvard University Press, 1998).
- ⁵² Tom R. Tyler, *Why People Obey the Law* (Princeton: Princeton University Press, 2006).

- ⁵³ Schuck, 410. This is not to deny, of course, that levels of compliance could still be better. Cynthia Giles, “Noncompliance with Environmental Rules is Worse Than You Think,” Harvard Law School Environmental and Energy Law Program (April 14, 2020), <http://eelp.law.harvard.edu/wp-content/uploads/Cynthia-Giles-Part-2-FINAL.pdf>.
- ⁵⁴ Cary Coglianese, “Is Government Really Broken?” *University of Pennsylvania Journal of Law and Public Affairs* 1 (2016): 68–96.
- ⁵⁵ Ruger, 371.
- ⁵⁶ Ruger rightly recognizes the necessary interdependence between global and domestic governance. Ruger, 232. The final chapter of her book offers guidance specifically on domestic governance and merits a particularly close reading by anyone interested in national or subnational public health policy. Ruger, 359–381.
- ⁵⁷ Prah Ruger, 83.
- ⁵⁸ Prah Ruger, 339.
- ⁵⁹ Prah Ruger, 340.
- ⁶⁰ Prah Ruger, 339.
- ⁶¹ This goal has been institutionalized in regulatory practices and procedures. For example, in the United States, Executive Order 12,866, which has governed federal regulatory decision-making for more than a quarter century, specifically calls for regulators to seek to ensure that the expected benefits of new regulations will “justify” their expected costs. An earlier, even stronger, manifestation of the same tendency to focus on aggregate effects had been reflected in Executive Order 12,866’s predecessor, Executive Order 12,291, which called for benefits to “outweigh” costs.
- ⁶² The principle that agencies should consider distributional impacts in addition to aggregate impacts is in fact reflected in the United States in Executive Order 12,866, even though nearly exclusive emphasis has been on net benefits rather than their distribution.
- ⁶³ Lisa A. Robinson, James K. Hammitt, and Richard J. Zeckhauser, “Attention to Distribution in U.S. Regulatory Analyses,” *Review of Environmental Economics and Policy* 10, no. 2 (Summer 2016): 308–328, <https://doi.org/10.1093/reep/rew011>.
- ⁶⁴ Arthur M. Okun, *Equality and Efficiency: The Big Tradeoff* (Washington, D.C.: Brookings Institution Press, 1975).
- ⁶⁵ Hylland and Zeckhauser, 266.
- ⁶⁶ For the elaboration of the value of distributional analysis of environmental regulation, see the report issued by the American Water Works Association based on an expert panel that I co-chaired: *Improving the Evaluation of Household-Level Affordability in SDWA Rulemaking: New Approaches* (Denver, Colo.: American Water Works Association 2021).
- ⁶⁷ Joseph S. Nye, Jr., *Soft Power: The Means to Success in World Politics* (New York: PublicAffairs, 2009).
- ⁶⁸ Prah Ruger, 373.
- ⁶⁹ Prah Ruger, 201–203, 376.
- ⁷⁰ Mark H. Moore, *Creating Public Value: Strategic Management in Government* (Cambridge, MA: Harvard University Press, 1995); Cary Coglianese, ed., *Achieving Regulatory Excellence* (Washington, D.C.: Brookings Institution Press, 2017).
- ⁷¹ Eugene Bardach and Robert A. Kagan, *Going by the Book: The Problem of Regulatory Unreasonableness* (Philadelphia: Temple University Press, 1982).
- ⁷² New Deal regulator Chester Bowles had something like this in mind when he famously observed that “20 percent of the regulated population will automatically comply with any regulation; 5 percent will attempt to evade it; and 75 percent will comply so long as they think that the 5 percent will be caught and punished.” Chester Bowles, *Promises to Keep: My Years in Public Life, 1941–1969*, 25 (New York: Harper & Row, 1971). For empirical research on the impact of how regulators can use limited resources to promote general compliance, see Dorothy Thornton, Neil A. Gunningham, and Robert A. Kagan, “General Deterrence and Corporate Environmental Behavior,” *Law & Policy* 27, no. 2 (April 2005): 262–288, <https://doi.org/10.1111/j.1467-9930.2005.00200.x>.
- ⁷³ As Ruger (242) puts it when discussing pandemic control, “a regulatory framework explicitly permitting legal action following a breach of trust must undergird voluntary compliance.”
- ⁷⁴ Cary Coglianese, “Environmental Soft Law as a Governance Strategy,” *Jurimetrics* 61, no. 1 (Fall 2020): 19–51; Cary Coglianese and Jennifer Nash, eds., *Leveraging the Private Sector: Management-Based Strategies for Improving Environmental Performance* (Washington, D.C.: Resources for the Future,

- 2006); Michael P. Vandenbergh and Jonathan M. Gilligan, *Beyond Politics: The Private Governance Response to Climate Change* (Cambridge: Cambridge University Press, 2017).
- ⁷⁵ Prah Ruger, 183–185.
- ⁷⁶ Prah Ruger’s treatment of the World Health Organization’s (WHO) struggles to maintain legitimacy as well as efficacy illustrates well the intertwined connections between substantive outcomes and procedural fairness. Ruger, 247–265.
- ⁷⁷ Prah Ruger, 180. Ruger also sees an important role for global and domestic institutions to foster “public will” in support for health justice, a role that will undoubtedly be aided by institutional trust and legitimacy. Ruger, 290–291.
- ⁷⁸ Cary Coglianese, *Listening, Learning and Leading: A Framework for Regulatory Excellence* (Philadelphia: Kleinman Center for Energy Policy, 2015), 75–76, https://kleinmanenergy.upenn.edu/sites/default/files/spotlightonresearch/Listening%2C%20Learning%2C%20Leading_Coglianese.pdf.
- ⁷⁹ Daniel Carpenter, *Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA* (Princeton: Princeton University Press, 2010).
- ⁸⁰ Maria De Benedetto, “Regulating in Times of Tragic Choices,” *The Regulatory Review*, May 6, 2020, <https://www.theregreview.org/2020/05/06/de-benedetto-regulating-times-tragic-choices/>.
- ⁸¹ David Vogel, “The Role of Policy Learning and Reputation in Regulatory Excellence,” in *Achieving Regulatory Excellence*, ed. Cary Coglianese (Washington, D.C.: Brookings Institution Press, 2017), 207, 221–222.
- ⁸² Prah Ruger, 241.
- ⁸³ Prah Ruger, 185.
- ⁸⁴ Prah Ruger, 201.
- ⁸⁵ Prah Ruger, 239.
- ⁸⁶ Prah Ruger, 185.
- ⁸⁷ Cary Coglianese, “Obligation Alleviation During the COVID-19 Crisis,” *The Regulatory Review*, April 20, 2020, <https://www.theregreview.org/2020/04/20/coglianese-obligation-alleviation-during-covid-19-crisis/>.
- ⁸⁸ Cary Coglianese and Jennifer Nash, “The Law of the Test: Performance-Based Regulation and Diesel Emissions Control,” *Yale Journal on Regulation* 34, no. 1 (2017): 33–90, https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=2714&context=faculty_scholarship.
- ⁸⁹ Cary Coglianese, “Regulatory Vigilance in a Changing World,” *The Regulatory Review*, February 25, 2019, <https://www.theregreview.org/2019/02/25/coglianese-innovation-regulatory-vigilance/>; Cary Coglianese, “Regulatory Abdication in Practice,” *University of Pennsylvania Institute for Law and Economics, Research Paper Series*, no. 20-11 (February 2020), <https://dx.doi.org/10.2139/ssrn.3535895>.
- ⁹⁰ Prah Ruger, 261.
- ⁹¹ Cary Coglianese, Richard Zeckhauser, and Edward A. Parson, “Seeking Truth for Power: Informational Strategy and Regulatory Policy Making,” *Minnesota Law Review* 89 (2004): 277–341.
- ⁹² Sometimes this role for a regulator is described as one of being a “meta-regulator.” Christine Parker, *The Open Corporation: Effective Self-regulation and Democracy* (Cambridge: Cambridge University Press, 2002).
- ⁹³ Coglianese, *Listening, Learning, and Leading*, 14.
- ⁹⁴ Coglianese, *Listening, Learning, and Leading*, 14.
- ⁹⁵ Prah Ruger, 184.
- ⁹⁶ Prah Ruger, 200–201.
- ⁹⁷ Prah Ruger, 243.
- ⁹⁸ Prah Ruger, 243.
- ⁹⁹ Claudio M. Radaelli, “Regulating Rule-Making via Impact Assessment,” *Governance* 23, no. 1 (January 2010): 89–108, <https://doi.org/10.1111/j.1468-0491.2009.01468.x>; Jonathan B. Weiner, “The Diffusion of Regulatory Oversight,” in *The Globalization of Cost-Benefit Analysis in Environmental Policy*, eds. Michael A. Livermore and Richard L. Revesz (New York: Oxford University Press, 2013); Organization for Economic Co-operation and Development, *OECD Regulatory Policy Outlook 2018* (Paris: OECD Publishing, 2018).
- ¹⁰⁰ Cary Coglianese, “Thinking Ahead, Looking Back: Assessing the Value of Regulatory Impact Analysis and Procedures for its Use,” *KLRI Journal of Law and Legislation* 3 (2013): 5–27, https://scholarship.law.upenn.edu/faculty_scholarship/2125/; Cary Coglianese, *Measuring Regulatory*

Performance: Evaluating the Impact of Regulation and Regulatory Policy, Expert Paper No. 1 (Paris: OECD Publishing, 2012), https://www.oecd.org/gov/regulatory-policy/1_coglianeseweb.pdf.

¹⁰¹ Cary Coglianese and David Lehr, “Regulating by Robot: Administrative Decision Making in the Machine-Learning Era,” *Georgetown Law Journal* 105 (2017): 1147–1223, https://scholarship.law.upenn.edu/faculty_scholarship/1734/; Cary Coglianese, “Optimizing Regulation for an Optimizing Economy,” *University of Pennsylvania Journal of Law and Public Affairs* 4, no. 1 (November 2018): 1–13, https://scholarship.law.upenn.edu/faculty_scholarship/2116/.

¹⁰² Tom Nichols, *The Death of Expertise: The Campaign Against Established Knowledge and Why it Matters* (New York: Oxford University Press, 2017).

¹⁰³ Lisa Friedman and Brad Plumer, “Trump’s Response to Virus Reflects a Long Disregard for Science,” *New York Times*, April 28, 2020, <https://www.nytimes.com/2020/04/28/climate/trump-coronavirus-climate-science.html>; Jamie McGeever and Stephen Eisenhammer, “Biggest Threat to Brazil Coronavirus Response? President Bolsonaro, Says The Lancet,” *Reuters*, May 8, 2020, <https://www.reuters.com/article/us-health-coronavirus-brazil/biggest-threat-to-brazil-coronavirus-response-president-bolsonaro-says-the-lancet-idUSKBN22K29I>.

¹⁰⁴ Toluse Olorunnipa, Ariana Eunjung Cha, and Laurie McGinley, “Drug Promoted by Trump as Coronavirus ‘Game Changer’ Increasingly Linked to Deaths,” *Washington Post*, May 15, 2020, https://www.washingtonpost.com/politics/drug-promoted-by-trump-as-coronavirus-game-changer-increasingly-linked-to-deaths/2020/05/15/85d024fe-96bd-11ea-9f5e-56d8239bf9ad_story.html.

¹⁰⁵ Ruger, 290. It is much that same kind of public will that is needed to make substantial progress in addressing climate change. Cary Coglianese, “Climate Change Necessitates Normative Change,” *The Regulatory Review*, January 27, 2020, <https://www.theregreview.org/2020/01/27/coglianeses-climate-change-necessitates-normative-change/>.

¹⁰⁶ John W. Kingdon, *Agendas, Alternatives, and Public Policies* (New York: Little, Brown, 1984).

¹⁰⁷ Cary Coglianese and Neysun A. Mahboubi, “Administrative Law in a Time of Crisis: Comparing National Responses to COVID-19,” *Administrative Law Review* 73 (2021): 1-18.

THE LINKS OF GLOBAL HEALTH GOVERNANCE, KNOWLEDGE AND PREMATURE MORTALITY

Prabhat Jha

One of Jennifer Prah Ruger's important contributions to global health justice in her pivotal book, *Global Health Justice and Governance*¹, is to propose the key conditions that can enable progress in global health. I define three such conditions as the "Prah Ruger Conditions", and provide examples of their relevance both to actual progress in global health and to the generation of knowledge to reduce premature mortality.

The Prah Ruger conditions comprise three interrelated ideas. First is a global desire to affect change on one or more specific health issues or a collective aspiration. The second is a shared health governance model based on the shared aspiration. The third criterion is the central role of public finance in enabling these conditions to effect actual health improvements.

Let us first consider the application of these conditions to improvements in child survival. Improved child survival is one of the most extraordinary human achievements of the last few decades. In 1970, fully 14% of all children born worldwide would die by their fifth birthday. That is now down to 5% and continuing to fall.² This progress has occurred in many settings, even in poorer states with low levels of governance. India has saved at least one million child lives since the launch of the National Health Mission in 2005, which aimed to fund basic public health functions. Since that time, the mortality gaps have narrowed between boys and girls, and poorer/low governance states have matched richer states in rates of progress to reduce child mortality.³ Analogously, *the Economist*, reviewing the progress in Africa, wrote that "*aid does not seem to have been the decisive factor in cutting child mortality. No single thing was. But better policies, better government, new technology and other benefits are starting to bear fruit.*"⁴

An alternative explanation of the progress in childhood mortality would be that it occurred because it met the Prah Ruger conditions. A collective aspiration to reduce child deaths was noted in several United Nations and global declarations. Political leaders were aware of the benchmarks for their countries. John McArthur has estimated that the Millennium Development Goals for 2015 led to preventing perhaps seven million child deaths.⁵ The second Prah Ruger condition fulfilled was of shared health governance with a reasonably small set of implementors. Indeed, UNICEF and the advocacy of its late leader James Grant to expand basic immunization and clinical care for sick children played a substantial role in accelerating declines in child mortality starting in the 1980s.⁶ A more recent and welcome foray by the Bill & Melinda Gates Foundation brought large levels of funding. Although Professor Prah Ruger and Professor Devi Sridhar have identified Gates funding as distortionary in many respects,^{7,8} the foundation's participation occurred within an overall collective framework and focused leadership (mostly by UNICEF and the World Health Organization (WHO)). Finally, while there is ongoing debate about the role of official developmental assistance (ODA), countries which spent more of their own domestic funding achieved substantial improvements in child survival. India's National Health Mission spent \$30 billion, mostly in domestic finance.⁹

A contrasting story emerges in examining childhood and adult malaria deaths. The remarkable improvements after World War II in premature mortality in many countries

where malaria was endemic occurred because of rapid and effective control of the disease, including the widespread use of DDT and other insecticides.¹⁰ Perhaps a third of the overall decline in mortality globally from 1940 to 2010 might have arisen from malaria control, driven by indoor residual spraying (IRS), but also from early anti-malarials like quinine.¹¹

However, until about 2000, no collective aspiration for malaria control across countries was established. This was in part due to the success of IRS programs leading to such dramatic improvements that, in India, for instance, malaria control programs were themselves dismantled (so while malaria was not eradicated, malariologists were!). In addition, while DDT and other insecticides were used widely outside of Africa, within Africa most control programs did not implement IRS within malaria control programs (which were otherwise weak) for much of the time period from 1970 to 2000. This was due in part to claims (now mostly viewed as exaggerated) about harms of DDT if it appeared in the food supply. These claims led the United States and other western countries to ban DDT exports, even for malaria control. The result was that many African malaria control programs were denied an effective, inexpensive tool that already had been used widely and safely outside of Africa to reduce malaria deaths.¹² The delay in meeting the collective aspiration also arose due to increasing resistance to drugs and insecticides. Thus, inadequate science has contributed to a large number of avoidable child deaths in Africa. More recent studies showing that malaria is an important cause of childhood and adult mortality in India¹³ and in Africa¹⁴ have helped contribute to a renewed interest in malaria control, with proposals for better shared health governance models about control of the disease.

This raises then a key point which Professor Prah Ruger addresses, particularly in her proposed Global Institute of Health and Medicine, but which probably requires exploration in future scholarship. Global health justice approaches likely differ when generation of new knowledge is the key goal, versus the delivery of existing knowledge to control diseases. Prah Ruger's global health justice framework addresses both. In the case of childhood deaths, a substantial body of global research led to creation of effective tools, such as vaccines, antibiotics, oral rehydration therapies and other interventions. These help explain why the inflation-adjusted cost of saving a child's life today is lower than it was in 1970 (and conversely, the relative lack of investment in adult health research is why it is more costly to save an adult's life now than earlier).¹⁵ In the case of malaria, research into newer drugs and insecticides is required to guard against growing resistance to current tools.

A future serious examination of global health governance for research and development and knowledge generation would no doubt draw upon the emerging lessons from the ongoing COVID-19 pandemic. First, the welcome and largely "open-source" data sharing of the viral sequences and information on transmission of the virus has helped the world create diagnostic tests, accelerate vaccine development and enable public health actions. Yet, missing from global calls for action was the identification of a few key priority areas where existing knowledge is insufficient. This includes better understanding the role of asymptomatic infection, the reasons why some countries (such as Vietnam and Thailand) have had such low levels of infection and mortality, and understanding the determinants, including chronic diseases, obesity and smoking, that might help explain the remarkable variation in COVID-19 death rates across affected countries.¹⁶

More generally, knowledge, often created by universities, has played an outsized role in the remarkable improvement in health (in part as the technological innovations in health are uniquely large - perhaps more than those in education).¹⁷ Most universities are publicly financed, and universities, particularly in dense urban areas, have been well-recognized contributors to innovation.¹⁴ Many specific technologies used globally in recent decades arose from public finance for university-funded research. For example, the breakthrough of protease inhibitors for AIDS treatment in the 1990s drew from failed cancer drug discovery funded by the National Cancer Institute in the 1980s.¹⁸

Generating global health knowledge to meet shared global aspirations would also require re-examining the role of ODA, particularly as creation of new drugs, diagnostics, vaccines, therapeutics, research protocols and risk factor epidemiology provides global public goods that many countries can use concurrently. One such proposal has focused on scaling up vaccines against COVID-19¹⁹. It is likely that the Prah Ruger conditions would also hold for an expansive effort to create such knowledge: collective aspiration, shared health governance models and public finance.

Prabhat Jha is University Professor at the University of Toronto and Director of the Centre for Global Health Research at Unity Health, Toronto.

¹ Prah Ruger JP. *Global Health Justice and Governance*. OUP, Oxford, 2011

² Norheim OF, Jha P, Admasu K, et al R. Avoiding 40% of the premature deaths in each country, 2010-30: review of national mortality trends to help quantify the UN sustainable development goal for health. *Lancet*. 2015 17;385(9964):239-52. doi: 10.1016/S0140-6736(14)61591-9.

³ Million Death Study Collaborators. Changes in cause-specific neonatal and 1-59-month child mortality in India from 2000 to 2015: a nationally representative survey. *Lancet*. 2017;390(10106):1972-1980. doi: 10.1016/S0140-6736(17)32162-1.

⁴ Economist, The best story in development. May 19, 2012 <https://www.economist.com/middle-east-and-africa/2012/05/19/the-best-story-in-development>

⁵ McArthur J. Seven Million Lives Saved: Under-5 Mortality Since the Launch of the Millennium Development Goals (September 25, 2014). Brookings Global Economy and Development Working Paper No. 78, <http://dx.doi.org/10.2139/ssrn.2506871>

⁶ Hum RJ, Jha P, McGahan AM, Cheng YL. Global divergence in critical income for adult and childhood survival: analyses of mortality using Michaelis-Menten. *Elife*. 2012;1:e00051. doi: 10.7554/eLife.00051.

⁷ Prah Ruger JP. *Global Health Justice and Governance*. OUP, Oxford, 2018

⁸ Van de Pas R, Hill PS, Hammonds R, et al. Global health governance in the sustainable development goals: Is it grounded in the right to health? *Glob Chall*. 2017 1(1):47-60. doi: 10.1002/gch2.1022.

⁹ Million Death Study Collaborators. Changes in cause-specific neonatal and 1-59-month child mortality in India from 2000 to 2015: a nationally representative survey. *Lancet*. 2017;390(10106):1972-1980. doi: 10.1016/S0140-6736(17)32162-1.

¹⁰ Davis K. The amazing decline of mortality in underdeveloped areas. *Amer Econom Rev*. 1956 46(2): 305-18.

¹¹ Jamison DT, Jha P, Malhotra V, Verguet S. Human Health: The Twentieth-Century Transformation of Human Health – Its Magnitude and Value. In: Lomborg B, ed. *How Much Have Global Problems Cost the World?: A Scorecard from 1900 to 2050*. Cambridge: Cambridge University Press; 2013:207-246. doi:10.1017/CBO9781139225793.009

¹² Zubrin R. The Truth About DDT and Silent Spring. *The New Atlantis* Sept 12, 2012; <https://www.thenewatlantis.com/publications/the-truth-about-ddt-and-silent-spring>

-
- ¹³ Dhingra N, Jha P, Sharma VP, et al. Adult and child malaria mortality in India: a nationally representative mortality study. *Lancet* 2010; 376: 1768-74.
- ¹⁴ Gelband H, Bogoch II, Rodriguez PS, et al. Is Malaria an Important Cause of Death among Adults? *Am J Trop Med Hyg.* 2020 Jul;103(1):41-47. doi: 10.4269/ajtmh.20-0036. Epub 2020 Apr 16.
- ¹⁵ Hum RJ, Jha P, McGahan AM, Cheng YL. Global divergence in critical income for adult and childhood survival: analyses of mortality using Michaelis-Menten. *Elife.* 2012;1:e00051. doi: 10.7554/eLife.00051.
- ¹⁶ Brown P, Jha P for the Global Coronavirus Assessment Model (GCAM) Group: Mortality from COVID-19 in 12 countries and 6 states of the United States. medRxiv 2020; (published online 22 April 2020) DOI: 10.1101/2020.04.17.20069161
- ¹⁷ Jamison DT, Jha P, Malhotra V, Verguet S. Human Health: The Twentieth-Century Transformation of Human Health – Its Magnitude and Value. In: Lomborg B, ed. *How Much Have Global Problems Cost the World?: A Scorecard from 1900 to 2050*. Cambridge: Cambridge University Press; 2013:207-246. doi:10.1017/CBO9781139225793.009
- ¹⁸ Maksimovic-Ivanic D, Fagone P, McCubrey J, et al. HIV-protease inhibitors for the treatment of cancer: Repositioning HIV protease inhibitors while developing more potent NO-hybridized derivatives? *Int J Cancer.* 2017;140(8):1713-1726. doi: 10.1002/ijc.30529
- ¹⁹ Jha P, Jamison DT, Watkins DA, Bell J. A global compact to counter vaccine nationalism. *Lancet* 2021 (in press- online May 13th)

THE URGENCY OF MUTUAL COLLECTIVE ACCOUNTABILITY IN GLOBAL HEALTH GOVERNANCE

Jillian Clare Kohler

Prah Ruger proposes a new way forward in global health, focusing on shared health governance that prioritizes the global and domestic duty to achieve health equity. Within this enterprise is the concept of Mutual Collective Accountability (MCA). MCA is urgently needed in global health governance to foster a sense of solidarity amongst countries and bring global cooperation into force. The relevance of MCA is heightened today given the imperatives of global cooperation to meet the challenges of the COVID-19 pandemic.

INTRODUCTION

During the COVID-19 pandemic, we have witnessed deep deficits in global health governance, resulting in global collective losses.¹ The pandemic continues to yield substantial costs in terms of lives lost, morbidity, psychological stress, and economic losses.^{2,3} Nationalism has also emerged quite forcefully in some countries.⁴ That is to say, attention to the global community has been cast aside for a “my-nation-first” approach. This has included actions by certain countries to enforce trade protectionism on critical medical supplies, such as personal protective equipment (PPE), export controls on COVID-19 vaccines and to shore up an abundance of vaccine supply for their populations through multiple agreements with suppliers,⁵ as but a few examples. Paradoxically, as Jennifer Prah Ruger (2020) emphasizes, the COVID-19 pandemic is also illuminating our “*global and domestic interdependencies and shared vulnerabilities.*”⁶ Emphasizing our interdependencies and fostering global cooperation are essential if we hope to make substantial health gains in this pandemic globally and deter the amplification of state self-interest, such as vaccine nationalism, which only will lead to further collective losses. As a concrete example the Director General of the World Health Organization underscored recently, “*vaccine nationalism is not just morally indefensible... (it) is epidemiologically self-defeating and clinically counterproductive.*”⁷

The concept of MCA put forward by Prah Ruger, in *Global Health Justice and Governance*⁸ and in her empirical work⁹, is featured in the larger global health enterprise that she advances to correct global health governance (GHG). Indeed, GHG is messy given overlapping mandates between global health actors, competition and duplication of health activities and programming amongst them, and poor coordination, to name but a few.¹⁰ Recognizing this, Prah Ruger proposes a bold global health model that moves in a much-needed “new way forward”¹¹ based on the concept of shared health governance (SHG) that prioritizes both the global and domestic duty to achieve health equity. MCA is featured in this model and involves having a common goal for global health actors, a set of standards and, what stands out in terms of its practical application, measurable key indicators.¹² In terms of current global health priorities, MCA offers the global community potential, and even hope, in terms of achieving global equity of access to COVID-19 vaccines.

Prah Ruger's MCA is theoretically appealing, has clarity and is practical. This is refreshingly welcome as the concept of accountability, which MCA hinges upon, is too often obfuscated in the global health space. Clarity matters, because if we do not know specifically what accountability means, its authenticity is undercut. It is superbly easy within the global health space, to make accountability opaque. This is not surprising, given the multitude of actors included in the space, uncertainty about who is accountable to whom, how and when, and wide definitional differences in terms of what accountability means as a concept and how to put it into practice.

Indeed, the complexity and ambiguity of accountability continue to be a persistent challenge in global health governance. At the most basic level, we often grapple to understand what accountability means specifically and how it is different from responsibility.¹³ Accountability may in fact be understood, in very simple terms, as one group of actors holding another group accountable for their actions.¹⁴ Yet this definition is hardly satisfactory if we seek to generalize it. How stakeholders define and implement accountability may vary across countries and institutional contexts – as found by Vian et al.¹⁵

To elaborate, forms of accountability may very well depend on circumstantial factors.¹⁶ We have a plethora of accountability forms to choose from in our toolbox: external and internal accountability; performance and compliance accountability; bureaucratic accountability; horizontal accountability; financial accountability; and managerial accountability, as examples.¹⁷ When, where, and under which context accountability is applied also matters and depends on “mechanisms and policies” which has led to the slew of accountability mechanisms that exist in the global health space, particularly in international organizations.¹⁸ The practical application of accountability mechanisms, irrespective of form, are even more challenging in the global health space, given ossified power structures that govern global health and influence their application.¹⁹ We are thus left with a murkiness to accountability that calls for the corrective that Prah Ruger provides.

With MCA, accountability is expanded within and across institutions, it requires standard-setting and assessments that join all actors together with a common objective, for which responsibilities are divided and assigned.²⁰ MCA allows for healthy dependence between actors in the pursuit of a common goal. MCA, further, builds in attribution and agreed upon mechanisms to assess joint work. Additionally, MCA supports a universal definition of what accountability is and what it means in practice. This helps prevent facile relativism that can often be used to justify how accountability is defined and applied. It can also help minimize power asymmetries by advancing a horizontal form of accountability, with a focus on collaborative enforceability.²¹ MCA opens up a vital space for dialogue, debate, and negotiation amongst global health actors. These spaces matter as they can help build a common agenda, generate trust amongst actors and provide “reputational and relational” incentives for commitment to a particular task or initiative that is linked to a common goal.²²

Still, even with all of the appeal of MCA, some questions remain. What happens when accountability is too diffuse? How are the common understandings of MCA advanced? How will it function operationally? Who gets to determine the assigned roles? And, what safeguards are available to inoculate it against efforts to undercut it? As we gain experience with MCA, answers to these questions will become more apparent.

MCA fosters a sense of shared responsibility and ensures transparency by setting out responsibilities, clear objectives, and reporting methods for each actor involved.²³ It leads to actors depending on each other to reach agreed upon goals and it generates transparency on each side and ideally generates more trust. Prah Ruger's MCA is indeed a concept that has traction in terms of how to manage our global health crisis. It carries with it the potential to foster solidarity and cooperation amongst countries so that global health gains may be realised. As the COVID-19 pandemic continues to create unprecedented challenges for the global health community, the relevance and urgency of MCA are patently evident.

Jillian Clare Kohler is a professor at the Leslie Dan Faculty of Pharmacy, Dalla Lana School of Public Health, and the Munk School of Global Affairs and Public Policy, University of Toronto. She is also a Connaught Scholar and the director of the WHO Collaborating Centre for Governance, Transparency and Accountability in the Pharmaceutical Sector.

Acknowledgement: The author thanks Violet Rusu for research assistance and the Connaught Global Challenge Award for supporting this research.

¹ Musacchio, Aldo, Anita McGahan, Sergio Lazzarini and Joseph Wong. "Global Health Coordination Necessary in a Pandemic." *Policy Options*. (2020, July 6). Retrieved Feb. 12, 2021: <https://policyoptions.irpp.org/magazines/july-2020/global-health-coordination-necessary-in-a-pandemic/>

² Bell, David, and Eliah Aronoff-Spencer. "'Global Health': Time to Refocus while We still Have Time." *The American journal of tropical medicine and hygiene* 102, no. 6 (2020): 1175-1177.

³ Fernandes, Nuno. "Economic effects of coronavirus outbreak (COVID-19) on the world economy." Available at SSRN 3557504 (2020).

⁴ Devakumar, Delan, Geordan Shannon, Sunil S. Bhopal, and Ibrahim Abubakar. "Racism and discrimination in COVID-19 responses." *The Lancet* (2020).

⁵ Newton, Paul N., Katherine C. Bond, Moji Adeyeye, Marie Antignac, Ayenew Ashenef, Ghulam Rahim Awab, Wilbert J. Bannenberg et al. "COVID-19 and risks to the supply and quality of tests, drugs, and vaccines." *The Lancet Global Health* 8, no. 6 (2020): e754-e755.

⁶ Prah Ruger, Jennifer. "Positive public health ethics: toward flourishing and resilient communities and individuals." *The American Journal of Bioethics* 20, no. 7 (2020): 44-54.

⁷ Ghebreyesus, Tedros Adhanom. "Vaccine Nationalism Harms Everyone and Protects No One." Foreign Policy. (2021, February 2). Retrieved Feb. 12, 2021: <https://foreignpolicy.com/2021/02/02/vaccine-nationalism-harms-everyone-and-protects-no-one/>

⁸ Prah Ruger, Jennifer. *Global Health Justice and Governance*. Oxford University Press, 2018.

⁹ Wachira, Catherine and Jennifer Prah Ruger. "National Poverty Reduction Strategies and HIV/AIDS Governance in Malawi: A Preliminary Study of Shared Health Governance," *Social Science & Medicine*, 72(21) (2011): 1956-64; Wachira, Catherine and Jennifer Prah Ruger, paper presentation, "The World Bank and IMF's National Poverty Reduction Strategies and the Governance of HIV/AIDS in Malawi," American Political Science Association (APSA) 104th Annual Meeting and Exhibition, Boston, MA, 29 August 2008.

¹⁰ Prah Ruger, *Global health justice and governance*, 155.

¹¹ Ibid, page 146.

¹² Ibid, page 188.

-
- ¹³ Dunworth, Treasa. "The Legal Adviser in Intentional Organizations: Technician or Guardian." *Alta. L. Rev.* 46 (2008): 869.
- ¹⁴ Bruen, Carlos, Ruairí Brugha, Angela Kageni, and Francis Wafula. "A concept in flux: questioning accountability in the context of global health cooperation." *Globalization and Health* 10, no. 1 (2014): 1-15.
- ¹⁵ Vian, Taryn, Jillian C. Kohler, Gilles Forte, and Deirdre Dimancesco. "Promoting transparency, accountability, and access through a multi-stakeholder initiative: lessons from the medicines transparency alliance." *Journal of pharmaceutical policy and practice* 10, no. 1 (2017): 1-11.
- ¹⁶ Hapuhennedige, Sandani, Emma Charlotte Bernsen, and Jillian Clare Kohler. "Exploring accountability and transparency within international organizations: what do we know and what do we need to know?." *Integrity, Transparency and Corruption in Healthcare & Research on Health, Volume I* (2020): 125-139.
- ¹⁷ Ibid, page 130.
- ¹⁸ Ibid, page 131.
- ¹⁹ Prah Ruger, *Global health justice and governance*, 49.
- ²⁰ Prah Ruger, *Global health justice and governance*, 189.
- ²¹ Swedish Agency for Development Evaluation. *Mutual Accountability in Practice; The Case of Mozambique*. SADEV Report. 2012:6.
https://www.oecd.org/countries/mozambique/SADEV%202012_6_Mutual%20accountability%20in%20practice.pdf
- ²² Steer, Liesbet, Cecilie Wathne, and Ruth Driscoll. "Mutual Accountability at the Country Level: A Concept and Emerging Good Practice Paper." *Centre for Aid and Public Expenditure. London, ODI* (2009).
- ²³ World Health Organization. *Indicator and monitoring framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. Every Woman Every Child, 2016.
<https://www.who.int/life-course/publications/indicator-monitoring-framework-publication/en/>

GLOBAL HEALTH JUSTICE: REFLECTIONS ON PRAH RUGER

Kok-Chor Tan

This paper¹ discusses three questions: Should we adopt a human rights approach to health? Is inequality in health per se an injustice or is the lack of sufficient health the problem? Finally, is health justice to be understood as part of a larger conception of social justice, or can we understand what health justice requires in isolation from other issues of justice? I suggest that there is value to talking about a human right to health, that the idea of health equality has some purchase, and that framing health justice within a larger conception of global justice can tilt us towards a more cosmopolitan approach to global health justice.

Jennifer Prah Ruger's *Global Health Justice and Governance*² presents a distinctive and systematic approach to global health justice. Prah Ruger's "Provincial Globalism", as she calls her theory, is grounded in the universal idea of individual health capabilities. But it is also "provincial" (in a good way) in that it is sensitive to the complex local and global obligations of health justice and the diversity of international institutional arrangements.³

In this commentary, I reflect on three philosophical questions inspired by Prah Ruger's ambitious book. The first question concerns the relationship between health capability and a human right to health. Prah Ruger, reasonably, is uneasy with the idea of a human right to health and prefers the idea of health capabilities. The second question regards "the pattern" of global health justice: does global health justice require regulating or limiting health inequalities? Or does global health justice require only that of securing for all persons some defined level of health sufficiency? We can call this the equality vs. sufficiency question. The third is the distinctiveness of global health justice. Is global health justice a special case or is it part of a larger theory of justice? That is, when we evaluate whether a given distribution of health is just or unjust, do we take into account the fair distribution of other social goods - such as income and wealth, overall personal wellbeing and so on? Or do we assess health distribution in isolation from these matters? Prah Ruger's book offers much more food for thought than I am able to recount here, and my particular questions are indebted to the rigorous and imaginative arguments in her book. Indeed I leave aside Prah Ruger's important and novel proposals for institutional design and global health policy.

A HUMAN RIGHT TO HEALTH?

Is it useful to talk about *a human right* to health? Is there any normative advantage to this? To begin, some clarifications are in order. What might a human right to health even mean? If it means that each person is to be put in a position so as to actually enjoy some defined basic level of health (e.g., to actually say realize a 83 year life expectancy), and thus any failure on the part of a state to ensure this constitutes a human right violation, this would be too demanding and implausible an understanding of what it means to have

a human right to health. People can experience health deficits – e.g., natural illnesses - in spite of anyone’s best effort. Moreover, to actually realize good health as matter of obligation can be unreasonably costly and demanding for society if actual health attainment is understood as a matter of right that a society must do all within its powers to realize.

What a human right to health most plausibly mean is that, drawing here on Henry Shue’s seminal work on “basic rights”, individuals are to be protected against “standard threats” against good health. ⁴ One obvious “standard threat” to health is that of the lack of access to basic health care and lack of access to medication. But standard threats to health include more than just the lack of access to care and treatment. Other standard threats include the unavailability of clean water, the absence of proper sanitation, having to live amidst pollution and other toxic wastes, dangerous work conditions, and unsafe social or natural environments and the like. A country in which children have to navigate dangerous traffic or traverse torrential rivers just to get to school is one in which health is put at risk. If a human right to health means protection or coverage against such standard threats, then individuals have justified claims against their state (and the international community secondarily) if they do not receive these protections and coverage.⁵

Prah Ruger raises important concerns against framing health justice in terms of human rights. She worries that the legalistic and adversarial character of the language of rights can be counter-productive in the advocacy for better access to health. Also, she notes the controversial nature of a claim-right.⁶ A claim-right, a right that creates obligations on others to do something (as opposed to merely forbear) is not something everyone sees eye-to-eye on. Some libertarians, for instance, say that there are only liberty-rights, rights that impose only the negative duty of forbearance on others. A rights approach to global health thus risks getting stranded in a philosophical quagmire. The concept of health capabilities, in contrast, is more ecumenical and able to motivate actual commitments to global health Prah Ruger believes.

These are very well placed concerns. But I want to assuage them a little and note moreover how the concept of human rights can in fact be used to express and enforce health capabilities. First rights are justified demands against others. This may sound litigious, and naturally we prefer that people stand in relation to each other not on adversarial terms but in relations of concern and care. Yet, the function of the concept of rights is to be a shield for individuals against abuses. That is, a right can come into play, for example, when care or concern wanes or cannot be counted on. Rights are safeguards, as it were, that can be activated in times of moral failure. To say that a citizen has a human right claim against her state for better health provision does not mean that this confrontation view of state/citizen relationship is the ideal. It simply notes that when states fail in their duty of care, citizens are entitled to raise justified moral claims against them.

Second, Prah Ruger worries that positive rights are controversial, and hence to frame health justice in term of a human right will itself be controversial since a human right to health must engage positive rights of some sorts. But the controversy surrounding the positive character of human rights is perhaps less evident in practice than in philosophical discourse. There is an “emergent” human rights practice – to adopt Charles Beitz’s idea – in international political life, and this emergent practice for all intents and purposes takes it as a given that human rights include positive duties, such as duties to

provide basic subsistence.⁷ So while libertarians will resist the idea of positive rights, the idea of human rights as a global practice already operates on the assumption that there are positive rights. This is not to say that implementation and realization of rights have been a success or straightforward, but only that the concept of a positive right is already granted in international practice.

Moreover, it is not the case that the concept of capabilities is any less controversial than that of human rights. It seems equally controversial to say that people have positive moral duties with respect to the health capabilities of others. It is reasonably uncontentious that health capability is a moral good, that is, a thing of value to individuals. But just because something is a good or valuable for someone does not immediately put anyone under a moral obligation to provide the good or value. I am not saying that the further argument linking a moral good and some corresponding moral duty cannot be made. In fact, I believe it can in the case of health capability (and Prah Ruger certainly makes these arguments). My point here is that the idea of health capability does not evade philosophical controversy any more than the idea of a human right to health does.

Indeed one might say that this would be more controversial than the notion of a human right because the last is already an accepted practice in the international domain, and is already an established idea in global politics. If anything, one might think that the language of human rights can be used to operationalize and enforce the ideal of health capability. As mentioned, there is already a received human rights practice in international relations. Thus pegging the ideal of capabilities onto human rights can use human rights as a vehicle for securing and promoting health capabilities. The language of rights carries a moral force that health capability does not precisely because it provides a justified claim that capabilities per se do not. So rather than seeing human rights and capabilities as opposing approaches, we might see them as complementary, with the language rights providing the normative language with which we promote global health capabilities.

THE PATTERN OF JUST HEALTH DISTRIBUTION: EQUALITY OR SUFFICIENCY?

Is health inequality an injustice only when it causes some to fall below some identified health capability threshold; or is inequality in capability in itself a health injustice? I will introduce a pair of terminology, and though these terms appear in Prah Ruger's book, I need not be using them in exactly the same way. What is relevant are not the labels themselves but the substance that the labels intend to capture.

By "equality" or "egalitarian", as these terms are used in conjunction with the ideal of distributive justice, I mean that inequality in the distribution of the relevant distributive good (among the relevant agents) raises a potential question of justice. An egalitarian ideal of just distribution regards an equal distribution of the relevant good (or *distribuendum* – the thing to be distributed) to be the benchmark from which any deviation must be justified. An egalitarian ideal of justice thus aims to regulate or control inequality in distribution in that any departure from the default of equal distribution has to be justified by reference to some distributive principle. So, one clarification is that egalitarianism or equality in distribution does not mean that there must be absolute equality in terms of the outcome. An ideal of just distribution is egalitarian if it limits the range and kinds of inequality by reference to some principle.

In contrast, a “sufficientarian” approach to distributive justice does not concern itself directly with inequality in distribution. Sufficientarianism holds that a just distribution of the *distribuendum* is achieved when the distribution is such that the holdings of all relevant agents meet some identified threshold of sufficiency. Sufficientarianism is not necessarily a basic-minimum conception of justice. Different sufficientarian theories can define the threshold of sufficiency differently – some modestly, others more robustly. There is nothing in the logical structure of sufficientarianism that says the threshold must lie at one point rather than at another. What makes a theory of distribution a sufficientarian one is its form, its pattern, rather than its content: for a sufficientarian, when the threshold is met, any inequality above that threshold is not a concern of justice. A robust sufficientarian view, one that has a very demanding idea of what the requirement of sufficiency is, is still sufficientarian and not egalitarian in form because it has no direct interest in inequality above its threshold, regardless of how demanding that non-comparative threshold may be. Finally, while sufficientarianism does not take a direct interest in equal distribution, it can have an indirect interest in equality, as in cases when inequality in distribution causes some agents to fall below the sufficiency threshold. But the distributive commitment is motivated not by egalitarian concerns as such but by sufficientarian ones.⁸

“Egalitarianism” and “sufficientarianism” thus refer to two different views of the basic forms or *patterns* of distributive justice. On this distinction, Prah Ruger’s provincial globalism is a sufficientarian approach. Her notion of “shortfall equality” in health is a threshold conception. On this view, there is health injustice if a country falls below the threshold as defined by the average health attainment level of countries in its economic comparison class. The idea of a relevant comparison class means also that there are different sufficient-health thresholds for different countries depending on the levels of their economic development. Health expectation as a matter of justice rises as a country advances economically. There are several advantages to Prah Ruger’s “shortfall inequalities” approach. For one, it sets clear, realistic and ethically reasonable goals and therefore has feasibility on its side.

But, to step outside of Prah Ruger’s purpose for a moment, let us consider whether distributive justice should be sufficientarian or egalitarian. This is an interesting question philosophically as well as practically, for how we respond to it will identify what we should be aiming for or aspiring to with respect to global health justice. Take the difference in life expectancy between Norway (82.3 years) and Lesotho (54.6 years); or Japan vs Norway, with 83.9 years for Japan. Or consider access to health as measured by the ratio of medical personnel to citizens in a country. Should these inequalities count as a problem of health justice?⁹

Most of us will agree that the inequality between Norway and, say, Lesotho is a health injustice. But why? If the reason is that some people are so clearly below an acceptable threshold of health-sufficiency, then we are actually objecting to the fact of absolute deficit rather than relative-deficit or inequality *per se*. The inequality is associated with an absolute deprivation but the inequality as such is not the reason why we think there is a problem of justice. In fact, it is this commitment to a level of sufficiency that accounts for why global health disparities are in the first instance so clearly an injustice. If health is a human right, the problem is not inequality as such in these extreme cases, but a violation of people’s right to some minimum standards of health.

But if we put aside extreme cases where health deprivations amount to a human rights violation, are health inequalities themselves unjust? Should, say, the inequality between Norway and Hungary, or even Japan and Norway, be considered a potential problem of justice? Even if we allow that justice should adjust for voluntary choice and decisions, and we grant that the differences in health between these countries are the result of (intergenerational) deliberate social choices and policies, it is still a matter of mere luck that one is born in a country that has made social intergenerational choices resulting in higher or lower life expectancy for people in the present. So why should someone have lesser health expectations than another just because of decisions made by others?

If differences in health capabilities are the result of choices by free agents, then these inequalities will not exercise most egalitarians. But if the differences are due to circumstances, including background injustices in the distribution of resources and other goods that contribute to health capabilities, then egalitarians will find the health inequalities a potential problem of justice. Thus egalitarians can be sensitive to the fact that inequalities in health outcomes can be due to agential choices. What excites them are inequalities that cannot be traced to choice. In particular what will be deemed especially problematic will be health inequalities that are due to other kinds of social injustices. So if justice ought not to allow persons' life prospects to be shaped by circumstances outside an agent's control, then even the health differences between Norway and Japan could be an injustice. This injustice may not be as grave as the injustice present in the difference between Norway and Lesotho, and thus may be given lower priority in terms of global response, but it is an injustice nonetheless. So one question is this a plausible position? Should global health justice ideally aim for equality of health capabilities even as we recognize that not all inequalities are equally morally urgent?

On the one hand, if egalitarianism requires that we examine the health inequalities between Norway and Japan as a possible problem of justice, then one might reasonably conclude that this is a *reductio ad absurdum* of egalitarianism. On the other, the reason why this might seem absurd is that in the world we are currently in, there are more pressing health challenges to attend to, of the sort that involves basic capabilities or rights deprivation. Thus to get exercised by differences between well-off societies seems like a case of misplaced priorities. But if this is the reason, that of wrong prioritization of attention and effort, this is a consideration that egalitarians can accommodate. It is not inconsistent for an egalitarian to say that ideal justice tells us that the inequality between two well placed agents amounts to an injustice, but the more urgent practical task at hand, the greater injustice, is that inequalities that have put some below a sufficiency threshold. Thus, one might be able to say that global health justice is ideally egalitarian without demanding that all cases of inequalities pose equally significant or urgent problems of injustice. The *reductio* charge against global health egalitarianism is thus averted.

Anyhow, these are brief reflections on the ideal pattern of global health justice. For a project like Prah Ruger's that aims to affect realistic changes, and whose focus is on minimizing injustice, what the ideal is will be less germane. Whether ideal justice requires equality or not, it is obvious that present global health distribution is unjust, and the most pressing matter is to mitigate basic and absolute health deprivations. Prah Ruger, I take it, puts aside matters of ideal justice, and wants to attend to this more immediate and urgent task.

IS HEALTH JUSTICE SPECIAL?

I close with my third question, one that is perhaps furthest removed from Prah Ruger's project. Nonetheless, how we address this question will affect our understanding of what we owe to each other with respect to global health. The question is this: Is health justice a special case? To clarify, the question is not whether health is the most basic good. For all individuals, good health is clearly valued both for itself and for the other things good health enables them to do. So basic good health is obviously special in this way, in that it is something really important for individual agents, the thing without which most other pursuits are not possible.

The question about the *special status* of health justice is this: when we think about the just distribution of the good of health, do we think of this in isolation from how other goods are distributed, or do we see a just distributive of health as something that has to take into account how other social goods are assigned? We can call this the domain question: is health justice a special domain of justice, to be inspected on its own terms? Or is health justice to be understood and examined within a broader ideal of distributive justice? That is, is health justice separable from other concerns of social justice, or is health justice an integral part of a more general ideal of social justice?¹⁰

To illustrate, consider a different problem of justice, that of climate justice. To slow down global warming, all societies have the general duty of climate justice to do their part, including that of reducing their CO₂ emissions. If we take climate justice to be a special case, what some would call an "isolationist approach" to climate justice, we might then conclude that countries' duties of climate justice (ie the duty to reduce emissions), ought to be allocated equally per capita or something along this line.¹¹ On this isolationist approach, how we distribute the burdens of climate justice (limits on emissions e.g.) is carried out in isolation from other concerns of justice. All countries, regardless of their background conditions are to be given the same "package" in terms of climate justice

In contrast, if we examine climate justice as part of a larger theory of global justice and not in isolation, then our allocation of emissions entitlements will be differentiated against the economic developmental needs of different countries, will take into account the fact of economic inequalities, and the extent to which these inequalities are themselves unjust and so on. We can be led to a different conclusion from the isolationist one, concluding instead that from the perspective of global justice considered as a whole, what constitutes just emissions for countries must take into account their background conditions. Unlike the equal per capita emissions approach, an integrated approach will give different countries different (just) entitlement depending on their circumstances and conditions of background justice.

I don't mean to address these complex questions from a different and urgent topic here; the reference is meant only to be illustrative. Returning to our topic: Why would it matter whether health is considered special or an elemental part of social justice more broadly conceived? Here are perhaps general instances where it might matter: Suppose we have to prioritize the health care needs of one person over another's comparable needs. How do we make decide on whose needs to prioritize? Do we favor the (unjustly) disadvantaged, or do we work out the priority independently of background social justice? Imagine there is a need to allocate a scarce health good among two persons: do we say that the background advantages and disadvantages of both parties that are due to prevailing social injustice are irrelevant; or are they to be taken into consideration? To illustrate

further allow me the sort of examples favored by some philosophers. Imagine we have one organ and two patients in equal need of it. Yet one of the patients enjoys informational, educational, wealth advantages which the other lacks because of prevailing societal injustice. Do we say that both are equally entitled to the transplant, or that the unjustly disadvantaged has more of a claim from the standpoint of overall justice?

We can extend this question to the global domain. Suppose we see two societies with comparable health care deficits (say equivalent life expectancy), yet one is globally better off than the other because of background global injustice. From the perspective of *global health justice*, which society has greater health care claims on the international community? Or imagine two unequally endowed societies in terms of social capital and natural resources. Yet the better endowed society opts to exploit its environment to maximize economic growth whereas the second, less well endowed, chooses to go for a more environmentally sustainable and more health-conducive approach to development at the cost of slower economic growth. Suppose then that as result of its domestic decision, the average life expectancy of the members of the exploitative society falls below that of the second. No doubt one may criticize the first society for failing in its health care duties to its own citizens. But from the perspective of *global health justice*, what does the international community owe to each of these countries? With respect to global *health justice*, is the richer but less healthy society more entitled to assistance? Or is the healthier but poorer country more entitled?

Prah Ruger's concept of "shortfall inequality" allows us a method for evaluating how well countries are performing relative to their comparison group.¹² That is, we have a way of assessing countries for their health performance, and we are able to exert pressures on governments appropriately if need be. That is, for the purposes of assessment of health achievements, it doesn't matter if we adopt an isolationist approach since we are interested in health outcomes for individual countries relative to its class. But if our question is not just how to evaluate countries' health performance, but to work out what countries *owe to each other* in terms of health justice, then it seems it makes a big difference whether we take health to be a special and separate case, or whether we take it to be one aspect within some larger ideal of global justice. As I understand it, Prah Ruger's provincial globalism holds states to be primarily responsible and accountable for the health of their own citizens. In this respect, her approach is self-described as non-cosmopolitan.¹³ But if global health justice is analyzed as part of some larger conception of global justice, then in light of prevailing background global injustices, states (particularly well-off states) will have more of a responsibility to assist states facing health deficits and challenges. That is, while we want to hold states primarily responsible for the health of their own citizens, understanding global health to be only a part of the larger issue of global justice will spread this responsibility outwards towards the international community. In other words, states are the primary agents of health justice, but only on the assumption that the global order as such is reasonably just. In an unjust global order, however, we may have to edge towards a more cosmopolitan approach to global health justice.¹⁴ At least this seems to be an implication of taking global health justice to be an integral part of global justice.

Kok-Chor Tan is a Professor of Philosophy at the University of Pennsylvania. He is the author of *Toleration, Diversity and Global Justice* (2000), *Justice Without Borders* (2004), *Justice, Institutions and Luck* (2012), and *What Is This Thing Called Global Justice?* (2017).

¹ This commentary was prepared for a symposium on Jennifer Prah Ruger's book in May 2019. I thank all participants, and Jennifer most especially, for their helpful questions, suggestions and for their own contributions at the symposium.

² Prah Ruger, Jennifer. 2018. *Global Health Justice and Governance*. Oxford University Press.

³ Prah Ruger, pp. 51-53; 81-85.

⁴ Shue, Henry. 1999 2nd ed. *Basic Rights*. Princeton University Press.

⁵ See Wolff, Jonathan. 2013. *The Human Right to Health*. Norton and Company; and Hassoun, Nicole. 2015. "The Human Right to Health." *Philosophy Compass* 10 (4):275-283.

⁶ Prah Ruger, pp. 234-36; also 74-76.

⁷ Beitz, Charles. 2008. *The Idea of Human Rights*. Princeton University Press.

⁸ For a discussion on sufficiency versus equality, including an explication of the difference, see Casal, Paula. 2007. "Why Sufficiency is Not Enough". *Ethics* 117/2 pp. 296-326.

⁹ The figures in the example are from the 2018 UNDP Human Development Report.

¹⁰ For a perspicuous framing of this debate, see Segall, Shlomi. 2007. "Is Health Care (Still) Special?" *The Journal of Political Philosophy* 15/3 342-361. As Segall writes: "To say that health care is special, we said, is to imply that health care resources ought to be allocated in isolation from the distributions of other social goods." p. 343.

¹¹ As described in Caney, Simon. 2012. "Just Emissions". *Philosophy and Public Affairs* 40/4 255-300.

¹² Prah Ruger, pp. 106-108

¹³ Prah Ruger, pp. 135-36.

¹⁴ For one philosophical survey of contemporary cosmopolitanism, see Brock, Gillian. 2013. "Contemporary Cosmopolitanism" *Philosophy Compass* 8/8 689-698.

OF INEQUALITIES AND VALUES: THE CONFUSION AND HOPE IN GLOBAL HEALTH GOVERNANCE

Justice Nonvignon

*The book *Global Health Justice and Governance* by Jennifer Prah Ruger¹ raises key issues about the current state of global health governance, many of which issues represent a state of significant confusion. In this commentary, I focus on inequalities in global health, some of which are perpetuated by the very global institutions that are mandated to help reduce such inequalities. I further argue that such inequalities have been largely unexplored. I argue that building global health governance on values, as argued by Prah Ruger² is key to bringing global health closer to communities, but that values in themselves could present some confusion. Finally, I argue that the current confusion in itself presents hope.*

BACKGROUND

The global health landscape is undergoing significant changes that are re-defining the concept of global health – in many aspects - the key ones being financing and governance, both of which have implications on the organization and delivery of health services, human resource, availability and use of information. These, in turn, have clear implications on how the world reacts to emergencies such as the Ebola virus disease (EVD) and COVID-19 (Coronavirus) that have both challenged global health systems and structures.

Prah Ruger³ addresses fundamental issues often left unanswered – underpinning the current challenges in global health, governance and global health justice – including inequalities and externalities, development assistance for health and the myriad problems caused mainly by actors and organization in the space of development assistance for health (DAH), especially relating to vertical and horizontal programs and the capacity of national institutions to cope with the many challenges that come with donor “proliferation”.

This commentary focuses on key issues raised by Prah Ruger⁴, relating to inequalities within countries and groups, as well as the role of values in helping address some fundamental problems caused by global health governance.

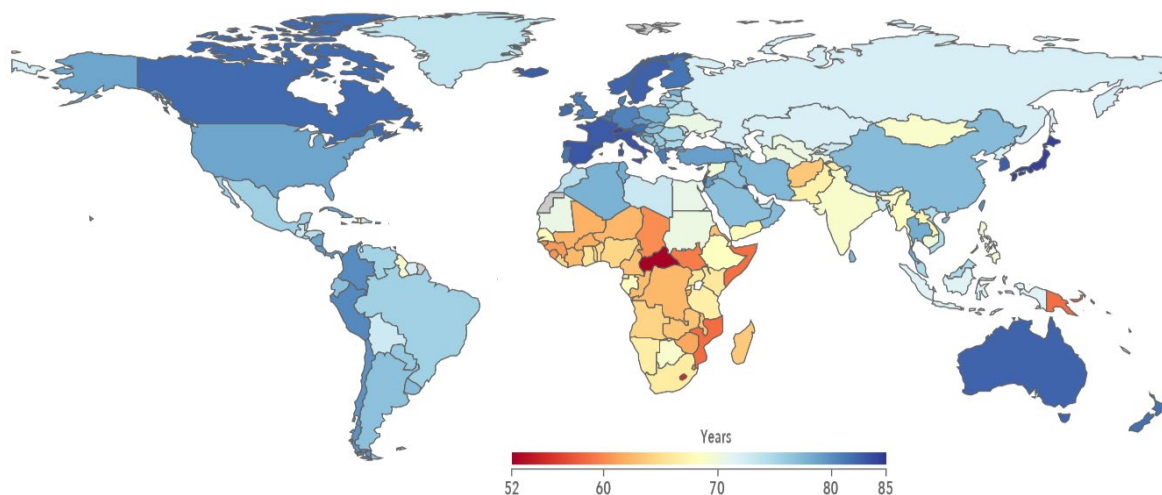
OF HEALTH INEQUALITIES AND DISPARITIES IN THEM

As clearly presented by Prah Ruger⁵, the world has seen marked reduction in health inequalities generally. However, disparities in key health indicators persist. For instance, though life expectancy has been estimated to have significantly improved between 1950 and 2017 (48 years to 71 years and 53 years to 76 years for male and females, respectively), significant country and regional inequalities remain⁶.

Furthermore, recent estimates have shown that while neonatal mortality rate has reduced by more than 50% globally between 1990 and 2017; low-income and lower-middle income countries account for 89% of these mortalities, with sub-Saharan Africa

and South Asia together accounting for 79%⁷. Within countries, inequalities in health manifest across rural-urban divide and mainly through income and maldistribution in health human resources and infrastructure.

Life expectancy, 2017*



*Data shown in the figure represent life expectancy at birth for both sexes.

Figure 1: Global estimates of life expectancy, 2019
Source: Dicker et al.⁸

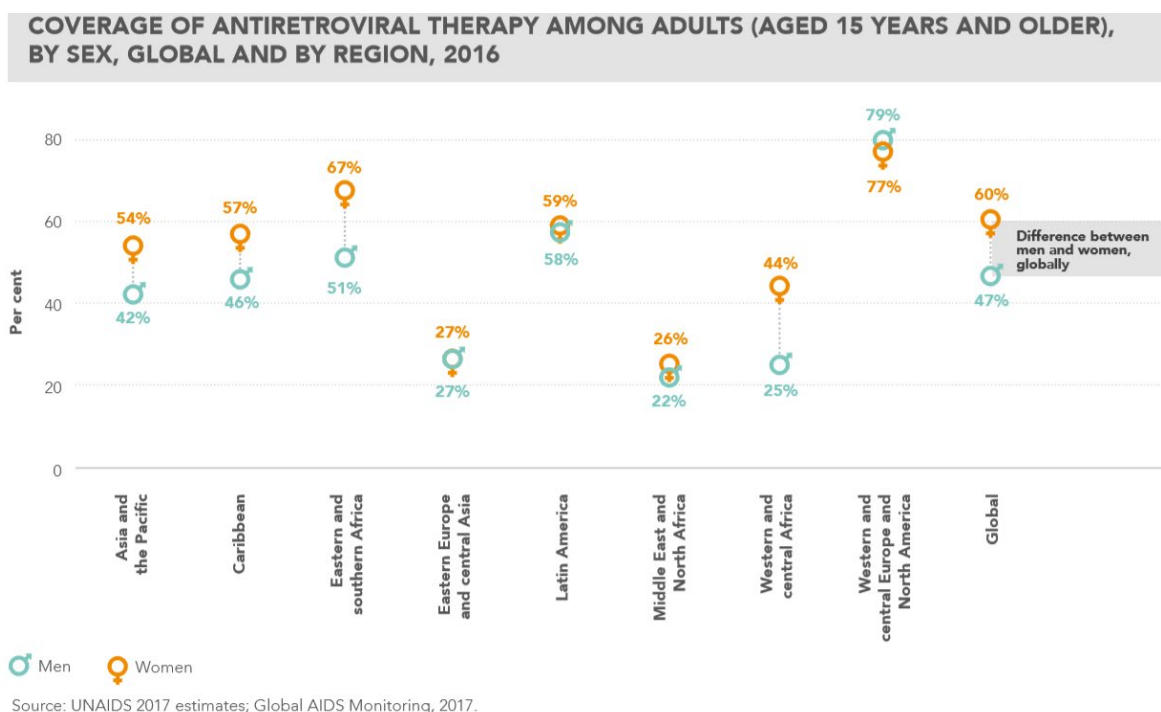
Global response to inequality skewed

Global responses to such cross-country and within-country inequalities have led to significant reductions in such inequalities. For example, through the establishment of global financing mechanisms (such as the Global Fund to fight HIV/AIDS, TB and Malaria, Gavi the vaccine alliance, and more recently the Global Financing Facility), the world has raised significant resources to reduce the burden of many diseases. However, such responses have, in some ways, either created further inequalities or exacerbated existing ones. For instance, the focus of the GFTAM on three diseases has led to increased financing of these diseases by major donors and governments, while other diseases (such as neglected tropical diseases and other infectious diseases of poverty) have not seen corresponding increase in financing. Hotez et al., 2020⁹ highlight, for example, that only 1-2% of people affected by Chagas disease and millions of others suffering leprosy receive diagnosis and treatment.

In addition to inequalities created by the focus on specific diseases, studies have shown widening gaps between populations suffering from same diseases. For instance, a recent report published by UNAIDS acknowledges that there is disparity in access to HIV treatment between men and women. In 2016, global antiretroviral therapy coverage was 47% among men and 60% among women, 15 years and above¹⁰. In sub-Saharan Africa, boys and men living with HIV are about 27% less likely to have access to treatment. Consequently, men account for 58% of global AIDS-related deaths in 2016.

Similarly, Horton et al., 2016¹¹ reviewed 83 publications of 88 nationally representative surveys in LMICs and find that the prevalence of TB is significantly higher in men than women, reflecting men's low access to TB treatment.

Whereas many global health institutions target specific populations, and rightly so due to historical inequalities against specific population groups, it is important to ensure that in attempting to reduce such inequalities, new ones are not created. Many have questioned the creation of institutions to target specific populations, such as mentioned above (the example of the Global Fund targeting three diseases, or specific funds targeting specific emergencies). The focus of global health actors needs to be on creating institutions that have the capability to target any and all health challenges that emerge – not some, which could create inequalities in others. In addition, existing programs need to identify and address other inequalities that emerge as a result of their actions and not wait for new institutions to be created to address these. Is it time to reform the WHO and other global financing mechanisms such as the Global Fund in that regard? Yes, and such reforms are urgently needed.



Of elitisms in global health decision making, inequalities in health research funding, authorship and so-called “colonization” of global health

The inequality in global health has affected not only the distribution of health outcomes across regions and countries, but the entire architecture of global health, from decision making structures, training, financing of global health research, to authorship and ownership of research outputs.

Arguably, the term “global health” seems to have garnered greater response to the call for collective action on the health problems that plague communities, compared to “international health”. However, the very meaning of “global” has been questioned by

many, as it seems to overshadow the place of communities. For many elite and high-income countries, the term “global health” means helping less privileged low and middle-income countries (“them”). That thinking is clear from the approach to providing solutions to global health challenges. For instance, the COVID-19, which has been declared a pandemic by the WHO has seen swift responses from many quarters in terms of financing (for research, vaccine development, etc.) than the EVD and, indeed, other emergencies which largely plague LMICs. The swift response has been justified by not only the health but also the huge economic impact the pandemic has caused in developed regions, through significant reduction in production and other economic activities, also affecting stock markets.

This notwithstanding, the underlying principle of “global health” should be “helping us”, not “helping them”. In ongoing work with Prah Ruger and colleagues, we are studying the role of values, especially traditional Akan philosophy and proverbs, the Adinkra, in health policy and governance in Ghana¹². The following Akan (Ghana) proverb (translated) is useful; “if your neighbour’s beard is on fire, you quickly dip your beard in water”, meaning it is better to act fast to protect yourself, sometimes by helping your neighbour – not because of your neighbour but because that helps to protect yourself. Global health has often been viewed as reciprocity (“I help you because you helped me”); it should be about helping others as a way of helping oneself.

Again, to others, global health refers to placing key actors (the elite) at the centre of decision making and action on the health issues that affect “local” people the most, giving the very people whose health is paramount little to no role in the decisions affecting their health. From Boards or Committees or Commissions that play key roles in driving the global health agenda to Editorial Boards of major journals that help shape global health agenda, significant inequalities exist, whether on the basis of gender or northern/southern distribution¹³. Many of such entities pretend to understand or be the ones vested with the authority to speak on behalf of communities, even if they do not understand the context within which communities live. There is also a growing phenomenon of civil society groups, some of which argue that they speak “for the people”, but many of whom frankly do business.

Recent studies have further explored gross inequalities in global health training^{14,15,16}, research financing, partnership and authorship of research outputs resulting from collaborative work^{17,18,19}, all in favour of the global north. Together, these “disturbing” trends have been popularly referred to as “colonization” of global health. Such “colonization” does not only lead to inequality, but also represents fundamental injustices, as Prah Ruger²⁰ also argues – that global health inequality is tantamount to injustice.

It is interesting to note the increasing discussion of such inequalities that serve to widen the north-south gap. However, these discussions have, to a large extent, been silent on the role of global south institutions and governments in reducing such inequalities. As a famous Ghanaian proverb puts it, literally, “as one advises the cat, one ought to advice the mouse”, meaning any attempt to solve a problem between two sides must involve both sides. Any arguments to this challenge need to explore both sides, thus, exploring the role of institutions and states in the global south in such inequalities could lead to a more comprehensive understanding of the problems and, therefore, solutions. Studies have shown that, where “catalytic champions” - who place the needs of countries above

external forces - exist within LMIC institutions, such countries fare better in managing issues relating to donor proliferation and translating global targets to national policies^{21,22}

OF VALUES: CAN GLOBAL HEALTH GOVERNANCE TRULY REFLECT VALUES?

An intriguing part of Prah Ruger's²³ arguments relates to the proposition of shared health governance that reflects the values of communities. Adler²⁴ argues that "*values may be seen as absolutes, as inherent in objects, as present within man [or society] and as identical with his behaviour.*" Values reflect what a community believes to be the standard of behaviour and is, therefore, context-specific.

The incorporation of values in health governance presents both opportunities and challenges to effective governance, especially challenging the universality of certain concepts. As opportunity, communities clearly get mobilized to build their health on what they already believe in. For instance, as ongoing work (with Prah Ruger) shows, the current state of health care delivery, financing and arrangements in Ghana reflect values, that have underpinned changes in such arrangements since pre-colonial periods²⁵. The greatest challenge to incorporating values into global health governance remains "what is acceptable" to everyone. As values mean different things to different people, universality of values becomes a difficult concept. A key example is the continuing debates relating to the acceptance of abortion and legalization of practices that some LMIC communities value as alien to them (e.g. homosexuality), which has significant implications on service delivery to such people. Some countries argue that this practice infringes their "values", making it difficult to legalize and ensure that the much-needed health services are provided to this group, in the face of the health challenges faced. Should that view be accepted because it represents community values? Thus, the concept of incorporating values has significant potential to improve the health of people, but also requires wider work.

THE CONFUSION AND THE HOPE

The current global health architecture has seen significant confusion – in the way institutions are structured and operate, to the way such institutions and global health actors proffer solutions to problems that the world faces – often on knee-jerk basis, seeking solutions that work (or do not even work) for specific situations, rather than those that work for similar situations in the future. Often, in an attempt to proffer solutions, global health institutions create further inequalities. Such inequalities discussed above represent significant confusion on the current global health landscape, with negative ramifications for health. For LIMCs, the proliferation of donors and so-called "civil society organizations" - some of which work contrary to their claim of working in the "interest of the people" – have been another source of confusion.

However, there is hope; hope that the increased discussion of global health elitism and the role of global health in proffering solutions to local health, that the identification of global health problems will bring global health actors closer to the people for whom they claim to work – communities. Hope, if some of the self-interest displayed in the global health governance arena could be transformed into collective interest – of the people, the community we ought to serve. National governments ought to take a fair share of the responsibility to take on challenging tasks that are difficult but that need addressing

to keep the interest of the people, who are at the heart of health, however “global” or “local”.

Justice Nonvignon is an Associate Professor of Health Economics, Policy and Financing at the School of Public Health, University of Ghana, Accra. He also Chairs the Global Evaluation and Monitoring Network for Health (GEMNet-Health) and is co-Chair of Technical Advisory Group of Health Economics Unit, Africa Centres for Disease Control and Prevention.

¹ Ruger PJ. *Global Health Justice and Governance*. Oxford: Oxford University Press, 2018, p.394

² Ibid

³ Ibid

⁴ Ibid

⁵ Ibid

⁶ Dicker D, Nguyen G, Abate D, et al. Global, regional, and national age-sex-specific mortality and life expectancy, 1950–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*. 2018; 392: 1684-735

⁷ Hug L, Alexander M, You D and Alkema L. National, regional, and global levels and trends in neonatal mortality between 1990 and 2017, with scenario-based projections to 2030: a systematic analysis. *The Lancet Global Health*. 2019; 7: e710-e20.

⁸ Dicker D, Nguyen G, Abate D, et al. Global, regional, and national age-sex-specific mortality and life expectancy, 1950–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*. 2018; 392: 1684-735

⁹ Hotez PJ, Aksoy S, Brindley PJ and Kamhawi S. World neglected tropical diseases day. *PLOS Neglected Tropical Diseases*. 2020; 14: e0007999.

¹⁰ UNAIDS. *Blind Spot - Reaching out to men and boys: Addressing a blind spot in the response to HIV*. Geneva, Switzerland: UNAIDS, 2017.

¹¹ Horton KC, MacPherson P, Houben RM, White RG and Corbett EL. Sex Differences in Tuberculosis Burden and Notifications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *PLoS medicine*. 2016; 13: e1002119.

¹² Ruger JP, Kim SD, Koduah A, Amexo SE, and Nonvignon J. “Transformation of Health Policy in Ghana,” International Studies Association (ISA) International Conference, Accra, Ghana, 03 August 2019.

¹³ Nafade V, Sen P and Pai M. Global health journals need to address equity, diversity and inclusion. *BMJ Global Health*. 2019; 4: e002018.

¹⁴ Karan A. Opinion: It's Time To End The Colonial Mindset In Global Health. In: NPR, (ed.). 2019.

¹⁵ Pai M. 10 Fixes for Global Health Consulting Malpractice. In: NOW GH, (ed.). Johns Hopkins Bloomberg School of Public Health 2019.

¹⁶ Ruger PJ. *Global Health Justice and Governance*. Oxford: Oxford University Press, 2018, p.394.

¹⁷ Abimbola S. The foreign gaze: authorship in academic global health. *BMJ Global Health*. 2019; 4: e002068.

¹⁸ Cash-Gibson L, Rojas-Gualdrón DF, Pericàs JM and Benach J. Inequalities in global health inequalities research: A 50-year bibliometric analysis (1966–2015). *PLOS ONE*. 2018; 13: e0191901.

¹⁹ Gautier L, Sieleunou I and Kalolo A. Deconstructing the notion of "global health research partnerships" across Northern and African contexts. *BMC Med Ethics*. 2018; 19: 49-..

²⁰ Ruger PJ. *Global Health Justice and Governance*. Oxford: Oxford University Press, 2018, p.394.

²¹ McRobie E, Matovu F, Nanyiti A, et al. National responses to global health targets: exploring policy transfer in the context of the UNAIDS '90-90-90' treatment targets in Ghana and Uganda. *Health Policy Plan*. 2018; 33: 17-33.

²² Pallas WS, Nonvignon J, Aikins M and Ruger PJ. Responses to donor proliferation in Ghana's health sector: a qualitative case study. *Bull World Health Organ*. 2015; 93: 11-8

²³ Ruger PJ. *Global Health Justice and Governance*. Oxford: Oxford University Press, 2018, p.394.

²⁴ Adler F. The Value Concept in Sociology. *American Journal of Sociology*. 1956; 62: 272-9

²⁵ Ruger JP, Kim SD, Koduah A, Amexo SE, and Nonvignon J. "Transformation of Health Policy in Ghana," International Studies Association (ISA) International Conference, Accra, Ghana, 03 August 2019.

GLOBAL HEALTH JUSTICE AND GOVERNANCE: A RESPONSE

Jennifer Prah Ruger

I am extremely grateful for, and have learned so very much from, the participants in the May 2019 workshop and symposium on my book, *Global Health Justice and Governance*, at the University of Pennsylvania Perry World House and published in this special symposium issue of *Global Health Governance*. I greatly appreciate the work that has gone into probing, expanding and critiquing my approach to global health justice and governance. My book addresses many issues, and the articles and commentary on it are wide ranging and enriching. In my response, I address each article separately, as well as contributions of other workshop participants. I have received extraordinary benefits from both the oral and written engagement of the distinguished contributors to the workshop and symposium, and I am deeply thankful to them and the organizers for the opportunity to continue this discussion.

BENJAMIN MASON MEIER: GLOBAL HEALTH JUSTICE AS A FOUNDATION FOR THE FUTURE OF GLOBAL HEALTH GOVERNANCE

Benjamin Mason Meier's ability to highlight many important areas succinctly and clearly is impressive. He appropriately notes that *Global Health Justice and Governance* covers a comprehensive range of issues. I am grateful for his clarity in communicating the many components of my book.¹

I agree with Meier when he stresses power as a foundational structure for global health governance. He notes perceptively that "governance grounded in power rather than justice, denying accountability in global health ... rais[es] an imperative for new moral theories". To transform our global health system, I believe we must revise the structure of international institutions and the terms of international cooperation, and justice must ground such reforms. I greatly appreciate Meier's focus on health agency in his appreciation for provincial globalism, something the less observant can miss. "Prah Ruger looks to 'provincial globalism,' a theory grounded in the idea of equal dignity, to provide a framework to secure health agency, an individual or group's ability to pursue health goals," he notes. "[P]rovincial globalism incorporates both individual and shared obligations in a framework for attaining global health justice," he observes. At the global level, I would add redistributing financial resources, providing technical assistance and other functions to Meier's list of "responsibilities for norm setting, leadership, and knowledge sharing to global health actors."

Meier offers a penetrating analysis of international law vis-à-vis global health law. "[I]n the absence of enforcement mechanisms under international law," he rightly notes, "the emerging field of global health law must draw from a normative theory to facilitate the redistribution of resources, implementation of related legislation and policy, development of public regulation and oversight, and fulfillment of public goods." This array of instruments at the disposal of designers and implementors of policy fits nicely with what Cary Coglianese calls the "policy toolkit", in addition to domestic regulation.

Meier's analysis, from a global health governance perspective, goes deeper, arguing that "[b]y promoting treaty regimes that build capacity, provide technical and economic support, and identify barriers, global health law can advance health capabilities— but this vision of global health law requires a moral foundation in justice." By focusing on building collective and individual capabilities through global health law that supports domestic health law and regulation, a new governance model takes fostering agency – individual and collective – as its cornerstone. Expanding the capabilities of individuals and groups will enable people to identify and solve problems for both their own and others' benefit.

On the relationship between human rights and health capabilities, Meier writes, "[t]o ensure compliance with these regimes, stakeholders must draw upon the ideals of shared health governance to bring a moral purpose for international relations to achieve global health equity. It is these same ideals that support the implementation of human rights law in global health governance, defining the legal responsibilities of duty-bearers to meet the needs of rights-holders." Shared health governance grounds the right to health in principles of provincial globalism and the health capability paradigm. Global health law, above and beyond international health law, additionally provides an alternative legal framework. "Providing a path to link provincial globalism with human rights, a health and human rights approach can support obligations and facilitate accountability for upholding health capability," Meier argues.

BOOK LAUNCH AND WORKSHOP DELIBERATIONS

LaShawn Jefferson expertly led a wide-ranging discussion on the book, highlighting the book's analysis about the link between health outcomes and where you live and who you are in this world, and the need to shift the global health focus towards justice. Jefferson facilitated a rich discussion of the role of the market and other institutions in health care and health delivery and why we must think more critically about market efficiency myths. With a market system that will not deliver justice – health equity for all – Jefferson asked us to consider shared health governance as an alternative framework for the current fundamentally broken system. She then moved to the implications of a shared health governance framework and changing the status quo – creating an enabling environment, particularly through global civil society, where people see themselves as better connected in outcomes and equity. Jefferson challenges us all to think about how we do that, how we go about advancing provincial globalism and shared health governance, how we envision a different world and let go of no longer functional institutions. How do we encourage political buy-in from different actors and institutions?

While I will not review the rich discussion from the Perry World House workshop comprehensively – and I will respond below to those who have articles in this special symposium issue – I do want to highlight some of the excellent points in that discussion.

In the first workshop session on Global Public Health, a powerful discussion ensued from the invaluable contributions of Mary T. Bassett and Prabhat Jha. Below, I respond specifically to Jha's article in this special symposium issue. Bassett, a former public health commissioner and global health practitioner, has worked expertly and humanely on health equity her entire professional life. She underscored the focus on values in *Global Health Justice and Governance*, and that they have been a focus as well in her professional work. She pointed out, rightfully, that avoiding premature mortality (a central health capability in provincial globalism) will take time to accomplish. To be

sure, this is a medium and longer term project. Bassett also noted health agency and the importance of individual responsibility's apolitical standing in global health governance. Bassett expressed concern about individuality and the meaning of group phenomena in any public health theory or work. Collectives, she noted, are not solely the sum of individuals. I agree wholeheartedly. The book argues for the development of both individual and collective capabilities, and even individual capabilities are socially dependent; humans are social creatures and we impact and are impacted by our environment.

I highly recommend Bassett's articles and presentations on racism,² and, more recently, reparations.³ I have learned much from her clear and cogent analysis of structural racism and the dynamics that set the patterns, beliefs and institutions (housing, education, media, criminal justice, health care, employment, economic, etc.) that produce and reproduce marginalization and exclusion of Indigenous and Black people, all deeply embedded in the history of the world and the United States. Our world has been built on social and global injustices. I believe that the health capability paradigm at the domestic level and provincial globalism at the global level can be extended even further to address injustices based on race more directly. In her comments, Bassett highlighted that 2019 was the 400th year since the first enslaved African came to the United States and elsewhere she has said how critical it is to educate people to be structurally competent.⁴

In conclusion, Bassett reminded us of how difficult change toward justice will be with the current power dynamics and concentration of wealth and influence. She pointed us to a report in the *The Guardian* that Bezos, Buffet and Gates's combined wealth is the equivalent of half of all U.S. wealth.⁵ This is a stunning data point and one that needs serious and urgent reflection and rectification. I am glad that the issue of power was raised again: it is key to the provincial globalism and health capability paradigm lines of reasoning. Power analysis goes to the root of injustice — how we treat people differently, and the concentration of power to do so, mechanisms structurally embedded in our institutions. To change that, we need to create a framework of justice that values everyone's flourishing equally, rectifying existing injustices and preventing future ones.

In the workshop session on Global Health Governance, Yanzhong Huang and Jillian Kohler, two political scientists, astutely analyzed the governance dimensions of global health. Below, I respond specifically to Kohler's article in this special symposium issue. Yanzhong Huang observed, perceptively, that when we seek solutions to global health problems, we look for a unified global health infrastructure, but today instead we have open-source anarchy. The current global health governance infrastructure is unable to meet the collective needs of a globalized world. The world needs an overarching governance theory.

Huang noted existing theory offers several approaches: health as a public good, national security, human security, which is conceptually vague, or human rights. However, these approaches each pose problems. National security concerns exacerbate inequalities in global health. Huang argued that while the human rights approach may be the most viable alternate to provincial globalism, it has no universally agreed-upon definition, and enforcement is an issue.

Huang observed that the US-China collaboration on health is a case study for testing the viability of the shared health governance (SHG) and provincial globalism (PG) frameworks, suggesting a lot of potential for the PG/SHG approach. Huang noted that US-China relations improved after 1972 due to the Soviet threat and within China-US

relations, the health collaboration had its own dynamics. The 1989 Tiananmen Square massacre and significant concerns about China's human rights notwithstanding, Huang remarked that Merck signed an agreement with China to transfer Hep B vaccine to China and that it trained Chinese personnel. This deal was important, Huang says, because millions of babies were inoculated in a country in which roughly 10% of adults have been Hep B carriers. Huang argued that this case demonstrates how a health capability approach works better than the security approach. Conversely, Huang notes, using a realist agenda in health collaboration, for example, through trade wars and firing scientists who collaborate with China, impedes health collaboration.

Huang acknowledges that we need a universal normative framework and standards to recognize central health capabilities, but in an increasingly divided world, both between and within nations, Huang asks how we achieve these shared values in health.

In his commentary in the workshop session on Emerging Countries, Thulasiraj Ravilla, a leader in the practice of public health and medicine, noted that most low and middle income countries have health systems that descended from colonialism and have been shaped by health officials who learned about health systems abroad and returned with those paradigms to their respective countries. In many low income countries, he argued, there are significant health inequities relating to location and ability to pay. In his work as Director-Operations of Aravind Eye Care System in India, he has learned the importance of starting with service design; solving problems in this area has led to a lot of innovation. Decreasing the costs of lenses for cataract surgery from \$200-\$300 to \$10 made a huge difference. Aravind has found that making services more effective makes them more inclusive. Ravilla said they recognized that most people do not come to the hospital but instead require active outreach. Their network grew each week, to roughly 2,000 outreach events per year. To make pricing inclusive, Ravilla noted, Aravind implemented a scale ranging from negative pricing – paying for outreach to draw in indigent patients – to zero pricing to pay-for-service for those who can afford it. The Aravind model thus serves everyone, even providing transportation for those who need it. Careful protocols assure quality. Staff rotate each month between free and paid sections so that all patients are treated equally. The Aravind model exemplifies many aspects of the health capability paradigm at work.

LAWRENCE O. GOSTIN: HEALTH INJUSTICE: THE DOMINANT GLOBAL NARRATIVE OF OUR TIME

I am touched by Larry Gostin's kind contribution.⁶ He rightly discusses the current Covid-19 global pandemic as yet another data point, another example, of why we need a theory of global health justice and governance. Gostin and I agree that in the race to come up with a Covid-19 vaccine, "no one should 'own' the vaccine" and "[n]o company should profit from it," he notes. Rather, it should be made available to everyone, regardless of nationality, geography, race, religion, sexual orientation, ability to pay, or other characteristics.

Like Gostin, I am concerned about national competition and hoarding of vaccines, including by our own American government. National interest can considerably determine vaccine distribution, resulting in price fluctuation based on willingness and ability to pay and competition among nations. This favors the powerful, exacerbates

existing inequities, and delays overcoming the pandemic. A national interest driven competitive approach can create delays in vaccine manufacture, as demand overwhelms supply chains and redirects them to privilege wealthier nations. Hoarding may also be an obstacle, as it was before with masks and respirators and the U.S. purchase of huge amounts of remdesivir, an antiviral used to treat Covid-19.⁷

I appreciate Gostin's comment that the World Health "Organization has been unable to gain global cooperation, with its largest funder, the United States, blaming WHO for the pandemic." As Gostin notes, this is a key global health governance problem. It undermines the WHO's ability, as Gostin says, to "be at the center of global governance in ensuring equitable access to vaccines and other vital medical resources." I agree with Gostin's comments and I believe that the problem has deep roots. In particular, nations created our international health system to control infectious disease spread and to protect national interest, global and national security, travel, and trade. International agreements comprise bargains to serve national interests. These agreements can unravel if powerful nations shift positions, or if power relations change. They are thus unstable, contingent on precarious relationships rather than on principles of justice. Any nation can vacate an international agreement to advance its own interests whenever it believes it can position itself better at the expense of others. The tension between China and the US, and the ongoing controversy surrounding vaccine distribution and allocation, are examples.

Gostin gets right to the heart of the problem: "Faced with staggering inequalities, imperiling epidemics, and weak governance, the world desperately needs a new global health architecture," he writes. He acknowledges that "the Great Coronavirus Pandemic of 2020" provides lessons learned but also demonstrates "[n]ational and global responses have often failed." It is time, as Gostin makes clear, to put our resources to the task of addressing "Health Injustice: The Dominant Global Narrative of Our Time," an idea at the center of my book.

I admire Gostin's force and brevity in highlighting key issues as they relate to my efforts to reshape theories of global health justice and global health governance to create a safer, more prosperous world for everyone. Gostin emphasizes the powerful relevance of health injustice, central to my theory, and I am grateful for the gracious acknowledgement he gives my work.

CARY COGLIANESE: WHAT REGULATORS CAN LEARN FROM GLOBAL HEALTH GOVERNANCE

I learned much from Cary Coglianese's exceptionally thought-provoking article,⁸ in which he sets forth seven lessons domestic regulators can learn from my shared health governance model. I restate these lessons and several key sections from his article in organizing my response below. Like global health governance, regulation is a multi-faceted enterprise moving from identifying problems to identifying solutions, requiring a multidisciplinary understanding of the world. I fully agree with his thesis. I am grateful that he has illuminated these connections, extending the reach of these important ideas and guiding me and others in new and extremely fruitful directions. Coglianese's article builds on his and colleagues outstanding and voluminous body of work on regulation in an effort to achieve regulatory excellence.⁹

Common problems

With acuity and clarity, Coglianese begins with problem definition. He points out commonalities in problem definition between domestic regulatory governance and global health governance. Externalities are the first common problem; infectious diseases, like pollution, are negative externalities representing market failures, “because the terms of individual, private transactions do not fully account for the social costs of their spillovers,” Coglianese notes. For global health there are two additional issues. Governance is required to develop the public good of pandemic preparedness and control; and domestic governance, through government, is required to use force to control epidemics through, for example, quarantine, he notes. “Private markets are no match for a viral spread, as the prevention, management, and elimination of that spread essentially constitutes a public good; the full costs of addressing contagion vastly exceed the individual benefits to any single actor, but the provision of global health cannot be denied those who fail to contribute to it,” Coglianese observes. Coglianese highlights the government’s responsibility to prevent local outbreaks from becoming worldwide risks.

Coglianese also recognizes shared health governance’s concern with cross-border problems, where he sees a need for “regulatory cooperation or harmonization”, requiring “either a common set of institutional standards and rules about costs and capacities, or a system of mutual recognition of different countries’ standards,” he says. Such “interjurisdictional cooperation” is necessary and requires “both domestic regulatory responses and transnational regulatory coordination,” he notes. In federalist countries, such cross-border problems can occur within countries themselves, as in the United States with differing licensing schemes among states. Domestic regulation can be used as a policy tool, Coglianese argues, to create more equitable conditions for citizens.

Common solutions

Coglianese notes that while “regulation is associated with governmental entities that issue rules and rely on hard sanctions to enforce them,” over the past several decades things have changed. Coglianese makes a series of important points:

[B]oth the practice and the study of regulation has shifted toward recognition of its more highly fragmented and contested state of affairs, replete with multiple public and private actors. No longer is regulation viewed as merely a formalistic application of binding rules imposed by government on private industry. Today, governments around the world deploy a mix of tools, and binding rules are only one of many.¹⁰ The work of regulators encompasses extensive use of public outreach efforts, information campaigns, guidance statements, and technical assistance. Voluntary recognition or rewards programs are now quite common,¹¹ and public regulators take great interest in developing public-private partnerships in an effort to achieve regulatory goals.¹²

Especially illuminating for me has been Coglianese’s discussion of the “three ‘licenses’”: the “regulatory license”, which entails “the formal law and its enforcement”; the “economic license” involving “business imperatives”; and the “social license”,

encompassing “community pressure and social norms”. The latter two, particularly the social, can be as, if not more, influential than the regulatory license.

Common challenges

In “advanced pluralist societies,” “[r]egulators in the United States and Europe ... find themselves increasingly operating in an environment of growing inequality, polarization, and adversarialism”, says Coglianesi. I was fascinated to read his note, “[w]hen Prah Ruger observes that *shared* health governance ... depends largely on voluntary acceptance of norms, she could be writing about domestic regulatory governance as well.” While the enforcement power of the government is important and can actually serve as a step towards voluntary compliance, regulators also “aspire to solve problems rather than just impose penalties for their own sake,” Coglianesi notes. Regulation is fully successful at the “point where threats and sanctions are no longer needed,” he adds. His argument that compliance does not occur from the actual and continuous oversight of operations, a task too onerous for existing resources, but from what he states as the “widely shared norms about the legitimacy of the law to induce compliance”¹³ is illuminating.

Lessons for regulatory governance

The first lesson Coglianesi draws from my work is the important role for regulatory scholars and domestic regulators in “making progress toward health justice,” he says. He adds, “[b]uilding codes, environmental regulations, and workplace health and safety standards all purport to deliver benefits that promote healthy conditions for the overall public, including those with the least amount of resources.” Indeed, Coglianesi argues for considering the distributional implications of various regulations both in designing and evaluating regulations. I agree wholeheartedly that regulations can be an important tool for equity at the domestic level.

Use hard law strategically to reinforce soft law

Coglianesi rightly observes that I aim for iterative interactions among global and domestic institutions and that I recognize the need for hard law – particularly sanctions, incentives and punishments when needed. Ultimately, global support and incentives for domestic action interact such that “iteration and progression lead to an equilibrium in which global and national actors follow shared norms to carry out responsibilities in ways that rely on their respective comparative advantages,” Coglianesi says. Important in the application of hard law, he notes, is to use public resources as efficiently as possible to optimize public value, “targeting actors that pose the greatest risks to society,” he says. Regulations work in conjunction with non-legal norms and private motivations to create the conditions for what he calls “socially optimal behavior”. I agree completely with Coglianesi’s analysis.

Preserve and strengthen institutional trust and legitimacy

In my book, I argue that impartial institutions, by their impartiality and effectiveness, engender trust and legitimacy. When institutions deliver health equity and adhere to fair, open and accountable procedures, they will inspire confidence. “[P]ublic confidence, trust and legitimacy,” he notes, impact voluntary compliance as well as public support for regulation and oversight. Coglianese cites, usefully, the example of the United States Food and Drug Administration (FDA), Dan Carpenter’s analysis of the FDA and its fluctuating reputation for regulatory integrity and scientific rigor. Legitimacy and trust are essential in governance, as the Covid-19 pandemic has demonstrated, and they develop both through success in achieving substantive outcomes, such as health equity and through fair processes — what they achieve and how they act.

Be vigilant and dynamic in the face of changing behavior and conditions

The 2007 Andrew Speaker fiasco highlights the importance of dynamic, fast-moving and responsive public policy in contrast to dithering and status quo bias. Coglianese’s emphasis on “obligation management” is a useful concept that recognizes the need for governors to be agile and adaptable to govern effectively in turbulent times.

Coordinate with other actors and institutions

I appreciate Coglianese’s team sport analogy: shared health governance does indeed require multiple institutions and actors performing core functions and meeting fundamental needs through roles and responsibilities at the individual, local, state, and global levels. I also welcome the musical metaphor — that “domestic regulatory bodies often work best if they fulfill a role akin to the conductor of an orchestra — that is, by directing and steering others and leveraging businesses’ own capacities to fulfill regulatory functions,” he notes. The emphasis on nesting the regulator’s performance within a nexus of relationships provides a helpful picture of how regulation works at the domestic level. Regulators must be strategic in coordinating with other actors in the larger multi-level ecosystem of administrative entities, and with private sector actors.

Draw on a rigorous base of evidence and analysis

Empirical evidence of effectiveness, efficiency and accountability in global health governance is critical. Actors and institutions should use best practices and evidence-based standards for global and domestic public health interventions. I argue for a Global Institute of Health and Medicine to provide the needed scientific knowledge to undergird effective policies for both global and domestic systems. Coglianese rightly underscores the importance of grounding domestic regulations in rigorous “empirical evidence and analysis”.

Treat regulation as a relational activity rather than a mechanistic structure

Coglianese’s compelling reasoning leads us to the point, with which I very much agree, that both global health governance and domestic regulation are relational

activities, “intersecting with many different actors and sectors,” he says. He adds, “regulation is relational because it is ultimately about human behavior and about how to shape, direct, and modify that behavior.” I could not have said it better. A social movement or crisis reveals a need; the populace presses for legislation; the legislation authorizes regulations. The “social and political context” influences the “performance and meaning” of regulations, Coglianesse notes, which can be said for global health governance as well. In the end, both domestic regulatory governance and global health governance “are both about shaping human behavior in ways that will advance social objectives,” he says.

His article is a novel contribution, and I am immensely grateful for all that I have learned from his cogent comparisons between domestic regulatory governance and global health governance.

PRABHAT JHA: THE LINKS OF GLOBAL HEALTH GOVERNANCE, KNOWLEDGE AND PREMATURE MORTALITY

In his discerning article, linking global health governance, knowledge, and premature mortality,¹⁴ Prabhat Jha considers how provincial globalism and shared health governance are extended to solve global health problems. Jha reviewed case studies in global health that demonstrate significant progress and found that they fit what he calls the “Prah Ruger Conditions”. He argues, “I call three such conditions the ‘Prah Ruger Conditions’, and provide examples of their relevance both to actual progress in global health and to the generation of knowledge to reduce premature mortality.”

Building on Jha and colleagues extensive and important work in global epidemiology,¹⁵ childhood mortality declines, Jha argues, are one such case study. Jha argues that, rather than development assistance or any other single factor, progress in childhood mortality “occurred because it met the Prah Ruger conditions”. The first condition was fulfilled by what Jha called “collective aspiration[s]” in provincial globalism. These aspirations included the collective desire to reduce childhood mortality and the second condition, was met through a global minimalist approach, a streamlined collective effort by “a reasonably small set of implementors,” he says. In this second “Prah Ruger condition”, Jha refers to shared health governance based on a common goal. Jha also noted that saving a child’s life is becoming less expensive, similar to the cost curves for technologies like cell phones. Jha sees another “Prah Ruger condition” at work in the significant commitment made by governments to become low child mortality societies, by investing their own domestic resources and often by using low-cost technology, such as “basic immunization and clinical care for sick children,” he notes. This cost minimization in reducing child mortality is a promising case study and an application of the shared health governance and provincial globalism model, Jha notes, especially as it contrasts with the increasing expense of saving adult lives.

A second successful case study is that of the infectious disease, malaria, another area of Jha and colleagues’ multifaceted expertise.¹⁶ Malaria was taken particularly seriously in East Asia where many believe controlling malaria has been linked to the “East Asian Miracle”. At the same time, control of malaria in Africa wasn’t as successful, Jha notes, as “no collective aspiration for malaria control across countries was established.” In other words, a lack of shared values. As a result, Jha argues, “[t]he delay in collective aspiration also arose due to increasing resistance to drugs and insecticides.” However,

Jha believes the fact that more recent studies demonstrating that malaria is a critical contributor to child and adult mortality in India and Africa have renewed the focus on malaria control and, importantly, “proposals for better shared health governance models about control of the disease,” he notes.

A critical focus of Jha’s article is on knowledge generation. While he recognizes the role of my proposed Global Institute of Health and Medicine, Jha urges “greater exploration in further scholarship.” Jha astutely distinguishes between the generation of new knowledge and the dissemination and delivery of existing knowledge for disease control, provincial globalism addresses both. Jha makes the important point that, through new knowledge and technology, “the inflation-adjusted cost of saving a child’s life today is lower than it was in 1970.” I could not agree more. Knowledge and technology have improved population prospects for life expectancy. The Health Equity and Policy Lab (HEPL) that I founded and direct has collaborated globally to conduct research on the costs and cost-effectiveness of various therapies and interventions to save lives and improve health-related-quality-of-life with as few resources as possible. With collaborators, we have also conducted research on health financing worldwide, particularly the “role of public finance”, Jha notes, “in enabling these conditions to effect actual health improvements.” Research on health equity and health efficiency are essential components of the provincial globalism framework for advancing global health justice.

In arguing for a greater emphasis in global health governance for research and knowledge generation, Jha rightly points out the opportunity to draw lessons from the Covid-19 pandemic. Indeed, knowledge creation and dissemination would be the focus of the book’s proposed Global Institute of Health and Medicine, an independent and impartial institution to serve this function. Here again the proposed Global Institute of Health and Medicine serves a role in both creating a road map for what knowledge needs to be generated, disseminated and translated into effective policies, programs and practices to effectuate health equity. Public financing, as Jha rightly emphasizes, is critical for a stable and sustainable knowledge ecosystem. Indeed, knowledge generation has a role to play in improving governance conditions. He also highlighted the research in the book showing advances in what we know about public finance for sound public policy development and implementation. In conclusion, Jha argues for a re-examination of the role of overseas development assistance, in particular as the “creation of new drugs, diagnostics, vaccines, therapeutics, research protocols and risk factor epidemiology provides global public goods” and that “[i]t is likely that the Prah Ruger conditions would also hold for an expansive effort to create such knowledge”, he notes.

JILLIAN CLARE KOHLER: THE URGENCY OF MUTUAL COLLECTIVE ACCOUNTABILITY IN GLOBAL HEALTH GOVERNANCE

In her clear and concise article on the urgency of Mutual Collective Accountability¹⁷, Jillian Clare Kohler argues that shared health governance is a “bold global health model” towards a new way forward in global health. Kohler focuses on accountability, an area she has contributed expertly to for many years, particularly her important work on corruption, ranging from the problems with corruption in the pharmaceutical sector to those in countries and sub-national entities to within, and in working with, international organizations.¹⁸ Mutual Collective Accountability is a proposal that would hold states

democratically accountable, and other institutions like the World Bank and World Health Organization would also be held accountable, through joint requirements. This would involve ex ante agreements with continual and ex post assessments.

Kohler argues that Mutual Collective Accountability (MCA) “is urgently needed in global health governance to foster a sense of solidarity amongst countries and bring global cooperation into force.” She argues that taking a nations first approach to global health governance will only “lead to further collective losses,” and that a shared health governance approach to recognizing our interdependencies and to “fostering global cooperation,” are critical for global public health, including addressing the Covid-19 pandemic.

Kohler welcomes MCA as a concept of accountability, she particularly emphasized its clarity, noting that “[c]larity matters, because if we do not know specifically what accountability means, its authenticity is undercut.” MCA’s delineation of duties has the potential for correcting some of the problems that exist in global health governance. Kohler is rightly concerned about “the complexity and ambiguity of accountability” that “continues to be a persistent challenge in global health governance”, she notes. Kohler’s concise survey of accountability forms and mechanisms – citing “external and internal accountability; performance and compliance accountability; bureaucratic accountability; horizontal accountability; financial accountability; and managerial accountability” -- builds on her and colleagues’ prior work,¹⁹ and concludes with two key observations. First, she notes, “ossified power structures that govern global health and influence” the application of any and each of these accountability forms and mechanisms. As a result, she argues that we need a “corrective” that digs deeper, leading to Kohler’s second observation that, “[w]e are thus left with a murkiness to accountability that calls for the corrective that Prah Ruger provides.” In other words, it makes little sense to layer the various forms and mechanisms of accountability on an existing system with an existing underlying structure that is flawed, a corrective with roots in an alternative underlying approach to global health justice and governance is required. Moreover, MCA, rather than exacerbating inequitable structures and institutions can “minimize power asymmetries by advancing a horizontal form of accountability”, she notes.

Still, Kohler has questions about MCA’s implementation. She worries about the excessive diffuseness and how common understandings are advanced. A particularly important concern she has is how to safeguard MCA from efforts to undercut it. Kohler notes that MCA has the ability to “help build a common agenda” and to “generate trust amongst actors.” For example, MCA both enables and requires trust, and trust requires multiple transactions, not just one. Trust also assumes good will. MCA will face key challenges. First, it will need to be able to manage corrosive entities who undermine cooperation, particularly in an era of ample misinformation and fake news. Second, in order to establish collaboration, MCA requires a certain degree of trust and agreement, which is challenging in the real world. Third, MCA must reckon with identity politics, an us versus them mentality. Despite these challenges, and many more, MCA aims to “foster[] a sense of shared responsibility” and to “ensure[] transparency by setting out responsibilities, clear objectives, and reporting methods for each actor involved”, Kohler notes. This in turn will “generate [] more trust”, she says. As Covid-19 has made patently clear, we must accelerate these processes to solve problems of global health of the 21st century and beyond.

KOK-CHOR TAN: GLOBAL HEALTH JUSTICE: REFLECTIONS ON PRAH RUGER

In his article²⁰, Kok-Chor Tan asks three philosophical questions of global health justice. The first relates to “the relationship between health capability and a human right to health” and “could the concept and language of human rights not be utilized to *further* health capabilities,” he asks. The second compares equality and sufficiency and Tan asks whether global health justice requires securing a “defined level of health sufficiency” for all persons or “regulating or limiting health inequalities as a goal per se.” His third question asks whether global health justice is “a special case or ... part of a larger theory of justice.” In his article, Tan disintegrates provincial globalism and discusses these strands separately. I believe the issues are interrelated.

Directness of exposition distinguishes Tan’s work and benefits philosophers and non-philosophers alike. I will seek to respond to each question in turn. At the heart of my response is a belief that human rights, and a human right to health or health care in particular, are what we have reason to covet on grounds of justice. Thus, my theory of global health justice and governance attempts such integration and restructuring. I welcome the opportunity to collaborate with Tan in his critical probe.

Health capability vis-à-vis a human right to health

Tan wonders whether a human rights approach can further the health capabilities project. He distinguishes, correctly and persuasively, between negative and positive rights. He also notes the controversial nature of the human right to health and of positive rights more broadly. But Tan believes that the human right to health can be useful in furthering my project because as he notes, “rights are justified demands against others” and rights come in when care and concern fail. When a person has a human rights claim, then that person has a justified claim against the state when it fails in care. Tan believes that while there are still quarrels about whether a case can be made for positive rights, the concept of a human right to health is no longer an alien concept but is part of human rights language. Tan concedes that the follow through on positive rights in practice has been imperfect.

Tan also notes that both the human right to health and the health capability paradigm are controversial in that effectuating a moral duty to promote either is challenging. Tan believes that the human right to health has more force in that it has an international legal framework behind it. The health capability paradigm, however, has the moral force of both the deductive and inductive reasoning that undergirds it, as explicated elsewhere.²¹ To be sure, the health capability paradigm is a less familiar concept than the human right to health, and the idea of human flourishing is less neutral and may be more controversial than human rights. Tan argues that “rights” per se make a justified demand on other persons to provide them. So, rights, on this account, are procedural and deontological; they require a substantive basis for their content. Rights are claims — that’s the work of a right. But what are rights claims to? What is the substance or content of the right?

Tan’s point on practicality and strategic advantage is well taken. The language of rights is less foreign than the health capability paradigm; and enforcement of the human right to health is more immediately feasible through, for example, adjudicating an individual’s claim against the state. I agree with Tan: this is the current system, and it is

both familiar and established — existing claims have been enforced against states. However, I don't believe we need to shortcut the process of social change by accepting the status quo more broadly and the immediate feasibility of the human right to health more specifically. Indeed, problems with effectuating the human right to health have actually worked to disestablish this right, requiring a restructuring of its foundation. Thus, I have argued elsewhere for reconsidering the human right to health as an ethical demand for *equity in health* effectuated through *reforms and transformative change* in public policy and public moral norms, as well as the development of individual and collective capabilities.

In the health capability paradigm and provincial globalism, what we have reason to value is deeper and broader than the narrowly construed human right to health, or even health care. For one, the individualistic and self-interested nature of human rights is a double-edged sword, with problematic conceptualizations. As with many moral intuitions, the problems with current conceptions of the human right to health and health care are visible from conceptualization to implementation.

Secondly, individuals are not islands detached from each other and from the social environment. But the methodological individualism of the current human right to health and health care approach treats individuals as disconnected and isolated from each other and society. It leads to mechanistic social aggregation rather than capturing the dynamism and interaction among individuals and their environments. By contrast, valuing individuals' abilities to do and be what they want to do and be in a social context, also created and upheld by those individuals, respects each person's individuality, but doesn't lump them into one social category. It also respects the societies they create and in which they live.

Thirdly, restructuring a human right to health by reconceptualizing it as an ethical demand for equity in health amplifies the societal importance of and collective interest in the ability to be healthy. As a result, it is *effectuation* through public policies and public moral norms that *effectively* creates the conditions for individuals and societies to be healthy and flourish. The health capability paradigm is built both on deductive and inductive reasoning, the latter of which creates the empirical evidence base for realizing equity in health. The real world is a laboratory of natural experiments both throughout history and across cultures. On my view, justice requires integration of knowledge, the empirical evidence of what has worked and what needs to work better in effectuating health equity. This objective line of inquiry fosters creativity for social problem solving. My theory of provincial globalism and shared health governance thus proposes the design and implementation of impartial and independent institutions and procedures that reveal the truth and differentiate it from what is false. A just world needs just institutions to create a healthy and flourishing environment for all people, not just those with individual claims with access to lawyers and the courts.

The health capability paradigm provides this substantive basis and principles for grounding the right, but it can also ground entitlements from the state. Tan argues that the usefulness of rights is that if the state fails as the primary response then it is of international concern. If the state is unable to protect the human right then it becomes a global justice issue. An international response is both appropriate and required, according to Tan.

Tan suggests "that there is value to talking about a human right to health", and on this point I agree. He goes on to state that "Prah Ruger, reasonably, is uneasy with the

idea of a human right to health.” It isn’t so much that I am uneasy with the idea but that we need a coherent and compelling analysis that grounds what we owe each other in both substantive and deontological principles. My choice of focal space is that of human flourishing and capabilities and for global and domestic health policy domains the focal space is health capabilities and in particular central health capabilities – preventing premature mortality and avoidable morbidity. Problems arise with the human right to health in the following areas.

In offering his interpretation of a human right to health, Tan argues that this right should not require states to fulfil an obligation to “some defined basic level of health” because this requirement “would be too demanding and implausible.” The reasons are two-fold: (i) “[p]eople can experience health deficits – natural illness – in spite of anyone’s best effort” and (ii) “to actually realize good health as matter of obligation can be unreasonably costly and demanding for society if actual health attainment is understood as a matter of right that a society must do all within its power to realize,” Tan notes.

The first reason concerns people with disabilities. People will indeed experience health deficits despite “best effort[s]” to address natural illness, but an accepted understanding of what we do or do not owe such individuals is necessary. People with disabilities will require different levels of resources to function in society. What we owe individuals are conditions giving them the opportunity to be healthy and flourish, given their individual circumstances – a more caring and compassionate way to respect their human dignity. These conditions for functioning optimally in one’s social environment are neither easily individuated nor divisible. For example, medical and social scientific research as well as social structures and systems required for optimal functioning – to prevent illness and injury as well as treat it upon onset – are to be available to all, across the population, not divisible to a single individual.

The second reason relates to the so-called “bottomless pit problem;” some object to expending societal resources for particular health conditions – rare diseases, catastrophic accidents or significantly debilitating injuries due to their costs. Some health conditions do require considerably more costly treatment than others. The question is whether the solution is to eliminate these conditions from coverage or to tackle these high costs through cost minimization and other efficiency measures. I do not believe people in need should be denied treatment with blunt cutoffs, rather a stepwise approach in which clinical input precedes economic analysis is important.

Tan argues, drawing on Henry Shue’s²² work, that the right to health should require the state to protect individuals “against ‘standard threats’ against good health.” I appreciate Shue’s early work supporting positive rather than solely negative rights, and I am sympathetic to Tan’s concern for “standard threats,” but if the human right to health is to have the “moral force” Tan promises it needs greater conceptual clarity. To ensure the moral force, individuals must have recourse through their “justified claims against their state (and the international community secondarily) if they do not receive these protections and coverage,” Tan notes. His conception of a human right to health implies: (i) the human right to health is “a shield for individuals against abuses”; (ii) a human right to health is a “safeguard[], as it were, that can [be] activated in times of moral failure”; (iii) an individual has a claim against her state, “and the international community secondarily”, when abuses occur, and the safeguard of the human right to health is to be “activated” in such cases, Tan notes. Thus, Tan’s human right to health conception is a

backward-looking corrective justice account, one which deploys both domestic and global legal instruments. Individuals have claims against the state (and the international community secondarily) for rights violations as a result of state's wrongful conduct, which allows for failure to protect and cover. Moreover, if one's right to health is violated, making a claim on the state for remedy requires legal resources to meet the burden of proof, for example, demonstrating lack of access to health care. The legal and financial barriers to a successful outcome are significant.

But will justice be served on such an account? Will repairing the wrongs of state actors lead to justice? This is an empirical question, and these assumptions have been broadly tested in some states, including, for example, Brazil and Colombia²³. Individuals in Brazil have "activated" their claims against the state for moral failures to provide protections and coverage with litigants achieving high rates of success: corrective justice is served. Individuals have successfully pressed claims demanding curative medical treatment, primarily medicines, to satisfy their "health needs" in the majority of cases. The human right to health has carried the "moral force" and level of enforcement Tan asserts in his account.

But distributive justice has been the loser, as this approach has deepened health inequity.²⁴ My approach requires decisions about the distribution of resources more broadly; individuation is a conceptual mistake. Further, the scope, jurisdiction and content of the human right to health is conceptually indeterminate. The scope problem rises from the multiple factors influencing health within and beyond the health sector; provincial globalism places both internal and external health capabilities within the scope of justice. The jurisdiction problem results from the multiple agents and mechanisms with jurisdiction over a human right to health; shared health governance recognizes respective roles and responsibilities of state and non-state actors, families and individuals themselves. As to content, including both functioning and agency in the scope of justice is essential: both health outcomes and health agency have moral relevance because people must use health agency to promote their own health and the health of others.

Analysis at the philosophical level illuminates these worries. Some years ago, I had the privilege of participating in the Neubauer Collegium for Culture and Society and the Pozen Family Center for Human Rights at the University of Chicago symposium, "Is Health Care a Human Right?" While all the symposium presented papers and discussant commentary were excellent, Gopal Sreenivasan in particular highlighted several key philosophical challenges with the human right to health. This analysis, along with contributions from other participants, were published in a special 2016 issue of *Theoretical Medicine and Bioethics*. Sreenivasan argued that "[n]either a human right to health nor a human right to health care has a good footing," indeed, "causes of health fall outside the jurisdiction of any individual moral right. A fortiori, they fall outside the jurisdiction of a right to health."²⁵ Conducting a "standard philosophical analysis of claim-rights, according to which they correlate with (directed) duties," Sreenivasan states that, "[w]orking out a coherent and attractive alternative analysis would consequently be a useful service that philosophical advocates of health and human rights might render to their non-philosophical colleagues." This is precisely why I believe we need a social scientific approach, one that incorporates political economy at the intersection of philosophy, economics and political science, to offer theoretical and empirical solutions to these pressing problems.

Indeed, drawing on Cary Coglianese's excellent article in this issue, regulation, he states, "will not succeed if it is viewed a matter of just putting rules on the books. It must be agile and responsive." I believe similar reasoning applies to legal rights. We have learned this lesson, through inductive reasoning, from hundreds of attempts to hold states accountable for failing to uphold the human right to health. Just in Brazil, for example, scientific evidence has played little role in judicial and public decision making. The distribution of benefits has followed an individual's ability to litigate rather than principles of distributive justice and has had a severe impact on the public health budget.

Health and the ability to be healthy require large-scale social and political action among multiple actors. An individual is but one person among many who will benefit from a given policy, and the state is but one actor among many who collaborate to achieve health both for that individual and across the population. An individual right to health is thus unable to capture the full costs and benefits of addressing "threats" to health. Call this the "rights failures" problem, because it is analogous to "market failures" in which individual transactions do not fully account for social benefits and costs.

"From the outset right to health litigation in Brazil rules out the possibility of choosing the treatments that will do the most good from a population perspective," Daniel Wei L. Wang writes. "It makes the public health system less efficient because an enormous amount of resources are spent based on poor evidence and in a way that does not maximize the potential benefits. It also creates unfairness because it generates a two-tier public health system and distributes resources according to patients' capacity to litigate,"²⁶ he states

My approach to this quandary is to reconceptualize a human right to health as an ethical demand for health equity. This approach is grounded in health capability, but it also provides morally defensible ways to set limits on what we owe each other. Societal choices inevitably involve setting up moral hierarchies; rather than dodge this necessary element of social theorizing, provincial globalism takes it head on.

I agree with Tan that "rather than seeing human rights and capabilities as opposing approaches, we might see them as complementary," and have written previously on the relationship among flourishing, health capabilities and the human right to health.²⁷ And I agree that my "idea of health capability does not evade philosophical controversy any more than the idea of a human right to health does," as Tan notes. I also believe that in exploring the complementarities we might actually find that the health capability paradigm provides a coherent theoretical grounding for the right to health.²⁸

The Pattern of Just Health Distribution: Equality or Sufficiency?

Tan asks what constitutes just distribution of global health goods. For distributive justice, Tan suggests that there are two propositions. The first, egalitarianism, addresses inequality. The second, sufficiency, is to ensure people meet an identified level or threshold, which can be robust or minimal. Tan argues "that global health justice is ideally egalitarian without demanding that all cases of inequalities pose equally significant or urgent problems of injustice". He characterizes the shortfall inequality approach as sufficientarian.

While I agree with much of Tan's characterization of egalitarian and sufficientarian approaches, there is more to the story: my shortfall inequality approach is a hybrid among equality, sufficiency and priority, one that avoids the leveling down objection of

equality and the bottomless pit problem of prioritarianism. The core idea is human potential. Reducing shortfall inequalities in health capabilities constitutes a just distribution in global health.

Tan's analysis also did not address a significant philosophical problem with the straight egalitarian or equality perspective, and I believe that the shortfall equality concept helps to address this problem. Equality can be conceptualized as shortfall equality, *shortfalls of actual achievement from the optimal average* (such as physical performance or typical lifespan) or attainment equality, the prototypical egalitarian approach, involves "*absolute levels of achievement*".²⁹

Attainment equality does not take maximal potential of groups or individuals into account and limits societal obligations to address achievement potential. This levels down goal achievement to the low level equality for everyone and every group (e.g., life expectancy of 35 years for both groups). This does not allow individuals and groups to reach their full potential.

As an alternative, the shortfall equality concept takes human diversity into account without "levelling down" the entire group's achievement goals. It assesses arrangements in terms of whether it "brings people as close to good functioning as their natural circumstances permit."³⁰

Shortfall equality can be used at the societal level to quantitatively assess society's realization of its health potential and what remains unrealized, focusing on what is possible and prioritizing resources to reduce the gap between potential and achievements. The government is responsible for governing the correction of such injustices. Shortfall can also be assessed at the individual level. The state must create and maintain conditions for each individual to live and choose a good life.

The Economics of Health Capability: Efficiency, Scarcity and the Right to Health

With his focus on the human right to health and egalitarianism, Tan did not address scarcity or efficiency, essential analytical components in distributive justice theory. Efficiency is important in provincial globalism; efficiency principles apply to equity goals; reducing shortfall inequality in health capabilities efficiently.

Additionally, we owe each other health insurance, not just enforcement of a human right to health, because the financial implications of a medical need can be bad for our health and flourishing. The health capability paradigm supports financial protection in health in a way the human right to health does not.

As I argue elsewhere, attempts to reduce inequalities in individuals' abilities to be healthy and achieve optimal health levels with the fewest resources requires a joint economic and clinical solution.³¹ At the societal level, public health experts, physicians, and citizens design a package of services and goods to which all individuals are entitled, addressing equity. Then cost-effectiveness and cost-minimization analyses help shape these decisions to ensure efficiency.— This process addresses the competing social obligations of efficiency and equality, avoiding the conceptual and operational mishaps of legal enforcement of the human right to health noted above.

At the individual level, individuals, armed with full information about risks and benefits, decide for or against a public health or clinical intervention. Input from public health experts and physicians provides objective information for effective decision-making.

Is health justice special?

Tan asks whether health justice is a “separate case” or part of a larger theory of justice. Is health intrinsically valuable, instrumentally valuable or both? Do we look only at the distribution of health goods or do we consider it as part of the overall distribution of goods? Tan offers climate justice for comparison. Should the duty to reduce CO₂ emissions be allocated equally? Or should we take climate justice as a part of a larger theory of justice, thus requiring us to factor in economic inequalities and the situation of poorer countries?

I have argued that health is both intrinsically and instrumentally valuable. It is valuable in its own right and important for enabling other important capabilities. So, indeed, provincial globalism sits within a broader global justice theory that takes human flourishing in all its dimensions as the focal space for evaluation. That said, provincial globalism does not overreach in prescribing principles of justice for each and every area of our lives, a daunting and predictably futile exercise.

Several distinctions can help place these complex matters within an overall theory of justice.³² The first is the distinction between varying objectives of health policy. Provincial globalism develops and defends the use of a particular objective—health capability—for assessing justice and efficiency in global health policy. The second distinction is between global health policy and other policies (e.g. environmental or income policy), even though they are not independent. Thus, it is important to clarify, first, what health policy is and is not, and second, the role of other policies in affecting health and health capability. A third distinction is between replacing and supplementing domain-specific criteria in policy assessment. In assessing, for instance, income policy, do we supplement traditional criteria with health indicators? Or do we assess these other domains only by their impact on health? Multiple domains impact multiple outcomes in a system of interdependence.

Global players should focus on all determinants of flourishing and health. To promote human flourishing global actors and institutions should foster global financial stability, equitable growth, country participation in global fora, global public goods, development assistance and debt relief, technical assistance, and open markets and fair and equitable trade.

Global public health goods are promoted by global health functions. These functions depend on global health actors playing varying roles, fulfilling their duties to remedy inequities in health, and deploying their power, affluence, and political, social, and economic opportunities to this end. Though global actors are secondary to states in the health realm, they express the international community’s will to create public goods, address equity concerns, and rectify global market failures. While no global institutions have the power and authority of global government, the global health architecture can be developed and reformed to manage global health better and expand justice.

JUSTICE NONVIGNON: OF INEQUALITIES AND VALUES: THE CONFUSION AND HOPE IN GLOBAL HEALTH GOVERNANCE

Justice Nonvignon is concerned with values and inequalities, particularly the role of values in global and domestic health policy.³³ He scrutinizes the intended and unintended consequences of the current global health governance system, revealing both confusion

and the reasons we have to hope for reform going forward. Importantly, Nonvignon has highlighted the significance both of underlying values and of the global health institutions that entrench or fail to embed such values — centrally related to my theory of global health governance. I agree wholeheartedly that, as Nonvignon astutely notes, many “fundamental issues” in global health are “often left unanswered.” Nonvignon skillfully cuts to the crux of the issue: “the myriad problems caused mainly by actors and organization[s] in the pace of development assistance for health (DAH), especially relating to vertical and horizontal programs and the capacity of national institutions to cope with the many challenges that come with donor ‘proliferation’, he says. Nonvignon judiciously observes that the key issues in global health center around “financing and governance”, which in turn have implications for “the organization and delivery of health services, human resource, availability and use of information,” as well as “how the world reacts to emergencies such as Ebola virus disease (EVD) and COVID-19 (Coronavirus)”, he says. I could not agree more.

Skewing in global health

Nonvignon makes a critical point about the skewing of the global response to health inequalities. He argues that such responses have “either created further inequalities or exacerbated existing ones” as diseases like AIDS, TB and Malaria have received a preponderance of increases in financing and other diseases, like Chagas and Leprosy, get little. In addition, global responses have prioritized some population groups over others, for example by gender. Targeting, Nonvignon argues, has created new inequalities even in addressing existing ones, and yet global actors have ignored these resulting inequalities. Rather, congruent with *Global Health Justice and Governance*, Nonvignon states that global health actors need to focus “on creating institutions that have the capability to target any and all health challenges that emerge – not some”. This is precisely the challenge advanced in my book: we need a holistic paradigm for establishing institutions and systems that create the conditions for all people to be healthy, not just certain population groups, not just those suffering from particular diseases.

Helping them vs helping us

Nonvignon then takes on the global health architecture, arguing that global health inequalities have “affected not only the distribution of health outcomes ... but the entire architecture of global health, from decision making structures, training to financing of global health research to authorship and ownership of research outputs.” He rightly calls out the global health governance system as one in which wealthy and influential countries and actors are the *haves* helping the *have nots* or, as Nonvignon puts it, “helping them”. In this dynamic, inequalities persist and grow. Nonvignon argues that the focus should rather be on “helping us.” Stressing underlying values, he highlights our ongoing work on African values in the Akan philosophical teachings that emphasize “helping others as a way of helping oneself”, Nonvignon says.

Global health colonization as global health injustice

Nonvignon highlights “disturbing’ trends” of colonization in global health, creating a system that gives, he says, “little to no role in the decisions affecting” the health of those it purports to serve. Nonvignon cites the inequitable representation by gender and north-south geography on global editorial boards, commissions, and committees. He is equally critical of civil society groups who are similarly unaccountable. And he adds, “as Prah Ruger also argues ... global health inequality is tantamount to injustice.”

On the question of “what is acceptable’ to everyone,” he observes, “building global health governance on values, as argued by Prah Ruger is key to bringing global health closer to communities,” Nonvignon notes. This is provincial globalism, in which a global consensus accompanies a provincial consensus on health morality.

Clarity and accountability

In conclusion, Nonvignon argues that “global health institutions create further inequalities ... represent[ing] significant confusion on the current global health landscape, with negative ramifications for health.” Civil society organizations deepen the confusion by professing to “work[] in the ‘interest of the people,’” he notes, yet are not accountable to these very people. I agree with Nonvignon that hope for the future rests on national and global actors and institutions built and held accountable for addressing the needs of the people – global or local.

CONCLUSION

In conclusion, I am grateful for the opportunity to provide some responses to the fruitful commentary presented in the symposium and workshop on my book, *Global Health Justice and Governance*. I would like again to express my gratitude for participants for their generosity, kindness and for what I have learned from their thoughtful contributions.

Jennifer Prah Ruger is Amartya Sen Professor of Health Equity, Economics and Policy and Professor of Medical Ethics and Health Policy at the School of Social Policy & Practice and Perelman School of Medicine and Founder and Director of the Health Equity and Policy Lab (HEPL) all at the University of Pennsylvania.

Acknowledgments I gratefully acknowledge support from the University of Pennsylvania University Research Foundation (URF), Perry World House and Penn Global. We thank Victoria Wu, Sarah Kim, Anjali Mahajan, and Elisabeth Rogers for organizational, administrative and editing assistance. Many thanks again go to guest editor, Benjamin Mason Meier, and Global Health Governance Editor, Yanzhong Huang, as well as Managing Editor, Courtney Page-Tan, for their excellent work on the workshop and special symposium issue on *Global Health Justice and Governance*.

-
- ¹ Benjamin Mason Meier, “Global Health Justice as a Foundation for the Future of Global Health Governance,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ² Mary Bassett and Zinzi Bailey, interview with Rebecca Cooney, *America: Equity and Equality in Health 3: Structural racism and health inequities in the USA*, *The Lancet*, podcast audio, April 21, 2017, <https://www.thelancet.com/doi/story/10.1016/audio.2017.04.26.5193>.
- ³ Mary T. Bassett and Sandro Galea, “Reparations as a Public Health Priority – A Strategy for Ending Black-White Health Disparities,” *New England Journal of Medicine*, October 8, 2020, Retrieved from <https://www.nejm.org/doi/full/10.1056/NEJMp2026170>
- ⁴ Mary Bassett and Zinzi Bailey, interview with Rebecca Cooney, *America: Equity and Equality in Health 3: Structural racism and health inequities in the USA*, *The Lancet*, podcast audio, April 21, 2017, <https://www.thelancet.com/doi/story/10.1016/audio.2017.04.26.5193>
- ⁵ Rupert Neate, “Bill Gates, Jeff Bezos, and Warren Buffett are wealthier than poorest half of US,” *The Guardian*, Nov. 8, 2017, Retrieved from <https://www.theguardian.com/business/2017/nov/08/bill-gates-jeff-bezos-warren-buffett-wealthier-than-poorest-half-of-us>
- ⁶ Lawrence O. Gostin, “Health Injustice: The Dominant Global Narrative of Our Time,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ⁷ Jennifer Prah Ruger, “A healthy constitution,” *The RSA*, Sept. 25, 2020. Retrieved from <https://www.thersa.org/comment/2020/09/healthy-constitution>.
- ⁸ Cary Coglianese, “What Regulators Can Learn from Global Health Governance,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ⁹ Cary Coglianese (ed.), *Achieving Regulatory Excellence*, (Washington DC: Brookings Institution Press), December 2016.
- ¹⁰ Orly Lobel, “The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought,” *The Minnesota Law Review* 89 (November 2004): 342-470.
- ¹¹ Jonathan C. Borck and Cary Coglianese, “Voluntary Environmental Programs: Assessing Their Effectiveness,” *Annual Review of Environment and Resources* 34 (2009): 305-324, <https://doi.org/10.1146/annurev.enviro.032908.091450>.
- ¹² Cary Coglianese, “Getting the Blend Right: Public-Private Partnerships in Risk Management,” in *The Future of Risk Management*, eds. Howard Kunreuther, Robert J. Meyer, and Erwann O. Michel-Kerjan (Philadelphia: University of Pennsylvania Press, 2019), 325–343.
- ¹³ Tom R. Tyler, *Why People Obey the Law* (Princeton University Press, 2006).
- ¹⁴ Prabhat Jha, “The Links of Global Health Governance, Knowledge and Premature Mortality,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ¹⁵ Robert E. Black et al, “Global, regional, and national causes of child mortality in 2008: a systematic analysis,” *The Lancet* (2010): 1969-1987.
- ¹⁶ Hellen Gelband et al, “Is Malaria an Important Cause of Death Among Adults?” *American Journal of Tropical Medicine and Hygiene* (2020): 103:41-47.
- ¹⁷ Jillian Clare Kohler, “The Urgency of Mutual Collective Accountability in Global Health Governance,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ¹⁸ Jillian Clare Kohler, Andrea Bowra. Exploring anti-corruption, transparency, and accountability in the World Health Organization, the United Nations Development Programme, the World Bank Group, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Globalization and Health* (2020) 16:101.
- ¹⁹ Hapuhennedige, Sandani, Emma Charlotte Bernsen, and Jillian Clare Kohler. “Exploring accountability and transparency within international organizations: what do we know and what do we need to know?.” *Integrity, Transparency and Corruption in Healthcare & Research on Health*, Volume I (2020): 125-139.
- ²⁰ Kok-Chor Tan, “Global Health Justice: Reflections on Prah Ruger,” *Global Health Governance Journal*, Volume XVI, No. 1, Spring Special Symposium Issue, 2021.
- ²¹ Jennifer Prah Ruger, *Health and Social Justice*, (Oxford: Oxford University Press, 2010)
- ²² Henry Shue, *Basic Rights*, ed. 2, (Princeton: Princeton University Press: 1996).
- ²³ Colleen M. Flood and Aeyal Gross, “Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach?” *Health and Human Rights Journal*, Sept. 25, 2014, Retrieved from <https://www.hhrjournal.org/2014/09/litigating-the-right-to-health-what-can-we-learn-from-a-comparative-law-and-health-care-systems-approach-2/>.

-
- ²⁴ Octavio Luiz Motta Ferraz, "The right to health in the courts of Brazil: Worsening health inequities?" *Health and Human Rights Journal*, (2009): 11(2): 33-45, Retrieved from <https://www.hhrjournal.org/2013/08/the-right-to-health-in-the-courts-of-brazil-worsening-health-inequities/>.
- ²⁵ Gopal Sreenivasan, "Health care and human rights: against the split duty gambit," *Theor Med Bioeth* 37, 343-364 (2016), <https://doi.org/10.1007/s11017-016-9375-7>.
- ²⁶ Daniel Wei L. Wang, "Right to Health Litigation in Brazil: The Problem and the Institutional Responses," *Human Rights Law Review* 15, no. 4 (December 2015): 617-641, <https://doi.org/10.1093/hrlr/ngv025>.
- ²⁷ Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 Yale J.L. & Human (2006), Retrieved from <https://digitalcommons.law.yale.edu/yjlh/vol18/iss2/3>.
- ²⁸ Paul Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health," *Health and Human Rights Journal* 18, no. 2 (December 2016): 109-130, Retrieved from <https://cdn2.sph.harvard.edu/wp-content/uploads/sites/13/2016/12/Hunt-final-1.pdf>
- ²⁹ Sen A, Anand S. Gender Inequality in Human Development: Theories and Measurement. In: Background Papers: Human Development Report 1995. New York: United Nations Development Programme ; 1996. pp. 1-20.
- ³⁰ Martha Nussbaum, "Nature, function and capability: Aristotle on political distribution," *Oxford Studies in Ancient Philosophy* 6, (1988).
- ³¹ Jennifer Prah Ruger, "Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law," *Cornell Journal of Law and Public Policy* 15, no. 2, 2006, Retrieved from <https://scholarship.law.cornell.edu/cjlpp/vol15/iss2/3>
- ³² Jennifer Prah Ruger, "Ethics of the social determinants of health," *The Lancet*, 364, (2004): 1092,
- ³³ Justice Nonvignon, "Of Inequalities and Values: The Confusion and Hope in Global Health Governance," *Global Health Governance Journal, Volume XVI, No. 1, Spring Special Symposium Issue*, 2021.



A publication of the Center for Global Health Studies,
The School of Diplomacy and International Relations, Seton Hall University