BOOK REVIEW

Micah L. Berman. Pursuing Global Health with Justice: Review of Global Health Law. By Lawrence O. Gostin (Harvard University Press, 2014. 560 pp.).

In 2000, Lawrence Gostin published the first edition of Public Health Law: Power, Duty, Restraint. With that book, which now has a third edition in progress, Gostin sought to ‘explain why public health law is a coherent field, distinct from other intellectual activities at the intersection of health and law’. Gostin’s book played a major role in triggering a ‘renaissance’ of public health law, which, although possessing deep historical roots, had largely been lost in the shadow of health care law in the second half of the 20th century. Since 2000, there has been a ‘proliferation of public health law scholarship, with new law school courses, new casebooks, new treatises, and an ever-growing number of law review articles and symposia’. While world events such as the emergence of HIV/AIDS and the threat of bioterrorism attacks led to a renewed interest in public health issues, Gostin deserves much of the credit for crystallizing that interest into an emerging academic discipline.

With his new book, Global Health Law, Gostin has once again assumed the task of outlining a new field. As the O’Neill Professor of Global Health Law at Georgetown Law and the director of Georgetown’s O’Neill Institute for Global Health Law, Gostin has written extensively about global health law over the past decade. With this book, he seeks to organize the subject in a systematic way, while exploring in depth some key

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1 Lawrence O. Gostin, Public Health Law: Power, Duty, Restraint vii (2000).
2 Lawrence O. Gostin, Public Health Law: A Renaissance, 30 J. L. Med. Ethics 136, 140 (2002).
3 Micah L. Berman, Defining the Field of Public Health Law, 15 DePaul J. Health Care L. 45, 56 (2013).
4 Lawrence O. Gostin, Global Health Law xi (2014) [hereinafter Gostin, Global Health Law] (stating that one of the goals of the book is to ‘define the field of global health law’).
5 See, eg, Lawrence O. Gostin & Eric A. Friedman, Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice, 13 Yale J. Health Pol’y L. Ethics 1 (2013); Lawrence O. Gostin, A Framework Convention for Global Health: Health for All, Justice for All, 307 J. Am. Med. Ass’n 2087 (2012); Lawrence O. Gostin & Oscar A. Cabrera, Human Rights and the Framework Convention on Tobacco Control: Mutually Reinforcing Systems, 7 Int’l J. L. Context 285 (2011); Lawrence O. Gostin & Devi Sridhar, Reforming the World Health Organization, 305 J. Am. Med. Ass’n 1585 (2011); Lawrence O. Gostin, Redressing the Unconscionable Health Gap: A Global Plan for Justice, 4 Harv. L. Pol’y Rev. 271 (2010) [hereinafter Gostin, Health Gap].
topics including the surge of non-communicable diseases (NCDs) in the developing world and the international migration of health workers. From the very beginning, though, it is clear that Global Health Law is an underinclusive title. Gostin’s interest is not limited to laws about global health; his concern extends to nearly everything—that affects global health. As Gostin concedes early in the book, the true unifying topic is ‘Global Governance for Health’, which he defines as ‘the collection of rules, norms, institutes, and processes that shape the health of the world’s populations’. This incorporates law, norms, and policies related to trade, intellectual property, the environment, labor conditions, ethnic and gender discrimination, and much more.

In comparison to Public Health Law (especially the first edition of that book), Global Health Law takes a much more normative and prescriptive approach. Much of Gostin’s book is a powerful and heart-felt plea for social justice on an international scale, which is foreshadowed by a prologue containing brief yet disturbing firsthand accounts from children who live in urban squalor or rural deprivation in various places around the globe. Throughout the book, Gostin returns to the theme of ‘global health with justice’, highlighting the deep health disparities found both across and within countries. At the same time, the book is chock full of very specific policy recommendations, dealing with everything from retooling the World Health Organization’s (WHO’s) funding mechanism, to ensuring more equitable access to vaccines, to creating a new ‘Global Fund for Health’. These two characteristics—a social justice orientation combined with detailed policy suggestions—will make the book an invaluable resource for health advocates and NGOs working on the global level.

However, these same characteristics undercut the book’s coherence as a legal treatise. Early on, Gostin writes that his book ‘sets out the international legal framework that is needed, but is not yet established, to empower the world community to advance global health, consistent with the values of social justice’. But as impressive and inspiring as that vision is, it is difficult to build a legal treatise around one’s vision of what the law should be. It seems that Gostin was torn between writing a policy manifesto, a call to action, and a legal treatise, and in the end the book is an occasionally confusing combination of the three. For readers unfamiliar with the field, it may at times be difficult to discern when Gostin is explaining settled law and when he is setting forth his opinion.

Likewise, to the extent that Gostin was trying to lay the groundwork for a new academic field of inquiry, the broad, interdisciplinary reach of the book works against that goal. As Gostin correctly notes, international regimes relating to trade, intellectual property, finance, the environment, agriculture, and energy (to name just a few) impact health as much as, and probably much more so than, laws and norms that focus explicitly on health. Trying to create an intellectual framework that will stretch across such diverse fields, however, is a nearly impossible task. As a result, the animating themes Gostin uses to frame Global Health Law—‘health equity’, ‘good governance’, ‘global solidarity’, and others—are diffuse and highly subjective.

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6 Gostin, Global Health Law, supra note 4, at 72.
7 Id.
8 See Id. at xiii–xv.
provides a shakier foundation on which to grow an academic field than did *Public Health Law*.

**GLOBAL HEALTH LAW & PUBLIC HEALTH**

Although *Global Health Law* is a difficult book to categorize, it is full of creative and insightful intellectual contributions. The most important and enduring contribution may prove to be Gostin’s fluid harmonization of public health and global health. Throughout the book, but particularly in the book’s closing chapter (where he outlines his vision of the future), Gostin reconceptualizes global health law in a way that puts populations, prevention, and the social determinants of health at the center of the agenda. In particular, he emphasizes that the ‘right to health’ should not be considered in solely individual and clinical terms, because no one can live a healthy life if he or she lacks the basics of clean water, basic sanitation, access to safe food, and so forth.\(^9\) Likewise, the basic socioeconomic determinants of health—‘education, income, housing, employment, social inclusion, and gender/racial/ethnic equality’\(^10\)—influence one’s health more powerfully than clinical medical care and should therefore be included in the ‘right to health’ discussion as well.

Gostin is astounded that these basic insights of public health seem to be overlooked in the siloed, disease-specific world of international health assistance. He writes with some alarm:

> What seems remarkable is that modern conceptions of global health rarely focus on fundamental public health services. What rich countries take for granted in their domestic policies they rarely prioritize in international health assistance…. If there were a single message I could convey to global health leaders, it would be to first attend to the task of building a habitable, safe environment.\(^11\)

This lack of focus on public health basics has real and devastating consequences. For example, Gostin notes that despite the $8 billion in reconstruction aid poured into Haiti in the aftermath of the 2010 earthquake, ‘the most obvious, pressing needs—potable water, sanitation, safe/stable housing, and electricity—remain[.] unmet’.\(^12\)

Gostin’s call to re-envision what the ‘right to health’ and what ‘global health with justice’ might look like is the most powerful and engaging part of the book. He argues that the right to health ‘must be conceived as primarily a collective right’ to the basics of a healthy environment, rather than as an individual right to any specific set of medical services. As he explains, conceptualizing the ‘right to health’ as solely an individual right potentially undermines population health, because court-ordered spending on expensive medications or services may ‘crowd[.] out higher-priority health needs’.\(^13\)

This is a provocative and controversial stance, which is likely to be resisted by many in

\(^9\) Id. at 415–16.

\(^10\) Id. at 417.

\(^11\) Id. at 415–16.

\(^12\) Id. at 422 (according to Gostin, ‘[o]nly a fraction of the aid disbursed went to building a public health infrastructure, with the lion’s share going to current programs, medicines, and a teaching hospital’).

\(^13\) Id. at 268. Gostin instead suggests that courts could be sensitive to this dynamic by (1) enforcing a governmental obligation to spend ‘the maximum available resources’ on health, (2) requiring the provision of ‘at least prevention, primary care, and essential needs’, and (3) focusing on the needs of vulnerable populations. *Id.*
the (more individually focused) human rights community. But Gostin, whose distinguished career has spanned both human rights and public health,\textsuperscript{14} is the perfect person to initiate this constructive debate.\textsuperscript{15}

Gostin’s public health orientation also flows into other aspects of his book. For example, in addition to an extended discussion of NCDs, he also shines a spotlight on unintentional injuries, highlighting their global dimensions and their role in deepening global inequalities. For example, he emphasizes the dangerous and sometimes deadly working conditions facing low-income workers in countries who produce clothes and other consumer goods for export, and he notes that ‘low- and middle-income countries experience 80 percent of the world’s total traffic fatalities, despite having only 52 percent of registered vehicles’.\textsuperscript{16} These are not issues generally included in the global health conversation, but Gostin makes a persuasive case that caring about global health must mean caring about the conditions in which the world’s poorest residents live their everyday lives.

In the context of infectious disease, Gostin’s public health perspective is evident when he cautions that ensuring access to vaccines and antiviral medications is of limited use to low-income countries if they do not have efficient systems in place to ensure their timely and efficient distribution. This is another weakness of the disease-specific structures that provide most of the funding for global health; no one assumes responsibility for addressing the infrastructural issues that undermine the effectiveness of health-related assistance. As a result, Gostin’s depressing conclusion is that if a virulent strain of influenza emerged, ‘[t]he world would face the unconscionable situation where the rich were protected while the poor would die, unable to access … life-saving resources’.\textsuperscript{17} His suggested reforms therefore focus on improving governance and building sustainable distribution systems, not just on increasing levels of funding for the acquisition of vaccines and medications.

Gostin recognizes the difficulties in integrating public health concerns into global health, particularly the fact that governments ‘are less likely to provide support for broad systemic changes that fail to capture the public’s imagination’.\textsuperscript{18} (Building sanitation systems and health infrastructure is crucial, but not sexy.) As discussed in the following section, Gostin’s programmatic suggestions to overcome this challenge are not fully satisfying. Nonetheless, \textit{Global Health Law} adds critical new insights to the question of what the ‘right to health’ should mean, and it goes a long way towards a productive fusion of the fields of global health law and public health.

\textsuperscript{14} For background on Gostin’s career, see Lawrence O. Gostin, \textit{From a Civil Libertarian to a Sanitarian}, 34 J. L. SOC’y 594 (2007).
\textsuperscript{15} The discussion about whether and how global health assistance should incorporate public health dimensions has been going on for some time. See, eg, Laurie Garrett, \textit{The Challenge of Global Health}, FOREIGN AFFAIRS, Jan./Feb., 2007, at 14–38 (arguing that ‘because the efforts [global health funding] is paying for are largely uncoordinated and directed mostly at specific high-profile diseases—rather than at public health in general—there is a grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground’). Gostin, however, adds legal content to this debate and moves it forward by situating it within the context of the ‘right to health’.
\textsuperscript{16} Gostin, \textit{Global Health Law}, supra note 4, at 49, 50–52.
\textsuperscript{17} Id. at 381.
\textsuperscript{18} Id. at 432.
CHALLENGES OF PROVIDING GLOBAL GOVERNANCE FOR HEALTH
In Global Health Law, Gostin goes well beyond an exploration of the intellectual underpinnings of the field; he actively advances his vision of Global Governance for Health and tries to provide a roadmap—replete with specific policy recommendations—for reaching that goal. In doing so, his book is inspirational and visionary, but one could question whether his roadmap fully accounts for the many challenges and roadblocks along the way. In considering the possibilities of Global Governance for Health, one must fairly evaluate both parts of that phrase, including consideration of (a) the limits of global governance, particularly within the health sector, and (b) the challenge of prioritizing health in a world with many competing priorities.

The Limits of Global Governance
‘Global Governance’ may seem like a troubling term, as it suggests a supranational legal system that can override or dictate domestic law. In reality however, most global governance—particularly as it relates to health—is an exceedingly weak form of governance. If there is a single phrase that dominates Gostin’s text, it is: ‘Although not binding…’. The vast majority of international law involving health is ‘soft’ law (if ‘law’ is even the right term), meaning that states have no formal obligation to comply. Even many ‘harder’ forms of international law, however, have only limited force. For instance, consider the Framework Convention on Tobacco Control (FCTC), which is the only health-related treaty negotiated under the WHO’s auspices. It constitutes the most powerful form of governance available to the WHO. Yet in 2012, seven years after the agreement went into force (and 17 years after negotiations on the treaty began), fewer than half of the parties had implemented a complete ban on smoking in private workplaces as required by the agreement. The FCTC has undoubtedly prodded some countries to strengthen their tobacco control laws when they might have been slower to do so otherwise, but it has constituted a fairly gentle nudge, not a hard shove.

Gostin would like to make international health law ‘harder’, and in particular he calls for a more muscular role for the WHO. But it is not clear how this could practically come about. At its core, the WHO is an organization of member states, and when the WHO leadership has tried to push its members (especially its most powerful members) further than they were willing to go, it has backfired with serious consequences. As Gostin recounts, the WHO’s progressive policies in the 1970s, culminating in its ‘Health for All’ campaign based on the Alma-Ata Declaration, contributed to its loss of influence.

Once they realized the economic and political implications of committing themselves to primary health care for every person in the developing world, the United States and

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19 Gostin notes that the Nomenclature Regulations (standardizing disease classifications) and the International Health Regulations (addressing infectious disease control) were also technically negotiated under the WHO’s auspices. However, these agreements both predated the establishment of the WHO and were revised by the WHO under its Article 21 authority to issue regulations, not its Article 19 authority to ‘adopt conventions or treaties’. Id. at 110–13.

20 WORLD HEALTH ORGANIZATION, 2012 GLOBAL PROGRESS REPORT ON IMPLEMENTATION OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL 20 (2012), http://apps.who.int/iris/handle/10665/79170 (accessed 19 August 2014). This was only among the countries that reported their progress to the WHO; it is likely that countries that did not report had even lower implementation rates.

21 Gostin, Global Health Law, supra note 4, at 132–33.
other developed countries balked. Instead of joining the campaign to provide ‘primary health care’ for all, they turned to the World Bank to implement ‘selective primary health care’, a much less costly (and less comprehensive) set of targeted health interventions. Furthermore, in order to better control its activities, the large donor countries started attaching strings to funding provided to the WHO—a practice which continues to this day.

It is hard to see how things would play out any differently today, particularly given the still-sluggish global economy. Gostin devotes the closing pages of his book to the Framework Convention for Global Health (FCGH), a proposal for which he has been the leading champion. The FCGH, though not itself a central focus of the book, clearly reflects Gostin’s vision of a WHO that uses its ‘hard’ law powers to actively push forward a progressive normative vision focused on the ‘right to health’ (including the broader public health concerns discussed above). As envisioned, the FCGH would, *inter alia*, ‘establish clear national and international financing responsibilities, with enforceable norms’. Although this would be a welcome development, Gostin has written elsewhere—with considerable understatement—that ‘the negotiation of a multilateral treaty involving resource distribution from rich to poor states would face political obstacles that limit its prospects of success’. Most obviously, the USA is certain to oppose any international agreement based on the ‘right to health’. This is a right that the USA has resolutely refused to recognize, and the ‘right to health’ framework is, for better or worse, antithetical to the ‘constitutional structure, political tone, and judicial precedent that currently define U.S. health policy’.

Although the USA may be somewhat of an outlier in its outright refusal to acknowledge a ‘right to health’, in many other countries such a right is recognized only in the breach. (Gostin writes that ‘[h]uman rights [including the right to health] are routinely and often flagrantly violated, and enforcement is weak’. It is likely the ‘soft’ nature of

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22 See John J. Hall & Richard Taylor, *Health Care for All Beyond 2000: The Denise of the Alma-Ata Declaration and Primary Health Care in Developing Countries*, 178 MED. J. AUSTRALIA 17, 20 (2003).

23 Gostin, *Global Health Law*, supra note 4, at 133 (noting additional reasons why major donor countries lost confidence in the WHO).

24 In the notes following the text, Gostin refers to the FCGH as the ‘founding vision of the O’Neill Institute’. Id. at 522.

25 Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI), *Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health*, May 14, 2014, http://www.jalihealth.org/documents/platform-for-an-fcgh-march-2014-full-4-7-14.pdf (accessed 19 August 2014). Gostin tries to downplay the ‘hard’ nature of the proposed FCGH, writing that it could ‘begin as a soft, nonbinding instrument’ and morph into a more binding set of rules over time. Gostin, *Global Health Law*, supra note 4, at 437.

26 Gostin, *Health Gap*, supra note 5, at 272.

27 Gostin tries to argue implicitly that the USA has endorsed this right because it has ratified the International Covenant on Civil and Political Rights (ICCPR). Gostin, *Global Health Law*, supra note 4, at 244 (writing that ‘[a]ll countries have ratified at least one treaty recognizing the right to health’). This is a stretch, as the ICCPR includes a ‘right to life’, but does not specifically mention a ‘right to health’.

28 Indeed, in 2008, the US State Department went out of its way to criticize a mere fact sheet from the WHO for using the term ‘right to health’. Id. at 120; US Department of State, *Observations by the United States of America on “The Right to Health, Fact Sheet No. 31”*, http://www.state.gov/documents/organization/138850.pdf (accessed 19 August 2014).

29 Katherine L. Record, *Litigating the ACA: Securing the Right to Health Within a Framework of Negative Rights*, 38 AM. J. L. MED. 537, 538 (2012).

30 Gostin, *Global Health Law*, supra note 4, at 244.
international law (even in its ‘harder’ forms) that makes so many countries willing to recognize ‘rights’ that they proceed to willfully disregard. And even more concrete commitments, for example agreements with respect to infectious disease control, are readily flouted under pressure from domestic constituencies. For example, during the 2009 H1N1 influenza pandemic, ‘many states disregarded WHO advice, curtailing travel to North America, banning pork products, and screening or quarantining international travellers’.31

A push for greater ‘Global Governance for Health’ must realistically address the fundamental limits of global governance in a world of state sovereignty.32 But national governments play a relatively small role in Gostin’s account, and when they appear, the vast differences between their governmental systems, their geopolitical interests, their internal political dynamics, and their power on the world stage are nearly completely absent (apart from generic distinctions between high-, middle-, and low-income countries). Gostin rightly decries the ability of major donor states to control the WHO’s agenda, but why would those countries voluntarily give up that power?33 Similarly, why would countries agree to provide more stable and predictable health funding over the long term, if that would weaken their influence over the recipient countries? Gostin is relentlessly optimistic and high-minded, hoping that countries will realize their enlightened self-interest in reducing global health inequalities. But the structural limits of global governance, the very limited history of cooperation on health issues, and the inherent disorderliness of global politics all suggest that enhancing Global Governance for Health will be a much heavier lift than Gostin lets on.34

**Prioritizing Health Concerns**

A related challenge to Gostin’s vision of Global Governance for Health is the secondary status that health concerns occupy in the world of international diplomacy—and often in the realm of domestic policy as well. Trade and intellectual property issues are the key examples used in *Global Health Law,* and Gostin reviews case after case where international trade interests (driven by multinational corporations, as much as by national governments) have come into conflict with health concerns. More often than not, health has lost out when such clashes occurred.35 The one, partial exception is the case of HIV/AIDS, where unprecedented global activism led to some softening of the

31 *Id.* at 202.
32 See Lawrence O. Gostin & Devi Sridhar, *Global Health and the Law,* 370 NEW ENG. J. MED. 1732, 1734 (recognizing that ‘[t]he WHO … lacks the authority to enforce compliance and thus relies on governmental implementation through domestic law and policy’).
33 See Leigh Haynes et al., *Will the Struggle for Health Equity and Social Justice be Best Served by a Framework Convention on Global Health?*, 15 HEALTH HUM. RTS. 111, 113 (2013) (writing that ‘there is a sharp contradiction between the proposition that the WHO might adopt an FCGH and the significant influence some donors hold over the WHO’). Gostin’s book also lacks a clear theory that would explain why more powerful states should relinquish their control over the WHO and other international bodies. Gostin repeatedly states that ‘human health is a globally shared responsibility’, Gostin, *Global Public Health,* supra note 4, at 19, but the book lacks an overarching theory of the nation–state that would explain the origins and nature of such a responsibility.
34 In a ‘response to critics’, Gostin has argued than even if an FCGH is not achievable in the short term, the process itself will be beneficial because it can serve to mobilize civil society and generate higher visibility for global health concerns. Lawrence O. Gostin et al., *Towards a Framework Convention on Global Health,* 91 BULL. WORLD HEALTH ORG. 790, 792 (2013).
35 The secondary status of health concerns in global governance is one reason why Gostin has been advocating a Framework Convention on Global Health. See *Id.* at 791 (writing that ‘the human right to health cannot
intellectual property rules that had made effective therapies completely unaffordable for those in low-income countries. Even the flexibility provided for HIV/AIDS drugs, however, has been limited, and Gostin accurately sums up the issue this way: ‘[T]he net effect of trade rules has been to impede access to affordable treatments for the world’s most vulnerable people’.

Only a few pages later, however, Gostin downplays the tension between trade and health, suggesting that the World Trade Organization (WTO), in consultation with the WHO, should move health closer to the center of its agenda. Gostin writes:

At first glance, it might appear there is an antagonistic relationship between the objectives of health and trade. Yet success in both fields depends on mutually beneficial arrangements. A fair and vibrant trade system would raise everyone’s standard of living, which would benefit global health and development. At the same time, a healthy population is more creative and productive, which bodes well for trade and investment. All countries will be inclined to participate in the ideals of trade liberalization if they feel that their population’s health and welfare are high priorities.

Here, as elsewhere in the book, Gostin’s dogged optimism leads him to disregard the contrary historical evidence that he carefully recounted only pages earlier. The tension between trade interests and health is real and deep, and it cannot be so quickly or easily brushed away. Gostin provides little explanation for why the WTO, or the developed countries that largely drive its agenda, would suddenly shift gears and prioritize health concerns over economic ones.

Challenges for health are deeply engrained within the structure of the international trade regime. The tobacco industry’s use of international trade laws provides a telling case in point. If health concerns should be able to overpower trade interests in any sector, it should be tobacco, where the product at issue is unquestionably deadly and the vast majority of the world’s countries have (at least in theory) expressed their commitment to tobacco control by joining the FCTC. Nonetheless, trade laws provide a powerful tool for the tobacco industry, one that it has increasingly employed in efforts to override national tobacco control laws.

For instance, Australia adopted a plain packaging law in November, 2011, removing logos and imagery from tobacco packages and replacing them with standardized text (along with large, graphic health warnings). In addition to challenging the law in Australia’s domestic courts (which proved unsuccessful), the tobacco industry exploited every possible level of the international trade regime in its attempt to overturn the law. Even before the law was approved, Philip Morris announced that it would bring a trade challenge under the Australia–Hong Kong Bilateral Investment Treaty.

Bilateral agreements can compete with other legal regimes, such as those governing trade and investment, without a similarly robust treaty.

36 Gostin, Global Health Law, supra note 4, at 295.
37 Id. at 301.
38 In contrast to health-related law, trade law is made up of ‘harder’ legal commitments, although those too are sometimes ignored by member states.
39 Because countries like Australia that are active in international trade maintain BITs with numerous trading partners, ‘companies can “shop around” for the legal environment that will best aid their case, as Philip Morris appears to have done’. Holly Jarman, Attack on Australia: Tobacco Industry Challenges to Plain Packaging, 34 J. PUB. HEALTH POL’Y 375, 379 (2013).
investment treaties (BITs), of which there are more than 2500 worldwide, often provide that foreign companies can directly challenge laws adopted in countries in which they are invested, and, if successful, can demand compensation and legal costs (which, in a case like the plain packaging dispute, would likely amount to billions of dollars). Gostin appears to view the industry’s claim that the plain packaging law indirectly appropriates its property as somewhat frivolous, but BIT challenges are heard by arbitration panels composed of trade experts (not health experts). These panels are not bound by any system of precedent, their hearings are typically conducted in secret, and there is no system of appeal. Thus, the result of the arbitration panel, which is not expected to reach a decision until at least 2015, is highly unpredictable (and, in the meantime, the BIT challenge deters other countries from taking similar action).

Hedging their bets, the tobacco companies did not stop with the BIT claim. They also encouraged (and provided legal support to) other countries to challenge Australia’s law through the WTO process—even countries, like Ukraine, that had almost no direct tobacco trade with Australia. These challenges claimed that Australia’s law violated the Technical Barriers to Trade Agreement, the Trade-Related Aspects of International Property Rights (TRIPS) Agreement, and other international trade laws. Again, Gostin is unimpressed with the merits of these claims, but like the BIT claims, WTO disputes are heard by panels of trade experts, not health experts, which puts Australia at a disadvantage and makes the results uncertain. (Many health experts were surprised when a WTO panel, and subsequently the WTO’s appellate body, recently agreed with Indonesia that the USA had violated international trade obligations by banning clove cigarettes but not menthol cigarettes.)

The BIT and WTO claims provide multinational corporations like the tobacco industry with numerous bites at the apple—only one type of claim needs to succeed in order to scuttle the law. Moreover, these claims have a powerful deterrent effect on public health efforts, particularly in less developed countries; although Australia can bear the cost of simultaneously litigating in these various forums, many countries would be unable to afford to do so. Instead of pushing health concerns to the center of the agenda, international trade agreements seem to be moving in the opposite direction. The Trans-Pacific Partnership Agreement (TPPA), which is being negotiated among Pacific Rim countries including the USA and Australia, is likely to include ‘TRIPS-plus’ expanded protections for intellectual property, and it may include investor protections that allow multinational corporations to initiate arbitration claims against member nations. The major tobacco companies have specifically urged the USA to use the TPPA

40 Gostin, Global Health Law, supra note 4, at 232–33.
41 See JANE KELSEY, INTERNATIONAL TRADE LAW AND TOBACCO CONTROL 13 (2012); Gary Fooks & Anna B. Gilmore, International Trade Law, Plain Packaging and Tobacco Industry Activity: The Trans-Pacific Partnership, TOBACCO CONTROL [online first, June, 2013], http://tobaccocontrol.bmj.com/content/early/2013/06/19/tobaccocontrol-2012-050869.full (accessed 19 August 2014).
42 Jarman, supra note 39, at 381.
43 See Holly Jarman, Judith Schmidt & Daniel B. Rubin, When Trade Law Meets Public Health Evidence: The World Trade Organization and Clove Cigarettes, 21 TOBACCO CONTROL 596, 596 (2012) (concluding that the case demonstrates that ‘the piecemeal, incremental approaches that characterise much tobacco regulation in the USA and elsewhere do not fit well with the core principles of the global trading system’).
44 See generally Fooks & Gilmore, supra note 41; see also Jane Kelsey, The Trans-Pacific Partnership Agreement: A Gold-Plated Gift to the Global Tobacco Industry?, 39 AM. J. L. MED. 237 (2013). Following Philip Morris’s
negotiations to override Australia’s plain packing law and/or to keep other countries from adopting similar measures. The TPPA, and the Transatlantic Trade and Investment Partnership also currently under negotiation, may give the tobacco industry—and other industries that threaten public health—even more tools with which they can delay or obstruct much-needed regulations.

The public health community is increasingly (if belatedly) recognizing these dynamics and attempting to mobilize in response. But the international trade regime has been built up over decades in ways that put health interests at a severe disadvantage, and those concerned about health have little leverage in their efforts to force change. Attempts to introduce a ‘tobacco exception’ or a ‘health exception’ into the TPPA have so far been brushed aside. Gostin does an important service in bringing more attention to this issue, but he leaves the reader wondering how health concerns can be made more salient to the international trade regime.

As the health community shifts its focus to NCDs, the question of how health can compete with other priorities will be replayed over and over again, at both the international and domestic level. Unlike HIV/AIDS, tuberculosis, malaria, and polio, the main risk factors for NCDs—tobacco use, alcohol use, and unhealthy food—are promoted and exacerbated by powerful corporate interests. This may explain why NCDs account for two-thirds of deaths globally, yet account for less than one per cent of health-related development assistance. Responding to the surge of NCDs will require policy change more so than monetary assistance and pharmaceuticals (though those will be needed as well), and Gostin helpfully lays out a detailed policy agenda. But in addition to the trade challenges outlined above, countries—especially less developed countries—will face heavy opposition to both the adoption and implementation of laws that threaten corporate interests. Added to this are the general challenges in

challenge to Australia’s plain packaging law, Australia’s government stated that it would oppose the inclusion of investor–state dispute settlement provisions in future trade agreements. World Health Organization, Confronting the Tobacco Epidemic in a New Era of Trade and Investment Liberalization 87 (2012).

45 Fooks & Gilmore, supra note 41, at 4. In the past, tobacco companies have used the threat of retaliatory actions under regional free trade agreements like the TPPA to dissuade countries from adopting strong tobacco control measures. For example, Canada might have adopted plain packaging 20 years ago, if not for NAFTA. See R. J. Reynolds Tobacco Company, Submission of R. J. Reynolds Tobacco Company Re: Plain Packaging of Tobacco Products to House of Commons [Canada] Standing Committee on Health, May 4, 1994, http://legacy.library.ucsf.edu/documentStore/m/r/m/mrm97c00/Smmr97c00.pdf (accessed 19 August 2014) (claiming that proposed plain packaging law would ‘give rise to a claim under the provisions of NAFTA for hundreds of millions of dollars in compensation’). R. J. Reynolds also claimed that the proposal would violate GATT and the Paris Convention (a precursor to TRIPS). Id.

46 Holly Jarman, Public Health and the Transatlantic Trade and Investment Partnership, 24 Eur. J. Pub. Health 181 (2014).

47 See Fooks & Gilmore, supra note 41, at 5. As Fooks and Gilmore note, corporate representatives serve as official advisors to the US Trade Representative, meaning that they have access to and can influence drafts of the TPPA and other agreements (which are typically negotiated in secret), while the public health community is left in the dark.

48 For example, ‘trade disputes over access to NCD drugs are likely to increase, given the reality that US and European multinational drug companies have invested heavily in drugs for chronic conditions and see “emerging markets” ... as growth areas’. Roger S. Magnusson & David Patterson, The Role of Law and Governance Reform in the Global Response to Non-Communicable Diseases, Globalization Health [online first, June, 2014], http://www.globalizationandhealth.com/content/pdf/1744-8603-10-44.pdf (accessed 19 August 2014).

49 Id.
prioritizing preventive health, which Gostin has insightfully written about elsewhere, that only become more acute when governmental resources are limited.\footnote{See Lawrence O. Gostin, Health of the People: The Highest Law?, 32 J. L. MED. ETHICS 509 (2004) (explaining four key reasons why preventive health is ‘politically and publicly underappreciated’). Magnusson & Patterson have also written thoughtfully about these dynamics, noting, among other factors, ‘the reluctance of governments to adopt measures that could be perceived as creating a less favourable environment for foreign investment’. Magnusson & Patterson, supra note 48, at 8.}

Though he somewhat downplays them, Gostin is acutely aware of these tensions in prioritizing global health, and they are thoughtfully detailed in Global Health Law. But further innovative thinking is desperately needed to figure out how countries and international institutions can be effectively incentivized to prioritize health—and NCD prevention in particular—in the face of strong corporate opposition. In the long run, one measure of Global Health Law’s success will be the number of scholars and advocates Gostin inspires to take up this challenge.

CONCLUSION

In sharp contrast to most law treatises, Gostin’s passion, pathos, and outrage are evident throughout Global Health Law, and this emotional power lends extraordinary energy to the text. Although Gostin is optimistic about the capacity of global governance to improve living conditions for the world’s neediest, the legal doctrines he outlines demonstrate the limits of global governance and the glacial pace of reform, leading the reader (at least this one) to swing back and forth between hope and despair.

Global Health Law may fall short of laying out a well-developed template for a new academic field, and one can quibble with the specific policy recommendations, but Gostin’s vision of ‘global health with justice’, drawn from his experience in both public health and human rights, is nothing short of inspirational. The book—especially in its final chapter—seeks to move beyond the disease-specific programming that pervades the current global health landscape and initiates a broader discussion of what global health and justice would actually look like (and how we can get there). This is a difficult but long-overdue conversation, and hopefully Global Health Law will lead to a surge of interest in global health law scholarship that can tackle the bold challenges Gostin sets forth. Judging from Gostin’s successful track record of field building, one suspects that it will.

CONFLICT OF INTEREST

None declared.

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