Introduction

Improving and promoting global health continues to be one of the largest and most important challenges facing humanity in the twenty-first century. The task has become even more difficult since our first edition appeared almost a decade ago, given the accelerated destruction of the planet and the associated compounded threats to health that now present themselves. The emergence and spread of COVID-19 and the implications of this pandemic for life, health, and our planet exemplify how the world can change so rapidly and profoundly. The domino effects of the pandemic in an unstable global system are triggering multiple tipping points with implied radical alterations to the trajectory of life as we have known it. This is a stark reminder that despite all the major advances in science, healthcare, health, and longevity since the Enlightenment, and despite all the promises of genetic medicine and artificial intelligence, the long-term health and survival of our species are now, more than ever, intensely threatened.

This second edition, which was largely completed before COVID-19 and therefore cannot include a comprehensive review of its effects and ramifications, aims to showcase some of these new and escalating threats, along with illuminating some of the many other obstacles we now face in partnering globally to solve these formidable challenges.

By *global health*, we mean the health of all people globally within sustainable and healthy living (local and global) conditions. In order to achieve this ambitious goal, we need to understand, among other things, the value systems, modes of reasoning, and power structures that have driven and shaped the world over the past century. We also need to appreciate the unsustainability of many of our current consumption patterns (and here we include the escalating appetite for eating meat with all its implications for the live-animal ("wet") food markets and intensive animal farming that enable the transmission of zoonotic infections from animals to humans, as well as the severely adverse effects of meat production on the environment) and the driving forces that lie behind them, before we can address threats to the health and lives of current and particularly future generations.

The world and how we live in it have been changing dramatically over many centuries, but in the past 60 years, change has been more rapid and profound than ever in the past. Many positive changes have been associated with impressive economic growth and advances in science and medicine and in social policies regarding access to health promotion. These include greater focus on a primary healthcare approach with more equitable access, expansion of social programs to improve living conditions, and a welcome increasing emphasis on the rights of all individuals to be equally respected.

Sadly, emphasis on the exaggerated expectations of the most privileged people has resulted in neglect of a large proportion of the world's population with consequent widening disparities in wealth and health and exacerbation of the social and societal determinants of health. To give just one example, increases in air pollution caused major reductions in intelligence amounting to the equivalent of losing one year or more of education and killed 7 million people in 2015 – 16% of all deaths globally.[1] This is three times the annual deaths from HIV/AIDS, tuberculosis, and malaria combined. In addition, many of the world's healthcare "systems" have increasingly become *distorted*, *dysfunctional*, and *unsustainable*. By *distorted*, we mean that healthcare services are not designed to meet equitably the range of local demands posed by changing burdens of disease in aging and more ethnically diverse populations with multiple chronic noncommunicable diseases.

[1] Zhang, X., Chen, X., & Zhang, X. (2018). The impact of exposure to air pollution on cognitive performance. *Proceedings of the National Academy of Sciences of the United States of America* 115(37), 9193–9197. https://doi.org/10.1073/pnas.1809474115.

Dysfunctionality arises from health services being driven more by powerful adverse market forces and the escalating requirements of bureaucracy than by emphasis on serving patients optimally and sustaining the professionalism required of healthcare workers in the care of patients and the training of new generations of professionals. Increasing commodification of healthcare services and a much-expanded bureaucracy are among other complex forces contributing to physician burnout and patient dissatisfaction with the services they receive. Finally, marginal benefits for a few (driven by the self-interest of segments of the health machine, for example, the pharmaceutical industry, and the pressure to raise research funds and publish) are often prioritized while other cost-effective activities of potentially great benefit to many more people are ignored. The introduction of new, effective, but expensive therapies further strains resources and contributes to disproportionate rising costs of healthcare that are becoming *unsustainable*.

The stresses imposed on health systems globally by emergencies such as the COVID-19 pandemic reveal the "rescue" emphasis of biomedicine, with neglect of the public health and pandemic planning required to face such threats when they arise. COVID-19 has also been a stark reminder of the many millions of deaths and social devastation caused by the 1918 flu pandemic. The deaths of many front-line health workers and the inadequate provision of protective equipment highlight the personal risks resulting from weak commitments to public health, and remind us of the ethical challenges that healthcare professionals face with dedication and courage.

Disparities in health and access to healthcare thus continue to widen globally. Such disparities, combined with population growth, unsustainable consumption patterns, the emergence of many new infectious diseases (and multidrug resistance), accelerating catastrophic anthropogenic climate change, escalating ecological degradation, numerous local and regional wars, a stockpile of nuclear weapons, and massive dislocations of people and new terrorist threats, including cyber attacks (to list just some relevant factors), have severe implications for individuals' and populations' health.[2] Deeper understanding of the urgency of the challenges we face and the feasible changes that could be made to address them is a necessary first step toward expressing better commitment to genuine respect for the dignity of all people (and showing respect for everyone's dignity is an ideal our international agreements increasingly claim to embrace).

Adequate understanding of ethical issues concerning health requires that we extend our focus from the micro level of individual health and the ethics of interpersonal relationships to include ethical considerations regarding public and population health and justice concerns more generally, including environmental justice and stewardship for future generations. The domain of global health ethics provides a context within which the many relevant disciplines that have valuable insights to offer can usefully engage to promote better understanding of the extensive changes that are needed to assist in developing a global state of mind about the world and our place in it. Arguably this is more relevant than ever to making many of the necessary progressive changes required for survival on a wounded planet.

After noting the poor state of global health, there are *three main issues* covered by almost all contributing authors. They *direct our attention to ways in which we exacerbate poor global health* and *what we should do to remedy the factors identified* and *offer reasons why we ought to do something* about the highlighted problems, thereby connecting global health issues more strongly with the domains of social and intergenerational justice. Many of the chapters in this volume provide constructive suggestions about how national and global policy and institutional changes could function differently to make significant improvements. Together they contribute to a deeper understanding of the challenges we face in trying to improve global health and provide much practical and theoretical guidance toward building a case for our ability and motivation to make a real difference.

In what follows, we give a brief description of some key themes discussed in the chapters. A note

[2] We note here that the topics covered in this volume are by no means fully inclusive of the numerous problems that undermine and aggravate conditions for overcoming global health challenges. For example, we have not included chapters on such issues as global mental health, illicit trade in human organs, child labor, use of children as soldiers, trade in sex and drugs, cultural practices that have serious adverse health effects, pervasive corruption in business and healthcare, and widespread Mafia-like organizations that increasingly influence (even control) the lives of many. All these factors contribute to global injustices as well. Several chapters from the first edition of this book (11, 21, 22, 23, 26, and 27) have not been updated and included – yet remain of great relevance.

about structure might be important here. Because almost all the authors cover the issue of responsibilities and global health, it has been difficult to impose a rigid structure on these chapters and the subsections of the book. Like the subject matter under investigation, several issues are intimately linked. Our subsections are meant to guide the reader to some ways in which we might group the various chapters to highlight certain core issues, even though there are many possible pathways through this innovative collection. Indeed, most of the chapters tackle several key themes, presenting some important empirical information helpful in understanding why there is so much poor health, providing ethical analysis and argument, along with offering constructive ideas about how we should shape the future in efforts to improve global health.

The chapters in Section 5 perhaps diverge from this general pattern. They focus on an issue that we see as increasingly important to address, namely developing helpful insights into and guidelines regarding how we can better communicate with each other about global health issues across differences in ways of seeing ourselves and the world. The need for constructive cross-cultural dialogue in partnering to address global health issues has, in our view, been a neglected issue that deserves a much greater focus. Diverse perspectives, which rely on contrasting metaphysical, epistemological, cultural, political, and religious assumptions (to name just a few sources of widespread difference), inform the range of orienting normative frameworks adopted by people across the planet. In tackling our global health challenges, we need to take this diversity more seriously and develop stronger tools for meaningful communication to traverse divides that threaten the global solidarity required for peaceful progress. In short, we must improve our interphilosophies dialogue – a challenge requiring humility and tolerance. We hope that our highlighting this important need will encourage more theorists and practitioners to develop well-reasoned work in this crucial area.

Global Health: Definitions, Descriptions, and Some Central Relationships

Probably the most striking feature about the current state of global health is that it is characterized by such radical inequalities. Here are some examples of the more widely noticed and documented kinds: (1) maternal mortality in 2015 ranged from 7 per 100,000 pregnancies in Canada to 134 in South Africa, 789 in southern Sudan, and 1,360 in Sierra Leone,[3] (2) the death rate under five years of age ranges from 5 per 1,000 live births in Canada to 137 per 1,000 live births in Somalia, where the average fertility rate is 6.6 children per woman and 1 of every 12 Somalian women dies from pregnancy-related causes, (3) life expectancy at birth spans the wide range of 49 years to over 80 years, (4) annual per capita healthcare expenditure in 2014 extended from a low of less than $50 in many poor countries to over $9,000 in the United States, and (5) the number of physicians per 100,000 people ranges from 2 in Malawi to 351 in the United States, 328 in Sweden, and 591 in Cuba.[4] Within most countries, these patterns of difference also persist with dramatic (although typically smaller) differences in life expectancy and other key metrics of health between the highest and lowest socio-economic groups and across population groups.

Ted Schrecker and Ronald Labonte argue that a largely accurate explanation for these types of differences involves potentially avoidable poverty and material deprivation (Chapter 1). However, these authors remind us that we should resist the inference that policies that promote economic growth are therefore the best way to achieve good population health. There is a threshold level (at annual per capita income of about US$5,000) beyond which the relationship between life expectancy at birth and per capita incomes breaks down. In addition, we see many countries with very good life expectancies at birth despite quite low per capita incomes. For example, in Costa Rica, with a per capita income of about US$10,500 per year, life expectancy is 79 years, notably more than the 78 years those who reside in the United States can expect to live, where per capita income is greater than US$45,000.[5] Other social changes besides economic growth can have significant consequences for health. For example, improved female literacy and

[3] Of all the maternal deaths worldwide, 88% occur in two regions, Sub-Saharan Africa and South Asia (Roser, M., & Ritchie, H. [2013]. Maternal mortality. Available at https://ourworldindata.org/maternal-mortality).

[4] Gill, S. R., & Benatar, S. R. (2019). Reflections on the political economy of planetary health. *Review of International Political Economy* **27**(1). https://doi.org/10.1080/09692290.2019.1607769

[5] However, it should not be forgotten that economic growth remains important in countries with very low per capita incomes (e.g., <$2,000–$3,000) and that the extent of income disparities within countries is also important.

commitment to health as a social goal in Kerala (in India) have resulted in low infant and maternal mortality despite very low income (annual per capita income of about US$3,000). Another example is how increased urbanization and globalization have allowed the consolidation of power over food systems, which can lead to detrimental consumption patterns. Consider, for instance, how Mexicans now consume 50% more Coca-Cola products per person than those who reside in the United States.

Some gains in the state of world health have been achieved through improved vaccination coverage and access to affordable antiretroviral therapies, but much work remains to amplify these meager gains. Providing extra resources for healthcare is at least part of what is needed. Jeffrey Sachs has calculated that a tax of 1 cent in every $10 earned by the wealthiest 1 billion people in the world could provide the $35 billion required per year to give the poorest 1 billion people a $50 annual per capita healthcare package.[6]

However, we must be careful not to assume that health inequalities will resolve themselves as more resources are devoted to addressing deprivations in health directly. Many other factors are relevant. For instance, economic globalization is contributing to rising inequalities, which are likely to affect health inequalities through both direct and indirect channels, notably by affecting the distribution of political power and influence. Power asymmetries associated with globalization create and sustain harmful outcomes on many levels.

Indeed, the distribution of power and social, political, and economic resources is crucial in influencing and explaining population health. In Chapter 2, Anne-Emanuelle Birn and Ramya Kumar analyze the societal determinants of health: factors that shape health at various levels, including household, community, national, and global levels. Living conditions both at the household and at community levels can cause numerous ailments including respiratory, gastrointestinal, and metabolic diseases. Availability of potable water and adequate sanitation is a key factor. Though water is essential for life, more than a billion people (one-sixth of the world's population) have an inadequate supply. The facts about access to adequate sanitation are even more striking – almost half the world's population has inadequate access to basic sanitation facilities, which can result in soil contamination and increased rates of communicable diseases. The impact of other factors analyzed includes nutrition and food security (over 50% of child deaths are attributable to poor nutrition), housing conditions, public health and healthcare services, and transportation. Social policies and government regulation (or the lack thereof) can also affect health in dramatic ways through, for example, the domains of education, taxation, labor, and environmental regulations. Patterns of unequal resource distribution and political power thus play a fundamental role as the societal determinants of health. To address radical health inequalities effectively, we must adopt a societal determinants of health approach.

Infectious diseases are one of the most important areas for global concern. Historically, these have caused more morbidity and mortality than any other cause, including wars. Tuberculosis alone has killed a billion people during the last two centuries. The evolving global health system has done much to protect and promote human health. However, the world continues to be confronted by long-standing, emerging, and reemerging infectious disease threats. These threats differ widely in terms of severity and probability. They also have varying consequences for morbidity and mortality, as well as for a complex set of social and economic outcomes. To various degrees, they are also amenable to alternative responses, ranging from clean water provision to regulation to biomedical countermeasures. Whether the global health system as currently constituted can provide effective protection against a dynamic array of infectious disease threats has been called into question by recent outbreaks of Ebola, Zika, dengue, Middle East respiratory syndrome, severe acute respiratory syndrome, influenza, and most recently and spectacularly COVID-19 and by the looming threat of rising antimicrobial resistance. The concern is magnified by rapid population growth in areas with weak health systems, urbanization, globalization, climate change, civil conflict, and the changing nature of pathogen transmission between human and animal populations. There is also potential for human-originated outbreaks emanating from laboratory accidents or intentional biological attacks.

In Chapter 3, David Bloom and Daniel Cadarette discuss these issues, along with the need for a (possibly self-standing) multidisciplinary "Global Technical

[6] Jeffrey Sachs during a video conference presentation at the Canadian Conference on International Health, Ottawa, October 2009.

Council on Infectious Disease Threats" to address emerging global challenges with regard to infectious disease and associated social and economic risks. They suggest that such a council could strengthen the global health system by improving collaboration and coordination across organizations (e.g., the World Health Organization [WHO], Gavi [the Vaccine Alliance], the Coalition for Epidemic Preparedness Innovations [CEPI], national centers for disease control, and pharmaceutical manufacturers); filling in knowledge gaps with respect to (for example) infectious disease surveillance, research and development needs, financing models, supply chain logistics, and the social and economic impacts of potential threats; and making high-level, evidence-based recommendations for managing global risks associated with infectious disease. It has been argued elsewhere that without new forms of governance that transcend the current dominant paradigm, which has been causally implicated in current global health threats, insufficient progress is likely.[7]

Gender equality in medicine, global health, and science could potentially lead to substantial health, economic, and social gains. In Chapter 4, Geordan Shannon, Melanie Jansen, Kate Williams, Carlos Caceres, Angelica Motta, Aloyce Odhiambo, Alie Eleveld, and Jenevieve Mannell highlight both missed and future opportunities. They suggest that to understand these potential opportunities, gender analyses should be situated in the context of political influences and structural inequalities and draw on contemporary social movements. They outline some important differences between male and female patterns of health and illness and the care different health practitioners might offer. They argue for endeavors that go beyond quantitative gender equality and include striving for a cultural transformation that allows for the inclusion of values of transparency, honesty, fairness, and justice. They conclude that achieving gender equality is not simply instrumental for health and development but rather that its impact could have wide-ranging benefits as a matter of fairness and social justice for everyone.

Martin McKee presents an account of how health, well-structured and well-integrated healthcare systems, and economic growth can all coexist and be mutually supporting (Chapter 5). Healthcare, when appropriately delivered, can yield substantial gains in population health which further reduce the demand for healthcare. Better population health can result in faster economic growth through enhanced productivity. The additional economic growth can increase resources available for healthcare, and further investment in healthcare can also contribute to economic growth. None of this necessarily follows, however. Concerted action by governments is needed to ensure that these relationships are mutually supportive and beneficial.

Global Health Ethics, Responsibilities, and Justice: Some Central Issues

David Hunter and Angus J. Dawson explore the question of whether there is a need for global health ethics (Chapter 6). They begin by examining different ways of understanding the term *global health ethics* and proceed to examine arguments that could be used either to support or rebut more substantive accounts of global health ethics, including those based on beneficence, justice, and harm, and more cosmopolitan accounts. Some of the arguments they explore that are used to resist more substantive global health ethics include those concerning the moral relevance of distance, property rights, and duties to prioritize the interests of compatriots. They argue that we need not necessarily take a stand on any of these arguments to make a convincing case for the various global obligations we have with respect to health. Sometimes a case for global responsibilities pertaining to health can be marshaled via more self-interested concerns, such as with infectious diseases or with the public goods nature of many global health issues (again, as is the case with infectious diseases). It is gratifying that interest in global health ethics has expanded in the past decade.[8]

Jonathan Wolff makes a case for the strategic value of a human rights approach in contributing to positive global health outcomes (Chapter 7). Whatever concerns one might have about the philosophical or

[7] Gill, S., & Benatar, S. R. (2016). Global health governance and global power: a critical commentary on the Lancet–University of Oslo Commission Report. *International Journal of Health Services* **46**(2). https://doi.org/10.1177/0020731416631734.

[8] See, for example, Robson, G., Gibson, N., Thompson, A., et al. (2019). Global health ethics: critical reflections on the contours of an emerging field, 1977–2015. *BMC Medical Ethics* (2019) **20**:53. https://doi.org/10.1186/s12910-019-0391-9; Lowry, C. & Schüklenk, U. (2009). Two models in global health ethics. *Public Health Ethics* **2**(3), 276–284; Stapleton, G., Schröder-Bäck, P., Laaser, U., et al. (2014). Global health ethics: an introduction to prominent theories and relevant topics. *Global Health Action* **7**(23569), 1– 7.

theoretical grounds for the approach, it does have an important advantage, namely that in many cases because human rights are objects of actual international agreements, there are some powerful mechanisms of potential enforcement available for protecting health in certain cases. Illustrating the approach with reference to case law, Wolff shows how and when the approach might prove especially effective.

While global health policy increasingly locates the imperative to advance the social determinants of health within a human rights framework, it is unclear what this actually means in law and practice. Lisa Forman explores the extent to which international human rights law addresses the social determinants of health within its protections of the right to health (Chapter 8). She considers the practical impact of such laws, given that many are skeptical of such an approach, concerned, for instance, that the right to health is vague, ineffective, or damaging to population health outcomes.[9]

The idea of who is responsible for doing what with respect to global health is a key issue and one touched on by most of the contributors to this volume. Allen Buchanan and Mathew DeCamp offer some useful guidelines in translating our shared obligation to "do something" to improve global health into a more determinate set of obligations (Chapter 9). They argue that states in particular have more extensive and specific responsibilities than is typically assumed to be the case because they are the current primary agents of distributive justice, influential actors in the burden of disease, and indeed have the greatest impact on the health of individuals in our world. But nonstate actors (such as the World Trade Organization [WTO] and global corporations) have important responsibilities as well, which are discussed. Furthermore, institutional innovation is needed to enable distribution of responsibilities more fairly and comprehensively and to ensure accountability. Some of the determinate obligations Buchanan and DeCamp identify for states include avoidance of committing injustice that has health-harming effects, for example, not fighting unjust wars abroad or assisting in training military personnel of states likely to use force unjustly. In supporting unjust governments and upholding the state system, we contribute to upholding unjust regimes that have health-harming effects, not least through displacement and migration of people desperate to escape unlivable conditions. Simply refraining from such activities could do much to improve global health. As one example, they point out that between 2000 and 2006, 3.9 million people died in the Congo from war and that every violent death in that war zone was accompanied by no less than 62 "nonviolent" deaths in the region – from starvation, disease, and associated events.

Avram Ezra Denburg and Denis Daneman are concerned with global child health in Chapter 10. As they note, wide and remediable disparities persist in the health and well-being of children worldwide that warrant sustained ethical inquiry if we are to identify collective obligations to address them. This chapter is an effort to highlight some of the differentiating biological and normative dimensions of childhood to arrive at a more nuanced conception of how prevailing bioethical principles apply to children in a global context. Denburg and Daneman focus on three sentinel overlapping ideas that have fundamentally changed societal views on the status of children: the best interests of the child, children's autonomy, and the rights of the child. They then examine the role of current child rights law and scholarship in establishing and defending international responsibilities for the promotion and protection of child health globally. Finally, they consider a set of core principles for global health ethics – equity, freedom, and solidarity – and their specific application to child health, exploring potential synergies between global health ethics and child rights through the lens of early childhood development. Their analysis suggests that the moral language for addressing children's health and well-being globally remains underdeveloped – particularly in regard to collective responsibilities for policy and action.

Analyzing Some Reasons for Poor Health

In Chapter 11, Meri Koivusalo traces the many ways in which trade can and does affect health, and vice versa. It is clear that robust interests in trade can undermine health-related priorities and practice. For instance, trade liberalization policies in agricultural products can affect price, availability, and access to basic food commodities that result in less healthy diets

[9] Several other authors discuss the issue of human rights and health – the pitfalls and possibilities. Some are more skeptical about its current usefulness and draw attention to the fact that failure to meet human rights on a grand scale is predominantly the outcome of defects in global legal and economic structural arrangements (see Chapters 18 and 38).

for local populations and related issues of food security. Furthermore, trade liberalization has made available more hazardous substances such as tobacco and alcohol, leading to unhealthy consumption patterns. Poor, developing countries may be more vulnerable to adverse effects of trade liberalization than wealthier ones. We need improved global governance concerning health and trade that better acknowledges and tackles the wide-ranging effects of trade on health. The call for better global governance in a variety of domains is one that is made by many other authors.

Jeff Rudin and David Sanders explore the origins and factors that perpetuate the crippling debt that poor countries owe to the wealthy, focusing especially on structural adjustment programs (Chapter 12). They also explore the connection between debt and health and note that the magnitude of the debt owed by poor countries is frequently unpayable, especially in the case of Africa (the poorest continent) and not least because of the ongoing extraction of resources from such countries that intensifies their poverty and reduces their ability to repay debt.

The link between armed conflict, violence, international arms trading, and detrimental effects on global health is easy to appreciate. These adverse impacts include death, injury, and maiming from weapons use in conflict. There are massive opportunity costs to health, economic development, and human well-being when there is large-scale diversion of resources from health and human services to weapons expenditure. The impact of conflict can be far-reaching and includes important effects on children, such as psychological damage, loss of educational opportunities, destruction of families and nurturing environments, abuse, and the conscription of child soldiers. With trade in weapons growing fast and currently constituting one of the largest economies in the world, the effects on human health and well-being are worrisome.

Given these facts, it is no surprise that the World Health Assembly affirmed that "the role of physicians and other health professionals in the preservation and promotion of peace is the most significant factor for the attainment of health for all."[10] In their contribution to this volume (Chapter 13), Jonathan Kennedy, David McCoy, and Joseph Gafton analyze how the international arms trade affects global health. They begin by analyzing recent trends in the prevalence and nature of armed conflict. They then move on to investigate the nature of the international arms industry and its patterns of military expenditure and trade in weapons, threats to health from weapons of mass destruction, and efforts to prevent war. They also discuss how artificial intelligence might influence the nature of armed conflict in the future and the implications of these developments for health. The indirect effects of war on health are often unappreciated, and protracted health crises are often a festering feature of war-torn countries.

Samia A. Hurst, Nathalie Mezger, and Alex Mauron discuss many of the complex issues involved when our duties to rescue bump up against significant resource shortages (Chapter 14). They describe the ethical challenges that face such organizations as Doctors Without Borders with humanitarian agendas that are driven by a rights-based view of international health. Both in the initial phases of many humanitarian disasters and in their aftermath, there are difficult issues concerning fair allocation. An increasing number of humanitarian situations are protracted rather than acute, and here it is particularly difficult to honor rights-based claims to healthcare. Hurst, Mezger, and Mauron illustrate how the challenges extend beyond meeting emergency needs to dealing with more protracted crises and the implications these have for "propping up repressive and irresponsible governments." They focus on how resources could be fairly allocated when it is not possible to meet all needs, and they offer a variant of the Daniels and Sabin account of procedural fairness as a plausible option.

The high media profile of humanitarian crises in recent years has attracted resources from wealthy countries. Whereas some of these resources are new, others represent shifts in allocations within only minimally increased official development aid (ODA) budgets. Indeed, there have been significant shifts away from projects that may contribute to structural developments with the potential to advance the economies of poor countries toward humanitarian emergencies and specific health problems – for example, HIV/AIDS. Whether or not such aid is effective has been a topic of great controversy in recent years. Overlapping and contesting views have been offered.[11] Although it is clear

[10] World Health Assembly, The Role of Physicians and Other Health Professionals in the Preservation and Promotion of Peace Is the Most Significant Factor for the Attainment of Health for All. Available at https://apps.who.int/iris/handle/10665/160590.

[11] See, for instance, William Easterly (2006), *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good* (New York: Penguin Press); Paul Collier (2007), *The Bottom Billion: Why the*

that some impressive short-term gains have been achieved in focused areas (such as HIV/AIDS), it is generally agreed that, for a variety of reasons, disappointingly little development of infrastructure or economies has resulted from ODA.

Anthony B. Zwi begins by describing the marked changes in patterns of health-related development assistance in recent years (Chapter 15). He provides an overview of both the value and the underpinning values that shape development assistance for health (DAH) in a chapter structured around four key elements: (1) motivations and influences on development assistance, (2) trends in development assistance for health, (3) debates and critiques of "aid" structures and approaches, and (4) ongoing challenges around more meaningful and equitable DAH. He also reviews some controversial aspects of ODA, such as trends in the magnitude of such aid, the intentions that lie behind it, possible shortcomings (in particular as ODA relates to global health), and some emerging issues that require attention. He does so by considering the "seven deadly sins" associated with ODA described by Nancy Birdsall. These constitute impatience with institution building, envy among competing donors, ignorance as evidenced by failure to evaluate impact, pride (failure to exit), sloth (using participation to justify ownership), greed (stingy transfers), and foolishness (underfunding of public goods). He focuses his discussion on how these sins impact on health and concludes with some recommendations for new approaches. Some new references update the metrics in this chapter.

Eduardo Gomez draws attention to an international consensus that has emerged in recent years that emphasizes the need for nations to combine the two previously separate areas of healthcare and foreign policy (Chapter 16). This has led to a movement toward global health diplomacy. Global health diplomacy certainly has an important role to play in sharing critical healthcare information and avoiding the spread of pandemic diseases. However, we should be mindful of important challenges related to inequality that this move presents; for instance, in the quest to increase a nation's international influence, it might underinvest in domestic healthcare systems or focus on particular diseases of international concern to the detriment of local populations' other health needs. The recent withdrawal of US funding for the WHO illustrates the potential adverse impact of unilateral decision making on global health.

Solomon Benatar, Ross Upshur, and Stephen Gill draw attention to the fact that scientific and technological progress and diverse socioeconomic systems contributing to fostering great "accelerations" in the scale of production, consumption, communication, and transportation, particularly since 1945, have improved the duration and quality of life for many people (Chapter 17). Yet disparities in health have been sustained and even increased. They argue that lying at the heart of many of these upstream causes of poor health is the way in which the global economy operates without any ethical underpinnings. They note that while spectacular progress, both intellectual and material, has been achieved through the Enlightenment notion of the centrality of the individual and the supremacy of science and technology in advancing health and healthcare practices, such progress, achieved through transformations driven principally by the power structures, geopolitical arrangements, and patterns of social and economic organization of world capitalism, in which the profit motive and the drive to consume today (often frivolous) are without concern for the well-being of future generations, negates the human rights and dignity of many today at costs that will also be borne by future generations.

In the past 30 years, an extreme form of capitalist and hypermaterialistic thinking and practice (neoliberalism) has come to pervasively dominate the practices and principles of healthcare systems and almost all aspects of social life, including education and the governance of nature and the biosphere. Accelerating the transformation of aspects of each into salable commodities has distorted some of the cherished key Enlightenment principles. It is the ethical, material, political, health, and ecological nature and consequences of this perspective that they critically address in this chapter. Developing alternatives to enhance the health of people on a finite planet would need to begin by acknowledging how value distortions have shaped and governed how we currently live within a structurally violent global political economy, in which crises of ethics, economy, social

Poorest Countries Are Failing and What Can Be Done About It (New York: Oxford University Press); Jeffrey Sachs (2005), *The End of Poverty: Economic Possibilities for Our Time* (New York: Penguin Press); and Dambisa Moyo (2009), *Dead Aid: Why Aid Is Not Working and How There Is a Better Way for Africa* (New York: Farrar, Straus & Giroux), for some of this debate.

development, health, and ecology have led to dehumanizing core/periphery disparities. Benatar, Upshur, and Gill suggest that use of our creative intellect and imagination could help a shift toward a global frame of mind capable of sociopolitical innovation to reconceptualize the idea and promotion of a more sustainable good society.

It is worth signaling here the as yet unknown but potentially serious and long-lasting implications of the COVID-19 pandemic for the airline, tourist, restaurant, and other business industries. In the short term, negative effects include loss of many jobs, and positive effects include radical reductions in pollution that are improving visibility and reducing deaths from pollution in many major cities and allowing some natural habitats to regenerate. The ideas for a more sustainable society are further developed by Stephen Gill, Isabella Bakker, and Dillon Wamsley, who remind us that it has been more than 10 years since the 2008 global financial crisis, and yet intensifying inequalities, global austerity, and ecological degradation continue to shape global health in profound ways (Chapter 18). Their chapter places these developments in the context of a wider *global organic crisis* – a fundamental crisis that has deep social, economic, and ecological dimensions in ways that are significantly reshaping communities, livelihoods, and the biosphere. To help clarify what is at issue, Gill, Bakker, and Wamsley outline several concepts to understand the current conjuncture of global capitalism and its various effects on health, illustrating these concepts by examining current crises in global food production and consumption and the social and political forces that challenge dominant models. Finally, they illustrate how fiscal pressures exerted on governments over the past several decades have undermined the provisioning of global health and contributed to the *enclosure of the social commons*, which threatens the livelihood and well-being of the majority of the world's population, some alternative solutions to which are highlighted in the final chapter (Chapter 38) by these same authors.

Ted Schrecker, Anne-Emaneulle Birn, and Mariajosé Aguilera make the case that extraction industries severely compromise global health justice in several ways (Chapter 19). Examining a range of resource-based economic activities organized around what Saskia Sassen calls "logics of extraction," they describe a *global extractive order* in which benefits and negative health implications are asymmetrically experienced. They first identify five generic pathways from extraction to health outcomes and summarize the case for considering the extractive order's impact on health as a matter of global justice. They analyze arguments that extraction can be managed to benefit health through expansion of resources available for social provision and poverty reduction. They also examine land and water grabs, a relatively new form of cross-border resource appropriation with potentially far-reaching effects on health. Finally, they suggest some prerequisites and challenges for transforming the extractive order to meet the requirements of global justice.

Environmental Considerations

One core issue that this second edition aims to emphasize is that planetary health is integrally enmeshed with global health issues. Failure to acknowledge the importance of planetary health omits a key component of how we should address our health challenges and neglects its increasing significance to many of the salient issues. The relationship between human health and the physical, biological, and social environment raises important issues that extend far beyond clinical medicine to encompass interactions between human beings and nonhuman species, habitats, ecosystems, the atmosphere, oceans, and the biosphere. These issues often have local, national, and international components with implications for public health, global health, social justice, international justice, intergenerational justice, climate justice, and more.

In Chapter 20, David B. Resnik provides an overview of environmental health ethics and explores some of the issues that arise in this area of study, including pollution control, waste management, chemical regulation, agricultural practices, the built environment, and climate change.

Colin D. Butler continues the exploration of these themes in Chapter 21 on ecological ethics, planetary sustainability, and global health. He argues that adverse global environmental change is the stepchild of inequality, population size, resource consumption, limited human ingenuity, and cooperation failures. Civilization, and therefore population health, is in grave danger, though we seem to fail to appreciate this. Climate-damaging carbon emissions are still subsidized in many countries. Recognition by health workers that climate change and other aspects of "planetary

overload" constitute an existential risk remains grossly inadequate, especially among researchers, funders, and policymakers. Encouragingly, younger generations are much better at sensing the danger and are advocating for solutions that could promote a wiser, fairer, and more sustainable civilization.

The Anthropocene epoch is characterized by changes in weather and climate that may make human life in some parts of the world difficult or impossible. This is expected to lead to massively increased migratory movements. In Chapter 22, Christine Straehle describes the challenges faced by migrants and the countries to which they migrate in increasing numbers because of climate change. She defines specific risks that climate-induced migrants face, and she explores relocation adaptation strategies taken by affected countries. She points out that from a health perspective, relocation may improve the social determinants of health but poses possible problems for individual autonomy and collective self-determination. She also addresses the call to identify climate-induced migrants as climate refugees and argues against their equivalence to those fleeing from abusive political regimes. She concludes that mass migration in the Anthropocene epoch demands new tools to protect individual basic needs and reveals the need for a dramatic change in the environmental policy and migration regimes of rich countries. Rich countries have the highest ecological footprint and therefore have remedial responsibilities to assist countries that have contributed least to climate change but suffer the greatest impact. Against this background, she regards current policies of nonentrée as moral failures. It should be noted too that the COVID-19 pandemic with its isolating preventive measures is having a profound immediate effect on migratory flows and the immediate health of migrants in transit, which further challenges humanitarian organizations.

David Benatar reminds us that concern with global health ethics is invariably limited to ethical issues that pertain to global *human* health rather than a more expansive notion of global health that includes other species (Chapter 23). He argues that this focus is unfortunate and that we do have duties (whether direct or indirect) concerning nonhuman animals and the environment. He draws attention to the ways in which human and animal interests coincide and also the ways in which environmental degradation from our mass breeding and consumption of animal products threatens human health. Whereas there is widespread awareness of how destruction of the environment can affect human well-being and health (through processes such as global warming, ozone depletion, and desertification), there is much less awareness of how connected animal and human interests are and of the extent of cruelty to sentient creatures in the meat and dairy industries. Many infectious viral diseases have animal origins, including some of the most recent high-profile ones, such as SARS, HIV, "swine influenza," and COVID-19. Although some animal-to-human transmission of diseases is probably inevitable, much could be avoided through better treatment of animals, especially keeping them in less crowded, more sanitary conditions. Of course, if humans did not eat them in the first place, fewer animals would be bred for human consumption, and the risks would reduce. Significant advantages could be accrued through an increasing shift away from eating meat to vegetarian diets, because about 20% of the warming the planet has experienced can be attributed to the methane produced by cows.

Henk ten Have draws attention to some of these planetary considerations with a key emphasis on environmental degradation (Chapter 24). Social media have made possible much inspirational global activism and social movements focused on health justice, environmental justice, food justice, and water justice, to name only a few. There is an important role for sociological and moral imagination in driving movements to overcoming injustice. Imagining is a creative way of knowing, as well as seeing things differently. It provides resistance against dehumanizing tendencies and can help to overcome experiences of disrespect and humiliation.

The Importance of Including Cross-Cultural Perspectives and the Need for Dialogue

As signaled, developing helpful models of how we talk about global health issues across lines of difference is a key need that deserves far more attention. This section includes some attempts to do just that.

Jing-Bao Nie and Ruth P. Fitzgerald point out that prominent bioethical debates, on such issues as the notion of common morality and a distinctive "Asian"