

EU's external borders: what is the role for global health law?

Public health and human rights do not end at national borders. And yet, when thousands of refugees were drowning in the Mediterranean, some northern countries of the European Union (EU) hid behind the excuse that these continuing tragedies were at the EU's external borders, beyond their sovereign territory.

After the mass of refugees who drowned in the Mediterranean in April,¹ the European Commission forged a ten point action plan. However, instead of moving from sovereignty to solidarity to meet contemporary challenges of interdependency,² the action plan merely "securitised" the governance response—a reaction which has proven to be a trap or insufficient in other global health contexts.³ Governments that are part of the EU seem united in the attempt to address underlying causes of increasing migration, but deliberately overlook the point that their policies in specific regions might fuel the causes of the causes—eg, through promotion of free trade agreements in African countries, which creates conflict with human rights.⁴

To address these underlying causes will include a reduced emphasis on the EU's economic interests. Governments worldwide need to implement global health strategies, which often only exist on paper, to create societies that accommodate peoples' free movement between countries and evenly share resources based on universal rights and duties.²

However, these processes will not be implemented without specific actions. Global health law—ie, "the legal norms, processes, and institutions that are designed primarily to attain the highest

possible standard of...health for the world's population"⁵—has a crucial, "yet underused and underdeveloped, role in providing solutions"⁶ in this context. Economic, cultural, and social rights entail extraterritorial obligations, but these are contested⁷ and have not been applied to the context of refugee boats in distress outside sovereign territories. Additionally, tensions between economic regimes and these extraterritorial obligations are not resolved. It is therefore timely that *The Lancet* launches a Commission about Global Health and the Law, emphasising its role in responding to major global health challenges.⁶ EU politicians (and populations) need to urgently heed the call.

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A premature mortality target for the SDG for health is ageist

Ole Norheim and colleagues' Article (Jan 17, p 239)¹ provides a robust empirical study of the effects of a reduction in mortality in people younger than 70 years. Although this analysis is itself perfectly valid, the ethical principles on which it is based are deeply troubling. Specifically, the concept of premature mortality—which has come to the fore in debates about non-communicable diseases and about the 2030 Sustainable Development Goals (SDGs)—has the potential to undermine the cherished, fundamental principle of health as a universal right for all. Put simply, the Article¹ tells policy makers, particularly in low-income countries, that people aged 70 years and above do not matter.

A chronologically exclusive premature mortality target sends out a strong signal that years lived beyond a given age, such as 60 years or 70 years, are intrinsically less valuable than those of a younger person. This misconception builds on a flawed tradition in health-care priority setting, which includes an explicit bias against older people (as opposed to people of so-called economically and socially productive ages). These issues have been recognised (even if not fully overcome) in the Global Burden of Disease estimates, which account for disability and are at least based on the maximum life expectancy at each age, even though an upper age limit is set out.² Consequently, the approach proposed by Norheim and colleagues¹ would be a retrograde step. Moreover, by focusing only on mortality, the authors also neglect the effect of age-related, chronic morbidity on sustainable development.

These bias matter because evidence exists from many low-income and



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middle-income countries (LMICs) that public investment has been channelled towards the existing Millennium Development Goal targets that are focused on maternal and child health and HIV, thereby reducing the available resources for other interventions.³ As such, any SDG based on premature mortality will drain resources from services of relevance to older people—services that are already woefully inadequate in many countries. Older people have higher rates of common disorders that are amenable to prevention and management than younger people. A health-care system that gives adequate priority to older people would contribute more to the achievement of targets to reduce overall mortality and morbidity than a system that only focuses on younger people who are at intrinsically lower risk.

Although perhaps not Norheim and colleagues' intention, setting a premature mortality target for the SDGs will inevitably reinforce the ageist bias that pervades many aspects of health-care decision making. Evidence from high-income countries suggests that this bias remains strong in areas such as cancer treatment.⁴ No studies of ageism in LMICs have been published, which in itself shows the low priority afforded to older people.

Norheim and colleagues¹ suggest that any specific premature mortality commitments should be supplemented by a general commitment to "improve health care at all ages". The vague framing of this objective would, however, be insufficient to provide a specific steer for policy makers unless supported by targets that include people throughout life—including those in old age. Norheim and colleagues claim that the health gains of extended provision for younger age groups will trickle down to the old to the benefit of all. However this hope glosses over the specific barriers that

many older people have to face to access health services, especially in low-income countries.⁵ For example, levels of detection and management of diseases such as diabetes and hypertension are often lower for older people than for younger age groups.⁵

Policy makers have to make choices, and these choices are most demanding in settings of scarce resources. Rather than design targets that explicitly exclude important population groups, would a policy that focuses on the key risk factors that contribute to easily prevented mortality in people of all ages not be better? A case in point would be a global target to increase hypertension control rates to 20%.

In their discussion,¹ the authors observe that "in old age death is inevitable". Death is an inevitable part of life, but that does not mean we should set policy priorities that explicitly exclude those people who are often in the greatest need and face the most hardship.

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Authors' reply

The Millennium Development Goals (MDGs) for health, adopted in 2000, targeted substantial reductions by 2015 in a few MDG-selected causes: mortality in children younger than 5 years, maternal mortality, and mortality from HIV, tuberculosis, and malaria. The World Health Assembly resolution on non-communicable diseases (NCDs), adopted in 2012, targeted a 25% reduction from 2008 to 2025 in NCD mortality at ages 30–69 years.¹

Consistent with these globally agreed goals, we have proposed that the Sustainable Development Goal for Health (SDG-3), which will be adopted by the UN in September, 2015, for the year 2030 should target a two-thirds reduction from 2010 to 2030 in mortality from the MDG-selected causes (already listed) and a one-third reduction in mortality from all other causes of premature death.² Consistent with the internationally agreed NCD goal, we defined premature death as mortality before age 70 years.

If the proposed goals are achieved, this would reduce mortality in people younger than 50 years by half, reduce mortality at ages 50–69 years (where NCDs predominate) by about a third, and hence reduce the total number of deaths at ages 0–69 years by 40% compared with what would have been reported in 2030 populations at 2010 death rates (table).² We further proposed that a target to avoid at least 40% of all premature deaths—ie, deaths at ages 0–69 years—should be pursued by each separate country.

Mechanisms are now in place to monitor global mortality trends for the MDG-selected causes. The UN Population Division already estimates age-specific death rates for every country that are required to monitor country-specific targets for all-cause mortality; although these rates might well be somewhat unreliable at ages older than 70 years, they should be reasonably reliable at younger ages.

See appendix for list of signatories