TRANSFORMING GLOBAL HEALTH THROUGH BROADLY IMAGINED GLOBAL HEALTH GOVERNANCE

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In this article I examine the compelling need for a new global health governance system and propose two innovative solutions.

The global community has widely accepted the normative value of health. Despite this recognition, unsettling disparities persist between the world's rich and poor. Donors' geostrategic goals and philanthropists' idiosyncratic interests perpetuate these disparities because they do not align with populations' dominant health needs. A new approach, therefore, is necessary.

I propose two alternative structures: a Framework Convention on Global Health ("FCGH") or a Global Plan for Justice ("GPJ").

The FCGH requires states to agree to a framework instrument that would establish the broad principles of global health governance. Subsequently, states would adopt specific protocols to create more detailed norms, structures, and processes to achieve the framework objectives. The FCGH contains five primary objectives: (1) prioritizing basic survival needs, (2) building country capacity for enduring, effective health systems, (3) engaging all relevant stakeholders to leverage their resources and expertise, (4) coordinating and harmonizing activities among global health actors, and (5) establishing minimal funding levels for international development assistance for health and requiring accountability for those commitments.

The GPJ would be a voluntary compact among states and private partners. It would entail creation of a Global Health Fund through which funding targets would be established. The GPJ's priorities include: fairly allocating essential medicines and vaccines, meeting basic survival needs, and mitigating health impacts of climate change. This soft-law approach could help animate state acceptance of norms.

Finally, I discuss the Joint Learning Initiative on National and Global Responsibility for Health launched by Georgetown Law's O'Neill Institute for National and Global Health Law, in partnership with academic and civil society groups throughout the world. This initiative would propel a bottom-up social movement to support the creation of a new global health governance structure. It would do so by involving key stakeholders in expounding the goods and services comprised by the right to health, the obligations of states, and a global architecture to improve health.

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INTRODUCTION

Health plays a fundamental role in our lives as individuals and as members of society. At the individual level, health is critical to a person's wellbeing and can affect his or her opportunities in the world. Health is also important to public welfare because a basic level of human functioning is a necessary condition for the development and stability of economic, social, and political structures within a society.

International norms recognize the special value of human health. A primary function of the United Nations is the protection of global health.[1] The Constitution of the World Health Organization ("WHO") expresses the universal aspiration that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," essential to the attainment of peace and security.[2] The human right to health became a treaty obligation for most states under the *International Covenant on Economic, Social and Cultural Rights*[3]—an obligation reiterated in multiple human rights treaties.[4]

Moreover, the United Nations Committee on Economic, Social and Cultural Rights ("CESCR") has offered guidance concerning the norms, obligations, violations, and implementation of the right to health,[5] and has appointed a Special Rapporteur to continue to improve its meaning and effectiveness.[6] These human rights obligations may lack specificity, as well as effective mechanisms of monitoring, accountability, and enforcement. Nevertheless, they reflect a broad international consensus about the normative value of health.

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[1] Article 55 of the *Charter of the United Nations* states that a primary objective of the UN is to promote "higher standards of living" and "solutions of international … health" (26 June 1945, Can. T.S. 1945 No. 7 (entered into force 24 October 1945)).

[2] *Constitution of the World Health Organization*, (Official Records of the World Health Organization, 2, 100), (adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force 7 April 1948), preamble, online: WHO <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

[3] 993 U.N.T.S. 3 (adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with art. 27).

[4] See e.g. *International Convention on the Elimination of All Forms of Discrimination Against Women*, 1249 U.N.T.S. 13 (opened for signature on 1 March 1980, entry into force 3 September 1981, in accordance with art. 27(1) [protecting women's right to health]) art. 12; *International Convention on the Elimination of All Forms of Racial Discrimination*, 660 U.N.T.S. 195 (adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965, entry into force 4 January 1969, in accordance with art. 19 [protecting the right to public health for racial minorities]) art. 5(e)(iv); *Convention on the Rights of Persons with Disabilities*, UN doc. A/61/611 (opened for signature 30 March 2007, entry into force 3 May 2008, in accordance with art. 45(1)) art. 25.

[5] UN Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN ESCOR, 22d Sess., General Comment No. 14: The Right to the Highest Attainable Standard of Health, Agenda Item 3, UN Doc. E/C.12/2000/4 (2000), online: UNHCR—The UN Refugee Agency <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> [UN CESCR, *Implementation of the International Covenant*].

[6] UN Commission on Human Rights, *Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt*, UN ESCOR, 61st Sess., U.N. Doc. E/CN.4/2005/51 (2005) [UN CHR, *Economic, Social and Cultural Rights Report, 2005*]. See also UN Commission on Human Rights, *Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt*, UN ESCOR, 59th Sess., UN Doc. E/CN.4/2003/58 (2003); Paul Hunt, "The UN Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions" (2003) 7:1 Health & Hum. Rts. 1; UN Human Rights Council, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, UN GAOR, 11th Sess., UN Doc. A/HRC/11/12 (2009).

The Millennium Development Goals ("MDGs")—a global compact to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water, and environmental degradation by 2015—similarly illustrate a global consensus around the health and development agenda. Three of the eight goals (four, five, and six) relate to health: reduce child mortality; improve maternal health; and combat AIDS, malaria, and other diseases.[7]

Despite robust ethical justifications and international norms concerning enhanced global health, unconscionable disparities in health exist between the world's rich and poor. At present, the world's poor bear a vastly disproportionate burden of disease and injury. As life expectancy has steadily increased in the developed world, the rate of increase has slowed in lower-middle income countries, and some sub-Saharan and transitional states have seen decreases.[8] Health disparities between the rich and poor, however, cannot be simplified to a division between rich and poor countries. Rather, health disparities also exist within countries because different levels of health are linked to socio-economic conditions.[9] These conditions frequently correlate with other determinants of health, such as smoking.[10] As a result, the health risks that some disadvantaged groups in high-income countries experience are more similar to those in developing regions, such as sub-Saharan Africa, than to those of their better positioned compatriots.[11] In addition, many of the health problems of poor countries can threaten wealthier countries as diseases have the ability to migrate rapidly across the globe. Hence, the concept of global social justice (or global health equity) promotes the attainment of health for the world's population.

The glaring health disparities between the world's rich and poor can be attributed to social and economic factors.[12] Addressing these factors, which are commonly referred to as the social determinants of health, can dramatically improve the patterns of systematic disadvantage that profoundly and persuasively undermine prospects for wellbeing of the poor. For example, a lower socioeconomic status (as determined by education, occupation, and income) is strongly correlated to poor health outcomes due to conditions of material disadvantage, diminished control of life circumstances, and lack of social acceptance.[13] In addition, factors such as daily living conditions, the built and natural environment, and equitable distribution of power and resources can have an impact on health.

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[7] UN Department of Economic & Social Affairs, *Millennium Development Goals Report (2006)*, online: UN <http://www.un.org/millenniumgoals>.

[8] People's Health Movement, Medact & Global Equity Gauge Alliance, *Global Health Watch 2: An Alternative World Health Report* (London: Zed Books, 2008) at 11 [*Global Health Watch 2*].

[9] Lawrence Gostin, "The Unconscionable Health Gap: A Global Plan for Justice" (2010) 375 The Lancet 1504 [Gostin, "Unconscionable"]; Lawrence O. Gostin, "Redressing the Unconscionable Health Gap: A Global Plan for Justice" (2010) 4:2 Harvard Law and Policy Review 271 [Gostin, "Redressing"].

[10] See Christopher J.L. Murray *et al.*, "Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States" (2006) 3:9 PLoS Medicine 1513 at 1522.

[11] *Ibid.* at 1516, 1520, 1522 (noting that Blacks in the age group 15-44 living in high-risk urban areas have mortality risks more similar to ones in the Russian Federation and sub-Saharan Africa).

[12] WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (Final Report of the Commission on Social Determinants of Health)* (Geneva: WHO Press, 2008), online: WHO <http://www.who.int/social_determinants/thecommission/finalreport/en/>.

[13] See generally B. Aldabe *et al.*, "Contribution of Material, Occupational, and Psychosocial Factors in the Explanation of Social Inequalities in Health in 28 Countries in Europe" (2010) Journal of Epidemiology & Community Health 1; Carme Borrell *et al.*, "Social Class and Self-Reported Health Status Among Men and Women: What is the Role of Work Organisation, Household Material Standards and Household Labour?" (2004) 58:10 Social Science & Medicine 1869; M.G. Marmot *et al.*, "Employment Grade and Coronary Heart Disease in British Civil Servants" (1978) 32:4 Journal of Epidemiology and Community Health 244.

The international community is well aware of the glaring problem of health inequalities,[14] but deeply resistant to taking bold remedial action. International development assistance for health ("IDAH") appears much more concerned with the geostrategic and philanthropic interests of donors than the health needs of the poor.[15] Foreign aid, as currently structured, lacks scale and sustainability, while failing to address the key determinants of health. As a result, the world remains fundamentally unfair in its distribution of human health "goods". This causes enormous physical and mental suffering by those who experience the compounding disadvantages of poverty and ill health.

I
BUILDING NEW SOLUTIONS IN GLOBAL HEALTH

In light of the challenges outlined above, global health governance requires a bold and innovative approach.[16] While a number of new initiatives have emerged to address problems of cooperation and coordination relating to global health, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the International Health Partnership, these approaches do not go far enough. A much more comprehensive global health response that tackles the fundamental issues is needed to address current and future problems, especially those faced by the world's poor and vulnerable.

International law can serve as a means to address grave problems of transnational significance that no single country or group of states can solve on their own. Global health, as a result, deserves to be a major focus in international law, but this has not been the case. In order to fill this void and to use international law in a more constructive manner, a new model of global healthcare governance will be necessary to channel more cooperative action and to get to the heart of the global health dilemma—building long-term capacity for poor countries to take ongoing responsibility for their own health in collaboration with other actors (i.e., transitional and rich countries, intergovernmental organizations, businesses, foundations, and civil society). I have proposed two, interrelated, structural legal mechanisms to dramatically improve global health governance: (A) a Framework Convention on Global Health[17] and (B) a Global Plan for Justice.[18]

A. Framework Convention on Global Health

The Framework Convention on Global Health ("FCGH") recognizes the power of international law in global health. Transnational problems of global health demand a stable commitment of resources for the long-term and a prioritization of these resources toward genuinely effective interventions. Such attributes require a governance mechanism that helps establish priorities, coordinate efforts, foster public-private partnerships, and allow poor countries to take ownership of policies and programs in a competent and transparent manner. To address this need, the FCGH promotes a treaty-based, "bottom up" approach to global health governance that is structured around the following key objectives.

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[14] See e.g. *Reducing Health Inequities through Action on the Social Determinants of Health*, WHA Res. 62.14, WHA (22 May 2009), online: WHO <http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf>; Lee Jong-wook (former Director-General of the World Health Organization), Address to the 57th World Health Assembly, WHA (17 May 2004), online: WHO <http://www.who.int/dg/lee/speeches/2004/wha57/en/>.

[15] See *infra* notes 42-45 and accompanying text.

[16] Lawrence O. Gostin & Emily A. Mok, "Grand Challenges in Global Health Governance" (2009) 90 British Medical Bulletin 7.

[17] *Ibid.*

[18] See Gostin, "Redressing", *supra* note 9.

1. *FCGH Objectives*

The first objective of the FCGH is to set priorities so that international assistance is appropriately directed at meeting basic survival needs. A persistent problem in global health has been the lack of donor resource alignment with activities that reflect the true burden of disease or address the underlying determinants of health in poor countries. Hence, there is an urgent need for a governance mechanism that facilitates evidence-based consensus building and communal priority-setting.[19]

Another objective of the FCGH works to build country capacity for enduring and effective health systems. Capacity building for health systems involves developing a country's human resources, organizational structures, and infrastructures so that all elements of the health sector can perform their core functions and meet the population's basic needs in a sustainable manner.[20] For example, by building a strong infrastructure, a country will be better equipped to detect, prevent, respond to, and treat disease, particularly among the most vulnerable. Capacity building, however, requires a fundamental shift in how international assistance for health has been provided to date. It requires the long-term commitment of all parties—both developed and developing countries and their partners—for the health of their populations. It also involves a change from the prevailing top-down approach that privileges the ideas and priorities of intergovernmental organizations and foreign governments over local leaders as well as a move beyond simply tabulating how much money has been donated.[21]

A third objective of the FCGH is to engage all stakeholders, both state and non-state actors, so that they can bring to bear their resources and expertise. It is essential to harness the ingenuity and resources of non-state actors (including NGOs, private industry, foundations, public-private hybrids, and civil society) because no single entity has the capability to solve today's daunting global health crises. The FCGH would include these major stakeholders in the process of negotiation, debate, and information exchange as well as reduce barriers for them to actively engage in capacity building.

The fourth objective of the FCGH is to coordinate and harmonize the activities among the current proliferation of global health actors. By having the FCGH set priorities and engage all major stakeholders, it is also imperative for this governance scheme to promote a new means for coordination. This will require more than a simple accounting of how much money has been spent by the donor community. In the currently fractured environment where states, NGOs, IGOs, and foundations all fund and prioritize different health interventions, establishing coordination will be essential.

The FCGH's final objectives are to establish minimal funding levels for international development assistance for health and to hold the actors accountable for their commitments through rigorous monitoring and evaluation. By establishing the FCGH as an ongoing diplomatic forum with established principles and defined obligations, the FCGH can help to transcend the current ebbs and flows of interest in international assistance for global health as well as shifts in political will. In addition, the FCGH would build in compliance measures as a component of this global health governance regime.

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[19] Sally K. Stansfield, "Philanthropy and Alliances for Global Health" in Inge Kaul, Katell Le Goulven & Mirjam Schnupf, eds., *Global Public Goods Financing: New Tools for New Challenges* (New York: UNDP/ODS, 2002) 94.

[20] Anneli Milèn, *What Do We Know About Capacity Building? An Overview of Existing Knowledge and Good Practice* (Geneva: World Health Organization, 2001).

[21] Merilee S. Grindle, ed., *Getting Good Government: Capacity Building in the Public Sectors of Developing Countries* (Cambridge, MA: Harvard Institute for International Development, 1997). See also Milèn, *ibid.*

2. *Advantages and Barriers to the FCGH*

Procedurally, the formation of the FCGH involves a framework convention-protocol approach that, in essence, is a process of incremental regime development. In the initial stage, states would negotiate and agree to the framework instrument, which establishes the broad principles for global health governance: goals, obligations, institutional structures, empirical monitoring, funding mechanisms, and enforcement. In subsequent stages, specific protocols would be developed to achieve the objectives in the original framework. These protocols, organized by key components of the global health strategy,[22] would create more detailed legal norms, structures, and processes. The framework convention-protocol approach provides states with considerable freedom to decide the level of specificity that is politically feasible in the present, saving the more complex or contentious issues to be built into later protocols. This avoids the problem of political bottlenecks over contentious elements that could hold talks at a standstill and prevent progress. The FCGH process also confers the advantages of: facilitating global consensus through a stepwise, incremental manner; fostering a shared humanitarian instinct through normative discussion, which can help to educate and persuade the various parties; and, building factual and scientific consensus through the collection and analysis of health data and scientific evidence.

Yet, the FCGH is not a panacea and there exist various social, political, and economic barriers to its creation. The framework convention-protocol approach cannot easily circumvent some current aspects of global health governance: the domination of the most economically and politically powerful countries; the deep resistance to creating obligations to expend, or transfer, wealth; the lack of confidence in international legal regimes and trust in international organizations; and, the vocal concerns about the integrity and competency of governments in many of the poorest countries. Furthermore, it does not ensure consensus on contentious issues. The framework convention's lengthy, incremental process could encounter a loss in momentum or the derailment of subsequent protocols due to its extended timeframe. Nevertheless, given the dismal nature of extant global health governance, a FCGH may be a risk worth taking.

B. A Global Plan for Justice

To overcome the challenges of the FCGH approach, I have also proposed an alternative model for the governance of global health—the Global Plan for Justice ("GPJ").[23] This approach involves the creation of a voluntary compact among countries and their private partners (e.g., businesses, philanthropic organizations, and civil society) to redress current global health inequities. The GPJ focuses on three core global health priorities, which address the most critical determinants of health for the world's poor. These core priorities are (1) fairly allocating essential medicines and vaccines, (2) meeting basic survival needs, and (3) mitigating the health impacts of climate change.

1. *Fair Allocation of Essential Medicines and Vaccines*

It is important to ensure the fair allocation of essential medicines and vaccines, especially in relation to the needs of low- and middle-income countries. Essential medicines and vaccines, according to the WHO, "are those [treatments] that satisfy the priority health care needs of the population."[24] Such treatments are necessary in the prevention and mitigation of human suffer-

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[22] The Framework Convention on Tobacco Control ("FCTC"), for example, anticipates that issues such as advertisement, illicit trade, and treatment will be addressed individually in separate protocols: World Health Organization, *Framework Convention on Tobacco Control*, 2003, WHO Doc. A56/VR/4, online: WHO <http://www.who.int/entity/tobacco/framework/WHO_FCTC_english.pdf>.

[23] See Gostin, "Redressing", *supra* note 9.

[24] World Health Organization, "Essential Medicines", online: WHO <http://www.who.int/medicines/

ing and play a critical role in addressing both chronic needs and emergency situations. Yet access to essential medicines has proven difficult in many developing countries, due to restrictively high prices for patented medicines and the lack of research investment for treatments targeted at diseases of poverty.[25]

Public health emergencies, such as the recent H1N1 pandemic, underscore the immediate and crucial need for the fair allocation of vaccines and medicines. When a mass disaster strikes, it almost inevitably leads to scarcity in medical resources caused by a limited supply and a surge in demand. Poor states, which are at greatest risk of serious illness and death from the spread of new infections, tend to be left behind as rich states hoard the available lifesaving medicines and vaccines for themselves—further widening the already large health disparities between the rich and poor. Such a trajectory is troubling for the state of global health as the allocation of resources to the world's most vulnerable is likely to confer the most beneficial effect on levels of morbidity and premature mortality.[26]

2. *Meeting Basic Survival Needs*

Another key priority of the GPJ is meeting basic survival needs through the provision of fundamental services and functions such as sanitation and engineering, health systems infrastructure and capacity building, and primary health care. Sanitation and engineering play a pivotal role in establishing sustainable development and health. Through cost-effective interventions that address waterborne, mosquito-borne, and rodent-borne diseases, such basic services hold massive potential to improve the health of the world's poorest populations. Building up health systems infrastructure and capacity is another component to ensuring population health. Governments function to identify, prevent, and ameliorate risks to public health. By helping developing country governments attain sound infrastructures (e.g., disease surveillance laboratories and data systems) and a competent workforce, they will have the tools needed to protect their people and the ability to discover solutions to their problems. Primary health care, which is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible [and affordable],"[27] is also a critical function upon which human survival is dependent. Components of primary health care include counseling, maternal and child health, family planning, and medical treatment.

The GPJ does not necessitate advanced tertiary care centers or even highly specialized physicians; rather, it simply requires essential health personnel (e.g., family doctors, nurses, midwives, and community health workers) to diagnose and treat the most common injuries and diseases, care for pregnant women and safely deliver babies, and teach people how to live safely. It also promotes individual and community self-reliance and participation in the planning, organization, operation, and control of health services, making fullest use of local and national resources. While attaining such everyday survival needs may lack the glamour of high-technology medicine or dramatic rescue, they possess the real potential to bestow a major impact upon population health because they deal with the underlying causes of common disease and disabilities.

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services/essmedicines_def/en/index.html>.

[25] *Global Health Watch 2*, *supra* note 8 at 88-89.

[26] Lawrence O. Gostin, "Pandemic Influenza: Public Health Preparedness for the Next Global Health Emergency" (2004) 32:4 J.L. Med. & Ethics 565.

[27] World Health Organization, *Declaration of Alma-Ata* (Copenhagen: WHO Regional Office for Europe, 1978) art. 6, online: WHO <http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf>.

3. *Mitigating the Health Impacts of Climate Change*

The GPJ's third priority seeks to address the problem of climate change because of the severe impact that it can have on human health in the poorest countries. Climate change brings increasingly intense and frequent natural disasters, which can lead to greater public health emergencies and additional devastation to daily living conditions through water contamination and infrastructure collapse. It can also lead to severe ecosystem changes that will impair crop, livestock, and fishery yields, subsequently increasing hunger and famine. Furthermore, climate change holds the potential to broaden the geographic range of disease vectors as well as exacerbate air pollution through increased temperatures.[28] While the effects of climate change will be felt in every region of the world, it will disproportionately burden the poor and lead to a greater gap in health disparities globally. These populations already experience major daily disadvantages, such as the scarcity of clean water and nutritious food, as well as high levels of infectious and chronic diseases. These challenges are compounded by the fact that they lack the capacity to ameliorate the potentially devastating effects of climate change due to weak national health care systems, poor infrastructures, and reduced technological and manufacturing capabilities to adapt to rapidly changing environmental conditions.

Climate change not only challenges the international community to find solutions to mitigate its health effects, but also challenges them to address the inevitable questions of global social justice. To address such concerns in the developing world, the GPJ calls for the adoption of two strategic actions on climate change. One action is to incorporate land-use and agricultural migration (such as avoiding deforestation and degradation) and to pursue sustainable agricultural practices. The second action involves fully funding adaptation projects as a global priority. Adaptation programs are aimed at altering natural or human systems in order to prepare populations to survive the effects of climate change.[29]

The linkages between climate change and health highlight the necessity of not only mitigating further climate change, but also implementing strategies for adaptation in order to enhance a population's resilience and reduce its vulnerability to observed or expected changes in the climate. Hence, it will be important to develop policy strategies that address the various human effects of climate change (such as disease, air quality, natural disasters, food and water supply) and to consult with public health experts during this process so that funds are properly applied for the adaptation of human systems.

4. *Implementating the GPJ*

Responding to the three global health priorities above, the GPJ could be established through a World Health Assembly resolution and administered by the WHO. The Director-General of the WHO could facilitate states and their non-state partners in the negotiation of funding commitments, spending priorities, an allocation system, and mechanisms for monitoring, compliance, and implementation. A special feature of this approach includes the establishment of a "Global Health Fund",[30] which is modeled off of the current Global Fund addressing AIDS, tuberculosis, and malaria. Through the Global Health Fund, achievable annual funding targets could be established for states based on their ability to pay and these funds could be prioritized and allocated based on the health needs of developing countries through measures of poverty, morbidity, and premature mortality.

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[28] Ulisses Confalonieri *et al.*, "Human Health" in M.L. Parry *et al.*, eds., *Climate Change 2007: Impacts, Adaptation and Vulnerability* (Cambridge, U.K.: Cambridge University Press, 2007) 391 at 408.

[29] Ira R. Feldman & Joshua H. Kahan, "Preparing for the Day After Tomorrow: Frameworks for Climate Change Adaptation" (2007) 8:1 Sustainable Development Law & Policy 61.

[30] Gorik Ooms & Rachel Hammonds, "Correcting Globalisation in Health: Transnational Entitlements Versus the Ethical Imperative of Reducing Aid-Dependency" (2008) 1:2 Public Health Ethics 154.

The GPJ's structural and procedural flexibility as a voluntary compact holds the promise of overcoming the challenges of achieving a formal multilateral treaty, such as the FCGH. While the FCGH offers a broadly imagined global health governance system for coordinating actors, setting funding levels and priorities, and harnessing the creativity of non-state actors, the political obstacles identified earlier limit its prospects for success. This does not mean that global health advocates should not continue to press the case for a global health convention, and press it hard. The continued "bottom up" agitation for a meaningful global health convention could bear fruit in the future. In the interim, however, the GPJ may be more appealing to states because it does not impose mandatory international obligations upon them.

Understandably, some critics assert that a voluntary compact would be less likely to hold powerful states accountable; however, the global health sector (as opposed to international trade) has never developed mechanisms for adjudication and enforcement, and is unlikely to do so in the near future. The trade-off between a binding and voluntary compact may be worth assuming because soft law can gradually alter state behavior and develop the necessary critical mass for state acceptance of agreed upon norms. To ensure progress, it will be necessary first to persuade states to voluntarily assume obligations, with soft, rather than hard, targets and enforcement as the creation of binding international obligations of health justice must be built over time. This process also provides the opportunity to call upon the WHO to exercise its constitutional powers in the establishment of norms and to assume a greater leadership role in global health.

II
ENVISIONING THE FUTURE OF GLOBAL HEALTH GOVERNANCE: A "JOINT LEARNING INITIATIVE" ON NATIONAL AND GLOBAL RESPONSIBILITY FOR HEALTH

Achieving an innovative global health governance system is far from easy—whether it is a formal treaty such as a FCGH or even a voluntary compact in the form of a GPJ, with resources devoted through a Global Fund for Health.[31] Before a bold plan can gain international support—particularly among rich states that often set the global health agenda, but are deeply resistant to international solutions—it will be necessary to build an international consensus through civil society action.[32] The most transformative changes in global health have come from "bottom-up" social movements, such as campaigns to rid the world of landmines[33] and fight the scourge of HIV/AIDS.[34]

To achieve such a consensus, an international group of experts, in cooperation with the Oslo 7 Group of Nations,[35] is proposing to launch a *Joint Learning Initiative on National and Global Responsibility for Health* ("Joint Learning Initiative").[36] The Joint Learning Initiative would undertake a wide participatory process that includes major stakeholders, such as Intergovernmental Organizations ("IGOs"), states, foundations, public/private partnerships, and civil society. This plan of broad engagement should ensure acceptance and legitimacy.

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[31] *Ibid.*

[32] Mark Heywood & John Shija, "A Global Framework Convention on Health: Would it Help Developing Countries to Fulfill their Duties on the Right to Health? A South African Perspective" J.L. Med. & Ethics (forthcoming in 2010).

[33] International Campaign to Ban Landmines, online: ICBL <http://www.icbl.org/index.php>.

[34] *Treatment Action Campaign v. Minister of Health* (2001), [2002] 4 B. Const. L.R. 356 (T) (S. Afr.).

[35] See the Global Health and Foreign Policy initiative launched by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, "Oslo Ministerial Declaration—Global Health: a Pressing Foreign Policy Issue of our Time" (2007) 369 The Lancet 1373.

[36] Lawrence O. Gostin *et al.*, "The Joint Learning Initiative on National and Global Responsibility for Health" (Background Paper for the Oslo 7, May 2010) (unpublished, on file with author).

Civil society, in fact, is already moving rapidly toward a broad health rights and social justice agenda, characterized by the People's Health Movement[37] and the South African AIDS Action movement.[38] Yet, a well defined framework that expounds the individual rights to health and corresponding state and international community obligations announced by this civil society movement does not exist.

The Initiative, therefore, is structured around four critical issues the international community must address: (A) a core package of essential health services and goods, (B) states' duties toward their own inhabitants, (C) rich countries' responsibility toward the world's poor, and (D) a global architecture to improve health and reduce disparities. Defining the contours of this structure is the need to move beyond the concept of "aid" and toward mutual responsibility and international obligations of justice.

A. What Are the Essential Services and Goods Guaranteed to Every Human Being Under the Right to Health?

The principal question for the Joint Learning Initiative is to determine the basic package of health services and goods that every person has a right to expect. Without an answer to this question, it is impossible to determine what states have a duty to provide to their inhabitants as well as the extent to which affluent states should enhance low and middle-income countries' capacities.

The WHO estimates that a basic set of health services costs as little as US$40 per person per year, which varies depending on the socioeconomic conditions and the burden of disease.[39] This may be a basic minimum level, and additional resources could bring the greater health and well-being that all people deserve. Yet, truly effective global health governance, even within present resource constraints, could achieve great strides in improving the lives of the world's least healthy people.

The United Nations is actively clarifying and expanding its understanding of the right to health through successive reports from the Special Rapporteur.[40] The Committee for Economic, Social and Cultural Rights defined states' core obligations for the right to health to be meaningful; all people should have, at least: access to health services, access to the minimum essential food which is nutritionally adequate and safe; and access to basic shelter, housing and sanitation, and an adequate supply of safe drinking water.[41] The core goods and services include all those necessary for people to lead lives in which they can function and gain the capacity for human agency.[42]

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37 "People's Health Movement", online: <http://www.phmovement.org>.

38 AIDS Law Project ("ALP") has recently launched Section 27, a new organization that combines the use of law with human rights advocacy to support and advance campaigns for social justice and human rights in South Africa, online: SECTION27 <http://www.section27.org.za>.

39 World Health Organization Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO, 2001) at 16, 57 [WHO, *Macroeconomics and Health*].

40 UN CHR, *Economic, Social and Cultural Rights Report,* 2005, *supra* note 6; Office of the United Nations High Commissioner for Human Rights, "Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines", online: OHCHR <http://www2.ohchr.org/english/issues/health/right/docs/Guidelinesforpharmaceuticalcompanies.doc>.

41 UN CESCR, *Implementation of the International Covenant*, *supra* note 5.

42 Amartya Sen, *Development as Freedom* (New York: Alfred A. Knopf, 1999).

B. What Do All States Owe their Population in Terms of Health?

Individual states hold the primary responsibility to assure the conditions for the health of their inhabitants. This requires that governments, within their capacity, provide the funding for and the delivery of all the essential goods and services guaranteed to every human being under the right to health. However, the duty of states should not only be to their own people, but also to the international community to contain health threats that endanger other countries and regions. More generally, state obligations should extend to fostering a functioning interdependent global community, in which all feel and know that our mutual survival is considered to be a matter of common concern. The elements of a state's obligations to its inhabitants should include, at least, the following:

(a) *Adequate health resources within a state's capacity*. The international human right to health posits that governments must ensure a minimum package of essential goods and services. Many countries also have constitutional entitlements to health, life, and a safe environment that require the provision of basic health services. Despite these domestic and international norms, developing country health expenditures as a proportion of total government spending are significantly lower than the global average (<10% compared with >15%).[43] Foreign assistance accounts for 15% of total health expenditures in low-income countries, and is as high as two thirds in some low-income countries. Worse still, developing countries often reduce their domestic health spending in response to increasing international assistance—the so-called "substitution effect", or "fungibility".[44] These data suggest that low-income countries should do much more to ensure the right to health for their inhabitants.

(b) *State responsibility to govern well*. The concept of "good governance" sets consistent standards for national management of economic and social resources for development. Those who exercise authority to expend resources and make policy have a duty of stewardship—a personal responsibility to act on behalf, and in the interests, of those whom they serve. Sound governance is *honest*, in the sense that it is avoids corruption, such as public officials seeking personal gain or diverting funds from their intended purposes. It is *transparent*, in the sense that institutional processes and decision-making are open and comprehensible to the people. It is *deliberative* in the sense that government consults with stakeholders and the public in a meaningful way, giving them the right to provide genuine input into policy formation and implementation. Finally, good governance is *accountable*, in the sense that leaders give reasons for decisions, assume responsibility for successes or failures, and the public has the opportunity to disagree and change the direction. Good governance enables states to formulate and implement sound policies, manage resources, and provide services efficiently.

(c) *State responsibility to fairly and efficiently allocate health resources*. States should have the authority and discretion to set their own health priorities. Yet, in doing so, they have a responsibility to ethically allocate life-sustaining, yet often scarce, resources. States, therefore, must fairly and efficiently distribute health goods and services to its entire population. This requires paying special attention to the needs of the most disadvantaged in society such as the poor, minorities, women, children, and persons with disabilities. Furthermore, it requires that health services are accessible and acceptable irrespective of language, culture, religion, or geography.

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43 World Health Organization, "Health Expenditures: Ratios and Per Capita Levels by World Bank Income Group" (2010), online: WHO <http://www.who.int/nha/country/regional_averages_by_wb_income_group-en_2010.xls>.

44 Chunling Lu *et al.*, "Public Financing of Health in Developing Countries: A Cross National Systematic Analysis" (2010) 375:9723 The Lancet 1375.

C. What Do All States Owe to the World's Least Healthy People?

To what extent are states responsible for the provision of health-related goods to the inhabitants of other states? The answers to the first and second questions above will largely provide the answer to the third question: once we agree upon the essential package of health-related goods and on the limits of state capacity to provide it, we will have a clear picture of the financial and technical assistance that capable states should provide.

Unfortunately, the vast burden of morbidity and premature mortality rests on those who have the least capacity to do anything about it. Again, the WHO estimates that a basic set of health services costs as little as US$40 per person per year.[45] George Schieber and colleagues suggest that low-income countries can raise, through taxes, no more than 17% of their Gross Domestic Product ("GDP") due to low formal-sector employment, low urbanization, and weak tax administration capabilities.[46] If these states were to allocate 15% of their government revenue to health-related goods (i.e. 2.55% of their GDP), as African heads of state promised in the Abuja Declaration,[47] only states with a per capita GDP of more than US$1,568 would have the domestic capacity to provide the essential package of health-related goods. About 38% of the world's people live in countries where the average yearly per capita GDP is less than US$1,568, which demonstrates that other countries will need to contribute.[48]

While the volume of global financial responsibility for global health certainly matters, it is not the only concern. An equally important concern is the long-term reliability of global financial responsibility. Financial assistance for health is typically provided in the form of grants with limited duration: three to five years. The global community seems to believe that this will encourage poor states to take their fate in their own hands, and mobilize additional domestic resources. Paradoxically the real effect might be quite the opposite. As Mick Foster explains:

> donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable. Governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.[49]

But that does not mean they will refuse the financial assistance that is available. It is more likely that they will fail to increase, or that they even decrease, their domestic contribution to the provision of health-related goods, as that is the only way to absorb the additional financial assistance without increasing the public expenditure.[50]

From this perspective, financial assistance that is not based on an understanding of mutual responsibility (and therefore unreliable in the long run) is an inefficient expenditure of resources, as it does not improve the provision of health-related goods. This reason alone should be sufficient to consider a global agreement on norms that clarify the national and the global responsibility for health, as it would transform ineffective short-term financial assistance into effective sustained financial contribution.

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45 WHO, *Macroeconomics and Health*, *supra* note 39.

46 George J. Schieber *et al.*, "Financing Global Health: Mission Unaccomplished" (2007) 26:4 Health Affairs 921.

47 Organization of African Unity, *Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases*, OAU/SPS/ABUJA/3 (2001), at para. 26, online: UN <http://www.un.org/ga/aids/pdf/abuja_declaration.pdf>.

48 International Monetary Fund, *World Economic Outlook Database: April 2010 Edition*, online: IMF <http://www.imf.org/external/pubs/ft/weo/2010/01/weodata/index.aspx>.

49 Mick Foster, "Fiscal Space and Sustainability: Towards a Solution for the Health Sector" (Paper for the 3rd meeting of the High-Level Forum on the Health MDGs, 2005) at ii, online: Mick Foster Economics Limited <http://www.mickfoster.com/docs/FiscalSpaceTowardsSolution.pdf>.

50 Gorik Ooms *et al.*, "Crowding Out: Are Relations Between International Health Aid and Government Health Funding Too Complex to be Captured in Averages Only?" (2010) 375:9723 The Lancet 1403.

D. What Kind of Global Health Governance Mechanisms Are Required to Make All States Live Up to their Mutual Responsibilities to Provide Health-Related Goods to All?

The preliminary answers to the questions above should be sufficient to understand the need for a better global health governance mechanism—one based on true global partnerships for health. Several noteworthy considerations follow. First, states where the people whose survival is most at risk will only accept international norms for their domestic health challenges if it is part of a genuine partnership for a global common good, which confirms their duties towards the international community but also the duties of the international community towards them. Second, affluent states will be reluctant to accept financial duties towards poor states, unless there is an agreed arrangement for equitable burden-sharing among all affluent states, and unless there are agreed norms about how these financial duties will complement domestic duties, and for which health-related goods they will be used. Third a lack of adequate domestic health spending and any misuse of global financial resources by national governments would seriously undermine the willingness of the international community to live up to their responsibilities. Last, the collection, management, and coordination of the global financial duties for global health will have to be governed by a body that reflects the global partnership—financial assistance as the counterpart for operational efforts to provide a basic package of health-related goods and services to all people, and vice versa—in which all states are equally represented, and in which the civil society of poor and affluent states has a meaningful voice.

The global health governance architecture the Joint Learning Initiative is looking for would have to reinforce the leadership and normative role of the WHO, and simplify the present architecture of global financial assistance for health. It must have the legitimacy and authority to assess poor states' health plans and domestic contributions, as well as to provide support to poor states that have state of the art health plans but have exhausted their domestic resources (i.e., no further conditions should be imposed).

CONCLUSION

As the current state of global health continues to struggle with a complex and jumbled array of actors and initiatives, along with increasingly limited resources, a rational governance solution remains glaringly at large. The Joint Learning Initiative asks the vital questions, and builds a global consensus toward more durable solutions such as a Framework Convention on Global Health or a Global Plan for Justice, with resources devoted through a Global Fund for Health.

What is most important is to use global health advocacy to stimulate current thinking about governance in a new and bold direction. This will require cooperation and deliberative action by a wide range of stakeholders. Stagnancy in global health will only result in further devastation and greater inequities; hence, action in reforming global health governance must be taken now.