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Global Health Justice: Towards a Framework Convention on Global Health—A Transformative Agenda for Global Governance for Health[†]

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[†] Prof. Gostin and Mr. Friedman are members of the Steering Committee of the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI). JALI is an international campaign comprised of civil society and academic leaders from the global South and North dedicated to achieving a Framework Convention on Global Health— a historic, innovative treaty on global health equity. See <http://www.jalihealth.org>. This article offers the first detailed account of the treaty’s mission, norms, and processes, together with a systematic justification for a radically new form of global governance for health. The authors thank members of the JALI Steering Committee, who met at the Rockefeller Center in Bellagio, Italy on February 23-24, 2012, hosted by SECTION27 (South Africa), the Lawyers Collective (India), and the O’Neill Institute (Washington, DC): Armando De Negri (World Social Forum on Health and Social Security, Brazil), Thomas Gebauer (Medico International, Germany), Anand Grover (Lawyers Collective), Adila Hassim (SECTION27), Mark Heywood (SECTION27), Gorik Ooms (Institute of Tropical Medicine, Antwerp, Belgium), Shiba Phurailatpam, Asia Pacific Network of People Living with HIV/AIDS, Harald Siem (Norwegian Directorate of Health), Devi Sridhar (Oxford University, United Kingdom), and Attiya Waris (Univesrity of Nairobi/Tax Justice Network).

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Global Health Justice Abstract

Global health inequities cause 20 million deaths annually, mostly among the world's poor. Yet, international law to reduce these inequalities is sparse. We propose a new global health treaty, a Framework Convention on Global Health (FCGH), based on the human right to health. Already endorsed by the UN Secretary-General, the FCGH would re-imagine global governance for health, offering a new post-Millennium Development Goals vision. A global coalition of civil society and academics has formed an international campaign to advocate for an FCGH—the Joint Action and Learning Initiative (JALI). This article provides the first systematic account of the goals and justifications of this historic treaty, the normative foundations, and how the treaty would be constructed.

Global Health Justice: Towards a Framework Convention on Global Health—A Transformative Agenda for Global Governance for Health

Consider two children—one born in sub-Saharan Africa and the other in Europe, North America, or another developed region. The African child is 20 times more likely to die in her first five years of life. If she lives to childbearing age, she is nearly 140 times more likely to die in labor. Overall, she can expect to die 26 years earlier than the child born into a wealthy part of the world.¹

Collectively, such vast inequalities between richer and poorer countries translate into nearly 20 million deaths every year – and have for at least the past two decades. This represents approximately one-third of global deaths,² and does not include millions of additional deaths related to inequalities within countries.

The persistence of such an unconscionable level of avoidable deaths reveals the single greatest gap in international law across a broad range of legal regimes. Some regimes have negligible – or even negative bearing – on these deaths, such as trade and investment treaties.³ Others positively affect health and save lives, such as environmental, refugee, and labor law, but compared to the scope of death, only at the margins.

¹ UNICEF ET AL., LEVELS AND TRENDS IN CHILD MORTALITY, REPORT 2011, ESTIMATES DEVELOPED BY THE UN INTER-AGENCY GROUP FOR CHILD MORTALITY ESTIMATION, at 6 (2011), at 6, http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf (last visited Jan. 4, 2012) [hereinafter LEVELS AND TRENDS IN CHILD MORTALITY]; WORLD HEALTH ORG. ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2008 (2010) [hereinafter TRENDS IN MATERNAL MORTALITY]; UNITED NATIONS DEVELOPMENT PROGRAMME, HUMAN DEVELOPMENT REPORT 2011, at 130 (2011), available at http://hdr.undp.org/en/media/HDR_2011_EN_Complete.pdf. The life expectancy at birth in the 47 countries that score highest on the UNDP's Human Development Index is 80.0 years, compared to 54.4 years in sub-Saharan Africa. *Id.*

² Juan Garay, *Global Health Equity and Its Trend* (forthcoming). The figure derives from the difference in death rates between high-income countries and other regions of the world.

³ Panel Report, *United States – Measures Affecting the Production and Sale of Clove Cigarettes*, WT/DS406/R (Sept. 2, 2011) (holding that U.S. ban on clove cigarettes violated the non-discrimination principle of article 2.1 of the Agreement on Technical Barriers to Trade, even though it was a valid public health measure). The tobacco industry giant Philip Morris, meanwhile, has brought separate suits against Uruguay and Australia under bilateral investment treaties. The company is claiming that Uruguay breached its obligations to protect their trademarks rights under a bilateral investment treaty with Switzerland. Uruguayan regulations implemented in 2009 require graphic warning labels that cover 80% of cigarette packages, and limit the number of cigarette varieties a brand could sell. Meanwhile, Philip Morris is asserting that Australia's new packaging legislation, requiring cigarettes to have graphic health warnings and standardized designs breaches Australia's bilateral investment treaty with Hong Kong, expropriating company investments and intellectual property without compensation. See *Philip Morris Brand Sàrl (Switzerland), Philip Morris Products S.A. (Switz.) and Abal Hermanos S.A. (Uruguay) v. Oriental Republic of Uruguay* (ICSID Case No. ARB/10/7); *Bilateral Treatment Treaty Claim, Uruguay*, PHILIP MORRIS INT'L, available at http://www.pmi.com/eng/media_center/company_statements/Pages/uruguay_bit_claim.aspx; *Philip Morris Sues Australia Over Cigarette Packaging*, BBC NEWS (Nov. 21, 2011), available at <http://www.bbc.co.uk/news/world-asia-15815311>; Winsor Genova, *Philip Morris Files Arbitration Case*

Several international law regimes have a greater impact on health inequities. Protecting the lives of non-combatants is a chief goal of humanitarian law, and with most of today's wars occurring in poorer countries, this body of law can reduce global health inequities. Recent arms control treaties, such as the Mine Ban Treaty, and those being negotiated, Arms Trade Treaty,⁴ will also prove most beneficial to developing countries. Yet except for the narrow set of countries facing large-scale armed conflict, humanitarian law does not impact global health inequities – and even here, notoriously poor compliance limits its impact (witness the genocide in Sudan, massive shelling of civilians in Sri Lanka, or violence of the Burmese military against ethnic minorities).

Even human rights law, while asserting the rights to health and an adequate standard of living, has yet to be developed and adequately enforced to the point where, on a wide scale, it can translate its norms into practices sufficient to avert large numbers of deaths. We will return later in this Article to the potential of human rights law to form the basis of a global health agreement to reduce health inequities.

Very few international law regimes are directed primarily toward the main causes of avoidable sickness, injury, and premature death. The two major World Health Organization (WHO) treaties – the International Health Regulations (IHR)⁵ and the Framework Convention on Tobacco Control (FCTC)⁶ – have the potential to save millions of lives. The IHR is devoted to public health emergencies of international concern such as rapidly spreading novel influenza, but does not reach the major causes of illness and premature death, such as enduring infectious diseases (e.g., AIDS, malaria, and tuberculosis) or chronic non-communicable diseases (e.g., cancer, cardiovascular disease, diabetes, and respiratory disease). The FCTC certainly is directed toward a major preventable cause of illnesses and death, but is *sui generis* given the near universal aversion to unethical tobacco company practices.

The IHR and FCTC, moreover, both lack enforceable standards and robust mechanisms for capacity building in developing countries.⁷ Beyond international health

Vs. Australia Over Plain-Packaging Law, INT'L BUS. TIMES, Nov. 22, 2011, available at <http://au.ibtimes.com/articles/253710/20111122/philip-morris-asia-challenges-australia-s-plan.htm>.

⁴ Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction (1997), *entered into force* Mar. 1, 1999; United Nations Office for Disarmament Affairs, *Towards and Arms Trade Treaty*, UN, <http://www.un.org/disarmament/convarms/ArmsTradeTreaty/> (last visited Dec. 1, 2011).

⁵ International Health Regulations (2005), adopted through Revision of the International Health Regulations, World Health Assembly WHA58.3 (May 25, 2005).

⁶ WHO Framework Convention on Tobacco Control, Feb. 27, 2005, available at http://www.who.int/fctc/text_download/en/index.html.

⁷ Implementation of the International Health Regulations (2005), Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, 64th World Health Assembly A64/10, May 5, 2011, at 13 (observing that many countries lack the core capacities to detect and respond to potential threats and are not on track to develop these capacities by the 2012 deadline, and that the lack of enforceable sanctions is “the most important structural shortcoming of the IHR”), http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf; Heather Wipfli et al., *Achieving the Framework Convention on Tobacco Control's Potential by Investing in National Capacity*,

law, including the Constitution of the World Health Organization, international regimes are remarkable primarily for their silence on matters of population health and safety.

It is not that law is powerless to improve human health and wellbeing. Wealthier countries with strong public health regulation have made considerable progress over the past several decades in reducing child and maternal mortality and combatting AIDS and malaria.⁸ It is abundantly clear that societal action – and the thus law itself, which can influence and even direct such action – can dramatically reduce illness, suffering, and premature death. Law’s potential to extend the benefits of good health to people in all countries, with dramatic improvements in health for those who live in the poorest countries and communities, is significant, yet largely, untapped.

This Article offers an innovative analytic framework for clarifying national and global responsibilities for ensuring the right to health designed to reduce global and national health inequities. To codify these obligations, and create accountability for their effective implementation, we show the potential of a new legal instrument, a Framework Convention on Global Health (FCGH).⁹ Our goal is to show the potential of international law to markedly transform prospects for good health, particularly for the world’s most disadvantaged people.

First, we describe the major causes of injury, disease and premature death, how they cause disproportionate levels of death among the poor both globally and within

13 TOBACCO CONTROL 433-37 (2004) (observing that lack of national capacity is a major barrier to implementing the Framework Convention on Tobacco Control, and the need for funding to build capacity); CAMPAIGN FOR KIDS FREE TOBACCO, CAMPAIGN FOR TOBACCO-FREE KIDS PROMOTES WHO INTERNATIONAL TREATY ON TOBACCO CONTROL: GRANT REPORT (2007), available at <http://www.rwjf.org/reports/grr/042060.htm> (last visited Feb. 9, 2012) (observing that only four of the key measures contained in the Framework Convention on Tobacco Control are obligator).

⁸ See generally LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2d ed. 2008).

⁹ In this article, we develop the idea of a Framework Convention on Global Health originally proposed in 2008, elucidating on the elements of such a treaty, as well as the value to national and global health. See Lawrence O. Gostin, *Meeting Basic Survival Needs of The World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO L.J. 331 (2008), available at <http://www.georgetownlawjournal.org/issues/pdf/96-2/Gostin-Article.pdf> [hereinafter *Meeting Basic Survival Needs*].

Since 2010, the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) has advanced the Convention as a realistic global health strategy. See Lawrence O. Gostin et al., *National and Global Responsibilities for Health*, 88 WHO BULLETIN 719-719A, available at <http://www.who.int/bulletin/volumes/88/10/10-082636/en/> [hereinafter *National and Global Responsibilities for Health*]; Lawrence O. Gostin et al., *The Joint Action and Learning Initiative on National and Global Responsibilities for Health*, *World Health Report (2010), Background Paper*, 53 (2010), http://www.who.int/entity/healthsystems/topics/financing/healthreport/JALI_No53.pdf; Lawrence O. Gostin et al., *The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health*, PLOS MEDICINE, May 2011, available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001031> [hereinafter *Joint Action and Learning Initiative*]. See also Lawrence O. Gostin, *Redressing the Unconscionable Health Gap: A Global Plan for Justice*, 4 HARV. L. & POL'Y REV. 271-294 (2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635895 (last visited Feb. 1, 2012) (proposing a voluntary compact among states and partners in civil society, philanthropy, and business to reduce global health inequities).

countries, and how extant global health law and governance is deeply inadequate to the task of resolving these inequities.¹⁰ The main purpose of the FCGH would be to redress the unequal burdens of suffering, disease, and early death among the world's poor.

Next, we argue that human rights law is the best conceptual and practical framework to underpin the international community's response to these health inequities. To be sure, human rights law has significant structural flaws such as the lack of hard standards, ineffective compliance mechanisms, and the "progressive realization" principle behind socioeconomic rights. Nevertheless, human rights law is uniquely positioned to advance global health justice given its universal acceptance, along with its emphasis on equity and accountability.

We then propose four fundamental questions to clarify national and international responsibilities for meeting responsibilities under the human right to health, as well as preliminary answers to these questions. We view these as the defining questions for the future of global health. If states and stakeholders followed the logic embedded in the answers to these four questions, it would result in markedly improved health outcomes and reduced health inequalities.

Finally, we explain the idea of a Framework Convention on Global Health, showing how it could drive national and global policies in these four areas. The Convention would establish the norms, monitoring, and accountability necessary to improve health for all and significantly narrow health inequalities.

I. The Impoverished State of World Health

Basic human needs continue to go unmet for the world's poorest people. In 2010, approximately 925 million people faced chronic hunger, 884 million people lacked access to clean water, and 2.6 billion people were without access to proper sanitation facilities.¹¹ Despite United Nations Millennium Development Goal (MDG) pledges to enable more people to meet these basic needs, this represents 100 million more hungry people than in the 1990 benchmark year of the MDGs (though the proportion of people suffering from hunger has decreased very modestly).¹² The current pace of extending sanitation is failing to even keep up with population growth. At the current rate of expansion of sanitation

¹⁰ See generally LAWRENCE O. GOSTIN, *GLOBAL HEALTH LAW: INTERNATIONAL LAW, GLOBAL INSTITUTIONS, AND WORLD HEALTH* (Harvard University Press forthcoming 2013).

¹¹ Food and Agriculture Organization of the United Nations, *925 Million in Chronic Hunger Worldwide*, FAO (Sept. 10, 2010), <http://www.fao.org/news/story/en/item/45210/icode/> (last visited Feb. 8, 2012). The Human Right to Water and Sanitation, G.A. Res. 64/292, U.N. Doc. A/RES/64/292 (July 28, 2010).

¹² In 1990-1992, the official baseline measurement for the Millennium Development Goal on halving the proportion of people suffering from hunger by 2015 was 828 million people suffering from hunger. UNITED NATIONS, *THE MILLENNIUM DEVELOPMENT GOALS REPORT 2011*, at 11 (2011), available at http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf.

infrastructure, 2.7 billion people will still not have access to even basic sanitation by 2015.¹³

Child/Maternal Health

Despite a 60% decline in the under-five mortality rate since 1970, too many parents still grieve over undersized coffins. Nearly 8 million children under five died in 2010. More than 3 million die in their first month of life from infections and complications, while infectious diseases including pneumonia, diarrheal diseases, and malaria are responsible for approximately two-third of child deaths.¹⁴ There are, however, gaping inequalities: 33.2% of child mortality occurs in Southern Asia and 48.7% occurs in sub-Saharan Africa, while 1.3% of deaths occur in high-income countries.¹⁵ Relatively simple and inexpensive interventions such as child nutrition, clean water, basic medications and treatments, and vector control would avert most of these deaths.

Like their children, mothers too face intolerable risks, including of dying in childbirth. Maternal mortality is dropping, from 546,000 in 1990 to 358,000 in 2008. The improvements, which mask extreme variations across countries and regions, are largely attributable to skilled childbirth attendants and emergency obstetric services.¹⁶ The overwhelming majority of these deaths, 99%, occur in developing countries.¹⁷

There are vast inequalities of access to obstetric care within countries. In Southern Asia, for example, women in the top wealth quintile are over five times more likely to be attended by a skilled health worker than women in the poorest quintile.¹⁸ For every maternal death, approximately twenty to thirty women suffer severe complications from pregnancy and childbirth, including acute and long-term disabilities.¹⁹ Most of this death, disability, and suffering could be entirely avoided by providing skilled birth attendants with back-up care, and inexpensive interventions.

¹³ UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2010 (2010); WHO & UNICEF, PROGRESS ON SANITATION AND DRINKING-WATER: 2010 UPDATE (2010), available at http://whqlibdoc.who.int/publications/2010/9789241563956_eng_full_text.pdf.

¹⁴ See LEVELS AND TRENDS IN CHILD MORTALITY, *supra* note 1, at 1 (reporting 7.6 million deaths of children under 5 in 2010); Julie Knoll Rajaratnam et al., *Neonatal, Postneonatal, Childhood, and Under-5 Mortality for 187 Countries, 1970–2010: A Systematic Analysis of Progress Towards Millennium Development Goal 4*, 375 LANCET 1998 (2010); Robert E. Black et al., *Global, Regional, and National Causes of Child Mortality in 2008: A Systematic Analysis*, 375 LANCET 1969 (2010).

¹⁵ See LEVELS AND TRENDS IN CHILD MORTALITY, *supra* note 1, at 6.

¹⁶ WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2008 (2010) [hereinafter TRENDS IN MATERNAL MORTALITY]. WHO, WORLD HEALTH REPORT 2005 – MAKE EVERY MOTHER AND CHILD COUNT (2005).

¹⁷ See TRENDS IN MATERNAL MORTALITY, *supra* note 1.

¹⁸ UNICEF, STATE OF THE WORLD'S CHILDREN 2009 38 (2008), available at <http://www.unicef.org/sowc09/docs/SOWC09-FullReport-EN.pdf>.

¹⁹ *Safe Motherhood*, U.N. POPULATION FUND, <http://www.unfpa.org/public/mothers/> (last visited Sept. 22, 2010) (reporting that “for every woman who dies, 20 or more experience serious complications”); WHO & WORLD BANK WORKING GROUP 1, CONSTRAINTS TO SCALING UP AND COSTS, at 30 (2009), available at http://www.internationalhealthpartnership.net//CMS_files/documents/working_group_1_report_constraint_s_to_scaling_up_and_costs_EN.pdf (reporting “For every woman who dies in childbirth, around 30 suffer short- or long-term consequences including a broad range of acute and long-term disabilities”).

Infectious Diseases

Infectious diseases continue to cause millions of deaths in developing countries, while threatening every region. Approximately four million people die annually from AIDS, tuberculosis, and malaria.²⁰ Global incidence of HIV is falling, and there have been real improvements in access to anti-retroviral therapy. Nearly 7 million people in developing countries were on anti-retroviral medication by the end of 2010.²¹ Yet, more than 7 million people in need of treatment were still not receiving it,²² and for every person who enters treatment each year, two become newly infected.²³

Some of the greatest global health successes in recent years have been against malaria. According to the WHO, malaria deaths fell from 985,000 in 2000²⁴ to 655,000 in 2010,²⁵ with 43 countries reducing disease incidence by more than half over the past decade.²⁶ Still, malaria persists as a leading cause of death for children in Africa.²⁷ A new study finds higher rates of malaria in older children, with malaria deaths peaking at 1.817 million in 2004 and then falling to 1.238 million in 2010.²⁸ Growing resistance to anti-malaria medications and climate change pose major threats, although a promising vaccine (the first against a parasitic disease) may be launched among African children by 2015.²⁹

Progress against tuberculosis has been slower, though incidence and mortality have begun to fall. Excluding people infected with HIV, global deaths from tuberculosis have fallen from 1.4 million in 1995 to 1.1 million in 2010, representing a one-third decrease in the mortality rate. In addition, 350,000 HIV-positive people perished from tuberculosis in 2010. Global incidence (including people living with HIV) reached 9.0 million in 2005, but fell to 8.8 million in 2009 and 2010. Some 85% of new cases occur

²⁰ UNAIDS, GLOBAL REPORT: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 2010 (2010). WHO, GLOBAL TUBERCULOSIS CONTROL 2010 (2010). WHO, WORLD MALARIA REPORT 2010 (2010), *available at* http://www.who.int/malaria/world_malaria_report_2010/worldmalariareport2010.pdf [hereinafter WORLD MALARIA REPORT 2010]. The tuberculosis mortality level does not include approximately 380,000 deaths from tuberculosis among HIV-positive people, who are included among AIDS deaths.

²¹ WHO, ET AL., GLOBAL HIV/AIDS RESPONSE – EPIDEMIC UPDATE AND HEALTH SECTOR PROGRESS TOWARDS UNIVERSAL ACCESS – PROGRESS REPORT 2011, at 89 (2011), *available at* http://whqlibdoc.who.int/publications/2011/9789241502986_eng.pdf [hereinafter GLOBAL HIV/AIDS RESPONSE].

²² *Id.*

²³ U.N. Secretary General, *Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS - Uniting for Universal Access: Towards Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths: Rep. of the Secretary-General*, U.N. Doc. A/65/797 (Mar. 28, 2011).

²⁴ *See* WORLD MALARIA REPORT 2010, *supra* note 20, at xii.

²⁵ WHO, WORLD MALARIA REPORT 2011, at 73 (2011), *available at* http://www.who.int/malaria/world_malaria_report_2011/en/index.html [hereinafter WORLD MALARIA REPORT 2011].

²⁶ *Id.* at viii.

²⁷ *Id.* at 3 (stating that malaria causes 16% of deaths of children under 5 in Africa).

²⁸ Christopher J.L. Murray, *Global malaria mortality between 1980 and 2010: a systematic analysis*, 379 LANCET: 413-431, 421 (2012).

²⁹ Nicholas J. White, *A Vaccine for Malaria*, 365 NEW ENGL. J. MED 1926-27 (2011).

in Asia, with the greatest overall burden of tuberculosis, and Africa, where the HIV pandemic contributed to a doubling of the number of people with tuberculosis from 1990 to 2005.³⁰ Multi-drug resistant (MDR) TB, especially in the former Soviet Union, and the particularly pernicious extensively drug resistant (XDR) TB threaten tuberculosis control.

Neglected tropical diseases (NTDs), meanwhile, are infectious diseases that thrive in impoverished, especially tropical, settings. There are 17 in all, including Chagas disease, trachoma, leprosy, schistosomiasis, lymphatic filariasis, and dengue. NTDs are often transmitted by insects or the eggs of worms, and infect more than 1 billion people annually, killing more than half a million.³¹ Beyond early death, the diseases of poverty cause great pain and physical anguish, for example, when a two-foot long guinea worm parasite emerges from the genitals, breasts, extremities, and torso; or filarial worms cause disfiguring enlargement of the arms, legs, breasts, and genitals (elephantiasis); or river blindness leads to unbearable itching and loss of eyesight. Sufferers are often tormented by social stigmatization for the rest of their lives. Diseases of poverty exacerbate the cycle of poverty, decreasing earning capacity and economic productivity.³²

Even emerging infectious diseases, such as SARS and novel influenza strains (e.g., H1N1 and H5N1), which threaten people wherever they live, pose a disproportionate threat to people in developing countries. The health systems in poorer countries are least prepared to detect and contain these emerging health threats. And absent a global agreement on sharing the vaccines and medications needed to prevent and treat them, people in developing countries are last in line for essential medical technologies needed to control and treat these diseases.³³

Non-Communicable Diseases

The terrible toll of infectious diseases has overshadowed a fast growing and even more substantial cause of morbidity and premature mortality in low- and middle-income countries— non-communicable diseases (NCDs), such as cardiovascular disease, stroke, cancer, diabetes, and chronic respiratory diseases. Though often thought to primarily

³⁰ WHO, GLOBAL TUBERCULOSIS CONTROL 2011, at 115-17 (2011), available at http://www.who.int/tb/publications/global_report/2011/gtbr11_full.pdf.

³¹ WHO, NEGLECTED TROPICAL DISEASES, HIDDEN SUCCESSES, EMERGING OPPORTUNITIES (2009).

³² Pan American Health Organization, *Neglected Diseases: The Diseases of Poverty*, PAHO, <http://www.paho.org/english/ad/dpc/cd/psit-nd-poster.pdf> (last visited Feb. 8, 2012). Paul Hunt, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, United Nations Economic and Social Council E/CN.4/2006/48/Add.2 (Jan. 19, 2006) (Neglected tropical diseases (NTDs) “cause immense suffering and lifelong disabilities among the poorest populations ...[contributing] to the entrenched cycle of poverty, ill health, stigmatization and discrimination experienced by neglected populations.”).

³³ The WHO’s *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits* offers some limited access to novel influenza vaccines; it was adopted at the 64th World Health Assembly, WHA64.5, May 24, 2011, available at http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R5-en.pdf. However, it is a highly limited vehicle for sharing vaccines and essential medicines in a global health emergency. David P. Fidler & Lawrence O. Gostin, *The WHO Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health*, 306(2) JAMA 200-01 (July 13, 2011), available at <http://ssrn.com/abstract=1890912>.

affect people in wealthy countries, recent statistics tell a different story. In 2005, 80% of deaths from NCDs occurred in developing countries.³⁴ The epidemiologic transition from infections to non-communicable diseases is unmistakable. NCDs are on track to cause fully 70% of all deaths in developing countries by 2020.³⁵ The poor already die at higher rates than the wealthy – from cancer especially – due to vastly inferior early detection and treatment.³⁶ For example, more than 80% of the 274,000 annual cervical cancer deaths worldwide occur in developing countries.³⁷

These rising numbers have become too daunting and disconcerting to ignore. In September 2011, the UN General Assembly held a high-level summit in New York,³⁸ where it adopted a Political Declaration on the Prevention and Control of NCDs.³⁹ This was only the second health issue that a high-level UN summit has addressed. The other has been HIV/AIDS, where the 2001 summit transformed the global response to the AIDS pandemic. The NCD Summit – while vital in raising the political profile of NCDs – has thus far has not mobilized a global response comparable to AIDS. The NCD Alliance – a global network of individuals and organizations devoted to combating chronic diseases – is calling for the UN to incorporate NCDs into the MDGs.

Mental Disabilities

If non-communicable diseases have, overall, received relatively little attention in developing countries, one category of NCDs has been particularly marginalized—mental illness. Mental illness was not part of the agenda of the NCD Summit.

Yet depression alone was the leading cause of disability and fourth largest contributor to the global burden of disease in 2000, and is expected to become the second largest contributor to the global burden of disease by 2020.⁴⁰ Most of the burden of depression, bi-polar disorder, schizophrenia, and other mental illnesses falls on people in low- and lower-middle income countries, where nearly three-quarters of the global burden of neuropsychiatric disorders is felt. More than 75% of people in developing

³⁴ WHO, 2008-2013 ACTION PLAN FOR THE GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES (2008).

³⁵ Abdesslam Boutayeb & Saber Boutayeb, *The Burden of Non Communicable Diseases in Developing Countries*, 4 INT’L J. FOR EQUITY IN HEALTH (2005).

³⁶ Tan Ee Lyn, *Developing Nations to Bear Cancer Brunt*, REUTERS, Aug. 19, 2010, available at <http://www.reuters.com/article/2010/08/19/us-cancer-preparedness-developing-idUSTRE67I1GT20100819>.

³⁷ Dylan Neel, “An Exercise in Economics: Cervical Cancer Prevention in the Developing World,” HARV. COLLEGE GLOBAL HEALTH REV., Nov. 15, 2011, available at <http://www.hcs.harvard.edu/hghr/2011/11/15/an-exercise-in-economics-cervical-cancer-prevention-in-the-developing-world/>.

³⁸ Kelly Morris, *UN Raises Priority of Non-Communicable Diseases*, 375 LANCET 1859 (2010).

³⁹ *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*, 66th Sess., Agenda item 117.

⁴⁰ *Depression*, WHO, http://www.who.int/mental_health/management/depression/definition/en/ (last visited Feb. 6, 2012).

countries have no access to treatment, in part due to an extreme paucity of mental health workers.⁴¹

The human rights violations against persons with mental disabilities are historic and enduring through official state policy (e.g., commitment to isolated and abusive institutions and loss of civil and political rights such as voting, driving, and managing personal and financial affairs) and popular culture (e.g., fear of dangerousness, deep stigma, and discrimination). Civil society and human rights courts have documented inhuman and degrading treatment in psychiatric institutions, prisons, homeless shelters, and even group homes.⁴²

Injuries

The health impact of injuries in developing countries is also frequently overlooked. More than 90% of deaths from unintentional injuries occur in low- and middle-income countries.⁴³ Poverty heightens the risk of injury in myriad ways: for example, through unsafe working conditions, uncovered wells leading to drowning, the use of open fires for cooking, and the use of kerosene or paraffin lamps, which can easily be knocked over and ignited. Poorly designed roads, defective motor vehicles, lack of safety equipment (e.g., seatbelts, airbags, motorcycle helmets), inadequately enforced traffic safety laws, and chaotic traffic (pedestrians, cars, trucks, bicycles, and sometimes animals crowd the roads) all contribute to horrific crashes. Although low- and middle-income countries have only 48% of the world's registered vehicles, they experience 91% of traffic fatalities.⁴⁴ Injuries are a major public health problem, which are amenable to cost-effective prevention strategies given the resources and political will.

Climate Change

Even as greenhouse gas emission levels are increasing to the point where 2010 emissions exceeded the worst case scenario under 2007 estimates by the

⁴¹ MENTAL HEALTH GAP ACTION PROGRAMME, SCALING UP CARE FOR MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDERS (2008); Diana Gregor, *Mental Illness as a Silent Predator in the Developing World*, MEDIAGLOBAL NEWS (Aug. 14, 2010), <http://www.mediaglobal.org/2011/03/15/mental-illness-as-a-silent-predator-in-the-developing-world/> (last visited Feb. 6, 2012).

⁴² Disability Rights International, *Torture Not Treatment: Electric Shock and Long-Term Restraint in the United States on Children and Adults with Disabilities at the Judge Rotenberg Center* (Washington, DC: Disability Rights International, 2010); Lance Gable & Lawrence O. Gostin, *Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights*, in PRINCIPLES OF MENTAL HEALTH LAW AND POLICY 103-166 (Lawrence O. Gostin et al. eds., 2010); Lawrence O. Gostin, 'Old' and 'New' Institutions for Persons with Mental Illness: Treatment, Punishment, or Preventive Confinement?, 122 PUB. HEALTH 906-13 (2008).

⁴³ Robyn Norton et al., *Unintentional Injuries*, in DISEASE CONTROL PRIORITIES IN DEVELOPING COUNTRIES 737-754 (Dean T. Jamison et al. eds., 2006).

⁴⁴ WHO, GLOBAL STATUS REPORT ON ROAD SAFETY: TIME FOR ACTION (2009). The cited statistics are based primarily on data from 2007.

Intergovernmental Panel on Climate Change,⁴⁵ climate change already exacts a grim toll. It causes 300,000 deaths annually,⁴⁶ and is projected to substantially exacerbate health hazards in the coming decades. Although climate change will affect the entire world, it will impose vastly disproportionate burdens on low- and middle-income countries.⁴⁷ Poorer countries are predominately located in warmer climates that will only become more extreme. And low- and middle-income countries have fewer resources with which to adapt to changing climatic conditions, such as by erecting flood barriers, sanitizing drinking water, and delivering emergency services.

As the climate changes and air temperatures rise, the intensity and range of climate-sensitive diseases such as malaria and dengue will increase. Changes to rain patterns, along with rising sea levels, will affect the supply of food and clean water, leading to increased hunger and waterborne diseases such as diarrhea and cholera. Extreme weather events will kill both directly and indirectly, by causing droughts and floods that destroy crops, reduce biodiversity, contaminate water sources, displace people, and expand habitats for mosquitoes. Models indicate that some of the world's poorest regions, in southern Africa and south Asia, will experience reductions of staple food crops of 10% to 30% by 2030.⁴⁸ Climate change will also degrade air quality and cause severe heat waves, contributing to cardiovascular and respiratory illnesses.⁴⁹ Further, the stress, trauma, and displacement wrought by climate change will lead to psychological suffering and mental illness.

National Health Disparities

Aggregate figures of the disabilities, diseases, and early deaths that continue to burden the world's poorer regions should not mask the disparities within these regions, and the extra burdens faced by poor and other disadvantaged populations, such as indigenous peoples and persons with disabilities. In Nairobi, Kenya, for example, the death rate for children under five in the worst-off slums is many times the rate in the wealthiest neighborhoods.⁵⁰

⁴⁵ *Greenhouse Gases Rise by Record Amount*, GUARDIAN, Nov. 4, 2011, <http://www.guardian.co.uk/environment/2011/nov/04/greenhouse-gases-rise-record-levels> (last visited Feb. 6, 2012).

⁴⁶ John Vidal, *Global Warming Causes 300,000 Deaths a Year, Says Kofi Annan Thinktank*, GUARDIAN, May 29, 2009, <http://www.guardian.co.uk/environment/2009/may/29/1> (last visited Feb. 6, 2012).

⁴⁷ U.N. Framework Convention on Climate Change Secretariat, *Climate Change: Impacts, Vulnerabilities and Adaptation in Developing Countries* (2007).

⁴⁸ *Climate Could Devastate Crops*, BBC NEWS (Jan. 31, 2008), <http://news.bbc.co.uk/2/hi/science/nature/7220807.stm> (last visited Feb. 6, 2012).

⁴⁹ See Gostin, *Redressing the Unconscionable Health Gap*, *supra* note 9, at 271-94.

⁵⁰ Neil MacFarquhar, *Wider Disparity in Life Expectancy is Found Between Rich and Poor*, N.Y. TIMES, Oct. 17, 2008, available at http://www.nytimes.com/2008/10/17/world/17briefs-WIDERDISPARI_BR.html; WHO, WORLD HEALTH REPORT 2008 – PRIMARY HEALTH CARE (NOW MORE THAN EVER) (2008), available at <http://www.who.int/whr/2008/en/index.html> [hereinafter WORLD HEALTH REPORT 2008]. African Population and Health Research Center, *Population and Health Dynamics in Nairobi's Informal Settlements*, APHRC (2002), available at <http://www.aphrc.org/insidepage/page.php?app=downloads&articleid=285>.

The yawning health gap, moreover, cannot be fully understood by using the oversimplified division of the world into the global rich and poor. In fact, more than one-third of the largest fortunes in the world are in low and middle-income countries (and more than 20% excluding Russians), with one-quarter of the world's billionaires in Brazil, Russia, India, and China.⁵¹ And even within wealthy states, dramatic health differences exist that are closely linked with degrees of social disadvantage. The poorest people in Europe and North America often have life expectancies similar to citizens of the least developed countries. A black unemployed youth in Baltimore, Maryland has a lifespan 32 years shorter than a white corporate professional.⁵² Infants born of black women in Pittsburgh, Pennsylvania are five times more likely to die than infants born to white women.⁵³

Experiences in countries such as Brazil demonstrate that such inequalities are not inevitable. Brazil has overcome vast inequities to achieve near universal coverage of skilled birth attendants. And the gap in Brazil between the prevalence of stunting among children in the richest and poorest quintiles shrank from 35-37% in 1989 to 5-7% in 2007.⁵⁴

Brazil's accomplishments, along with many other successes throughout the developing world, demonstrate that the extreme level of avoidable death and disease in developing countries is just that—avoidable. Effective interventions exist, but most of the world's poor cannot access them.

II. Prospects for a Permanent Underclass in Health: The Imperatives of Sustainable Funding, Good Governance, and International Legal Obligations

Progress over the past several decades demonstrates that the world has the collective know-how to dramatically improve people's health, even in the poorest settings. Undeniably, the international community has achieved stunning successes in global health. Several objectives enunciated in the UN Millennium Declaration⁵⁵ and the

⁵¹ WalletPop Staff, *Forbes: The Richest People in the World 2011*, DAILYFINANCE (Mar. 9, 2011), <http://www.dailyfinance.com/2011/03/09/forbes-the-richest-people-in-the-world-2011/> (last visited Feb. 6, 2012). Among the top 100 wealthiest people on the 2011 *Forbes* list of the world's billionaires, 37 were from low- and middle-income countries, primarily from countries that the World Bank classifies as upper middle-income, namely Brazil (3), Chile (3), China (1), Colombia (1), Malaysia (2), Mexico (3), and Russia (15). Others are from India (7), Nigeria (1), and Ukraine (1). *The World's Billionaires*, FORBES, Mar. 9, 2011, <http://www.forbes.com/wealth/billionaires/list> (last visited Feb. 6, 2012); *World Bank List of Economies (Nov. 2011)*, WORLD BANK (July 18, 2011), <http://siteresources.worldbank.org/DATASTATISTICS/Resources/CLASS.XLS> (last visited Feb. 6, 2012).

⁵² Vicente Navarro, *What We Mean by Social Determinants of Health*, 39 INT'L J. OF HEALTH SERVICES 423-441 (2009).

⁵³ Infant mortality among African-Americans was 20.7 in 2009, compared to 4.0 for white infants. Timothy Williams, *Tackling High Infant Mortality Rates Among Blacks*, N.Y. TIMES, Oct. 15, 2011, at A10, available at <http://www.nytimes.com/2011/10/15/us/efforts-to-combat-high-infant-mortality-rate-among-blacks.html/>

⁵⁴ Zulfiqar A. Bhutta et al., *Countdown to 2015 Decade Report (2000-10): Taking Stock of Maternal, Newborn, and Child Survival*, 375 LANCET 2032, 2040-2041 (2010).

⁵⁵ U.N. Millennium Declaration, U.N. Doc. 55/2 (Sept. 8, 2000), <http://www.un.org/millennium/declaration/ares552e.htm>.

resulting MDGs have become financial and programmatic priorities. Child and maternal deaths have seen notable declines.⁵⁶ Malaria deaths fell by 32% from 2004 to 2010,⁵⁷ and scientists are on the verge of launching a new vaccine.⁵⁸ The number of people in sub-Saharan Africa receiving anti-retroviral therapy to treat AIDS increased approximately 100-fold from 2000 through 2010,⁵⁹ while science has made remarkable progress in AIDS prevention and treatment, prompting UNAIDS to declare a goal that was unimaginable only a few years ago—“getting to zero.”⁶⁰

Yet even with this progress, the level of avoidable suffering and early death remains unconscionable, with millions of lives needlessly cut short and vast human and economic potential lost. Although progress in some countries has been impressive, populations in other countries suffer and die young, much as before. For example, while some countries are on track to achieve the MDGs on maternal⁶¹ and child health,⁶² others have made scant progress. National efforts towards universal access to AIDS treatment similarly vary. Some countries, such as the Democratic Republic of Congo and Ukraine, cover less than 20% of their HIV-infected population in the most immediate need of

⁵⁶ Maternal deaths dropped by approximately one-third between 1990 and 2008. WHO News Release, *Maternal Deaths Drop Worldwide by Third*, WHO (Sept. 15, 2010), http://www.who.int/mediacentre/news/releases/2010/maternal_mortality_20100915/en/index.html (last visited Feb. 6, 2012).

⁵⁷ See Christopher J.L. Murray, *Global malaria mortality between 1980 and 2010: a systematic analysis*, 379 LANCET 413-431, 421 (2012), *supra* note 28.

⁵⁸ PATH Malaria Vaccine Initiative, *Publication of First Results in Ongoing Malaria Vaccine Trial Marks Important Milestone*, PATH MALARIA VACCINE INITIATIVE, <http://www.malariavaccine.org/> (last visited Feb. 6, 2012) (title headline leading to a detailed overview of the progress made in late 2011).

⁵⁹ In 2000, about 50,000 people in sub-Saharan Africa were receiving anti-retroviral therapy. This number grew to 5,064,000 by the end of 2010, including an increase of more than 1 million during 2010 alone. See GLOBAL HIV/AIDS RESPONSE, *supra* note 21, at 89.

⁶⁰ The UNAIDS strategy, “Getting to Zero,” has become possible with the success of new prevention interventions such as male circumcision and treatment as prevention with the finding that persons in treatment reduce their risk of transmitting the virus by 95%. UNAIDS, GETTING TO ZERO: STRATEGY 2011-2015 (2010), available at <http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/>.

⁶¹ Among countries on or nearly on track for achieving the Millennium Development Goals’ maternal mortality target are China (66% reduction in maternal mortality ratio from 1990 to 2008), Equatorial Guinea (73% reduction), Eritrea (69% reduction), and Vietnam (66% reduction). Among those that have experienced little or no progress from 1990 to 2008 are Afghanistan (17% reduction), the Central African Republic (3% reduction), Kenya (38% increase), Lesotho (44% increase), Liberia (14% reduction), Somalia (12% increase), South Africa (80% increase), Sudan (9% decrease), Tanzania (10% decrease), Zambia (19% increase), and Zimbabwe (102% increase). See TRENDS IN MATERNAL MORTALITY, *supra* note 1.

⁶² Countries in Asia making significant progress in reducing child mortality in Asia include China (where child mortality decreased from 39.6/1,000 to 15.4/1,000 from 1990 to 2010) and Vietnam (decrease of 46.3/1,000 to 12.9/1,000), with lesser improvements in Afghanistan (163.5/1,000 to 121.3/1,000) and Pakistan (113.3/1,000 to 83.3/1,000). Among countries in Southern and Central Africa with little or no progress in reducing child mortality during this timeframe were Equatorial Guinea (178.7/1,000 to 180.1/1,000), the Republic of Congo (109.4/1,000 to 107.5/1,000), Swaziland (73.7/1,000 to 101.2/1,000), and Zimbabwe (73.3/1,000 to 70.4/1,000), with levels in many countries elsewhere in Africa remaining astronomical in 2010 (such as 168.7/1,000 in Chad, 161.1 in Niger, and 157.0/1,000 in Nigeria), even with reductions of the past decades. See Rajaratnam et al., *supra* note 14, at 1998-2008.

treatment, while coverage in Botswana and Rwanda, among others, exceeds 80%.⁶³ Can progress come for poor and marginalized populations? Or will they come to form a permanent global health underclass?

Global health is further imperiled as new challenges arrive in force, particularly the rapid growth in NCDs in developing countries and the impacts of climate change, especially on water and food supplies. Cardiovascular diseases, cancers, diabetes, mental illnesses, and other chronic diseases are now largely confined to the margins of health budgets of low-income countries and global funds for health. These NCDs are beyond the scope of major health funders, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and GAVI Alliance. Although these funders are placing greater priority on health system strengthening, they are still primarily funding narrow disease-specific interventions. There is no major funder devoting resources to prevention, primary care, and access to essential medicines.

With the failure of the December 2011 climate change conference in Durban, South Africa to take significant steps to strengthen present actions to limit climate change,⁶⁴ the parade of climate change's adverse effect – drought, flood, expanded ranges of disease vectors, heat waves, environmental refugees – that has already begun seems sure to worsen. Will countries and communities already under stress be able to develop the resilience required to prevent mounting tolls from disease, hunger, and natural disasters? In short, will countries meet these new, complex health threats, or will global health inequities be further compounded?

The persistence of global health inequities and extent of avoidable death demonstrates the shortcomings of national and global financing, governance, and law.

The Trajectory of Global Health Funding: Recent Promise and Future Peril

While health threats from infectious diseases, non-communicable diseases, and injuries escalate, resources are contracting. The past several decades have seen significant growth in both domestic and international health investments. From 2000 to 2008, governments in sub-Saharan Africa increased their health sector spending from 8.2% to 9.6% of their budgets, more than doubling their per capita health spending, from an average of \$15 to \$41 per capita (in nominal dollars and including on-budget external

⁶³ UNAIDS, WORLD AIDS DAY REPORT 20 (2011), available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf.

⁶⁴ Tim Gore, *The Durban climate deal failed to meet the needs of the developing world*, GUARDIAN - POVERTY MATTERS BLOG (Dec. 12, 2011, 12:24 PM), <http://www.guardian.co.uk/global-development/poverty-matters/2011/dec/12/durban-climate-deal-developing-world> (last visited Feb. 6, 2012). John M. Broder, *Climate Talks Yield Limited Agreement to Work Toward Replacing Kyoto Protocol*, N.Y. TIMES, Dec. 12, 2011, at A9 (quoting Alden Meyer, director of policy at the Union of Concerned Scientists: "While governments avoided disaster in Durban, they by no means responded adequately to the mounting threat of climate change.").

assistance).⁶⁵ International health assistance increased from less than \$6 billion annually in the early 1990s to \$10.5 billion in 2000, and climbed to nearly \$26.9 billion in 2010. In addition, official development assistance for water and sanitation reached \$5.6 billion in 2009.⁶⁶

Funding for AIDS, one of global health's most resource-intensive areas is becoming more efficient, including major reductions in the costs of anti-retroviral medications,⁶⁷ recent discoveries that these medications reduce transmissions by 96%⁶⁸ and that male circumcision also prevents transmissions by 60%.⁶⁹

Even these funding increases and added efficiencies are inadequate. The \$41 per capita of government spending in sub-Saharan Africa – and only half that level in South East Asia⁷⁰ – is well below the minimum \$60 per capita that WHO estimates is required by 2015. On average, 49 low-income countries would have required \$44 per capita spending in 2009 to be on track for near universal access to these interventions by 2015,

⁶⁵ WHO, WORLD HEALTH STATISTICS 2011 136-37 (2011), *available at* http://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Part2.pdf [hereinafter WORLD HEALTH STATISTICS 2011]. Government spending on health in South East Asia is the lowest in the world. It increased as a percent of total government expenditure from 4.7% in 2000 to 5.6% in 2008, and from \$7 per capita to \$20 per capita during the same time span. *Id.*

⁶⁶ WHO, WORLD HEALTH STATISTICS 2010 (2010); Christopher J.L. Murray et al., *Development Assistance for Health: Trends and Prospects*, 378 LANCET 8, 8-10 (2011); INST. FOR HEALTH METRICS & EVALUATION, FINANCING GLOBAL HEALTH 2010: DEVELOPMENT ASSISTANCE AND COUNTRY SPENDING IN ECONOMIC UNCERTAINTY (2010), *available at* http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2010/FGH_2010_REPORT_FINAL_051111.pdf; JEN KATES ET AL., DONOR FUNDING FOR HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES, 2001-2009 (2011), *available at* <http://www.kff.org/globalhealth/upload/7679-05.pdf>. The international health assistance figures of less than \$6 billion, \$10.5 billion, and \$26.9 billion use 2008 US dollars include funding from governments, multilateral agencies, foundations, and NGOs incorporated in the United States, and cover HIV/AIDS, tuberculosis, malaria, non-communicable diseases, maternal, newborn, and child health, and health sector support. The \$5.6 billion in health assistance for water and sanitation in 2009 includes only government and multilateral agency funding.

⁶⁷ The per person AIDS treatment costs for the President's Emergency Plan for AIDS Relief (PEPFAR) dropped by more than two-thirds from 2004 to 2011. Ezekiel J. Emanuel, *Foreign Aid Is Not a Rathole*, N.Y. TIMES – OPINIONATOR BLOG (Nov. 30, 2011, 11:07 PM), <http://opinionator.blogs.nytimes.com/2011/11/30/foreign-aid-is-not-a-rathole/> (last visited Feb. 6, 2012). These efficiencies enabled the United States to increase its treatment target from 4 million to 6 million people by 2013 without increasing funding. White House press release, *Remarks by the President on World AIDS Day*, Dec. 1, 2011, <http://www.whitehouse.gov/the-press-office/2011/12/01/remarks-president-world-aids-day>.

⁶⁸ National Institutes of Health, Treating HIV-infected people with antiretrovirals significantly reduces transmission to partners: *Treating HIV-infected People with Antiretrovirals Significantly Reduces Transmission to Partners*, NIH NEWS (May 12, 2011), *available at* <http://www.nih.gov/news/health/may2011/niaid-12.htm> (last visited Feb. 8, 2012).

⁶⁹ *Male Circumcision for HIV Prevention*, WHO, <http://www.who.int/hiv/topics/malecircumcision/en/> (last visited Feb. 8, 2012).

⁷⁰ Government spending on health in South East Asia is the lowest in the world. It increased as a percent of total government expenditure from 4.7% in 2000 to 5.6% in 2008, and from \$7 per capita to \$20 per capita during the same timespan. *See* WORLD HEALTH STATISTICS 2011, *supra* note 65, at 136-37.

but 31 of them were spending less than \$35 per capita.⁷¹ Meanwhile, the minimum requirement estimates assume, counterfactually, highly efficient spending,⁷² and covers only identified priority interventions, even as government health spending extends beyond these interventions.

Moreover, the upward trajectory of health investments, particularly international assistance, is under severe threat due to the global financial crisis. Austerity has become the order of the day. An agreement of all European Members except the United Kingdom on strict European enforcement debt limits will further pressure budgets and motivate cuts, including in international assistance. Meanwhile, a painfully slow economic recovery underway in the United States, combined with a political consensus on the need to cut the deficit, threatens U.S. global health funding for years to come.

These forces and the resulting shortfall in donor contributions led the Global Fund to cancel its Round 11 and postpone funding for new activities until 2014.⁷³ This unprecedented step means that after a regular pattern of annual funding rounds, the Global Fund likely will hold no new funding rounds for at least three years. Never has the Global Fund been in such a dire situation. Beyond the Global Fund, the United States is well behind pace for achieving the spending targets of the President's Global Health Initiative, originally planned at \$63 billion from 2009 through 2014.⁷⁴ Thus far, global health funding has continued to increase through the economic turmoil, though at a far slower rate than previously. While international health assistance jumped by 17% from 2007 to 2008, it has since increased by only 4% annually.⁷⁵

Although the financial crisis emerged largely from dishonest and irresponsible practices of the financial industry in the North, economies of the global South are directly affected, including through reduced demand for their products and reduced foreign investment. Even as African countries recover from the initial downturn, continued slow

⁷¹ WHO, THE WORLD HEALTH REPORT - HEALTH SYSTEMS FINANCING: THE PATH TO UNIVERSAL COVERAGE 22-23 (2010), available at <http://www.who.int/whr/2010/en/index.html> [hereinafter PATH TO UNIVERSAL COVERAGE]; See WHO & WORLD BANK WORKING GROUP 1, *supra* note 19.

⁷² Globally, approximately 20-40% of health spending is wasted, with levels higher in poorer countries. See PATH TO UNIVERSAL COVERAGE, *supra* note 71, at 71-72; HARMONIZATION FOR HEALTH IN AFRICA, INVESTING IN HEALTH FOR AFRICA: THE CASE FOR STRENGTHENING SYSTEMS FOR BETTER HEALTH OUTCOMES, at iv (2011), available at http://www.who.int/pmnch/media/membernews/2011/investing_health_africa_eng.pdf.

⁷³ Global Fund to Fight AIDS, Tuberculosis & Malaria, *Modification of Grant Renewals and Transition to New Funding*, Twenty-Fifth Board Meeting, Accra, Ghana, Nov. 21-22, 2011, Decision Point GF/B25/DP16, available at http://www.theglobalfund.org/documents/board/25/BM25_DecisionPoints_Report_en/. The Global Fund established a Transitional Funding Mechanism to continue to fund essential prevention, care, and treatment activities to current grantees. *Id.*

⁷⁴ Susan B. Epstein et al., *State, Foreign Operations, and Related Programs: FY2012 Budget and Appropriations*, CONG. RES. SERVICE, 9 (Nov. 23, 2011), available at <http://fpc.state.gov/documents/organization/169056.pdf>.

⁷⁵ Katherine Leach-Kemon et al., *The Global Financial Crisis Has Led to a Slowdown in Growth of Funding to Improve Health in Many Developing Countries*, 31 HEALTH AFF. 1, 3 (2012), available at http://www.healthmetricsandevaluation.org/sites/default/files/publication_summary/2011/Global_Financial_Crisis_Led_Slowdown_Health_Affairs_Dec_2011_IHME.pdf.

or no growth in wealthier countries threatens economic growth – and hence domestic health spending – in Africa. Foreign direct investment declined sharply in Africa in from 2008 to 2010, and a 1% decrease in GDP across countries of the Organization for Economic Development and Cooperation (OECD) could lead Africa’s export earnings to fall by 9%.⁷⁶

Why Extant Global Health Governance Cannot Reduce the Health Gap

The world has witnessed a dramatic rise in interest and funding in global health—on the part of states, philanthropists, advocates, service providers, volunteers, businesses, and public private partnerships. This unprecedented engagement, despite admirable achievements, has not fundamentally changed the reality for the world’s least healthy people. Nor has it significantly closed the health gap between the rich and poor. And with four global crises looming – finance, food security, energy, and climate change – if anything, global health investments will likely stabilize or decrease.

At this pivotal time for global health, much depends on the future of global governance for health – the collection of rules, norms, institutions, and processes that shape the health of the world’s population.

At present, global governance for health is highly dysfunctional. If effective governance is harnessing and coordinating global health actors and resources efficiently and effectively, then global health fails in almost every aspect. There is deep fragmentation of global health actors, such that there is vast duplication of effort (think of endless reports that health ministries must compile for different partners). Global health institutions have failed to articulate clear objectives and take steps to accomplish desired common goals. Priorities are badly skewed, such that funding and programs are disproportionately targeted to politically popular programs and the latest high profile disease (think of SARS, influenza, and bioterrorism) rather than the global burden of disease (think of cancer, heart disease, mental health, and injuries). Health often is given inadequate weight in other regimes, such as trade and investment, despite their impact on health.

Above all, the health sector has resisted attempts to measure its efficiency and effectiveness, eschewing close monitoring and accountability. The future, moreover, appears bleak, as the World Health Organization – the global health leader – is currently mired in a financial and political crisis, with little prospect of recovering in the near-term. In fact, the WHO’s member states fail to act as “shareholders,” with a stake in the Organization’s success. This is best illustrated by the fact that the agency was on track to run a \$300 million deficit in 2010/2011 and had to cut its headquarters staff by over

⁷⁶ African Development Bank, *Africa’s Performance & Mid-Term Prospects*, AFRICA EMERGING ISSUES, Nov. 2011, at 13, <http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Africa%20Emerging%20Issues%20Series.pdf> (last visited Feb. 8, 2012).

10%.⁷⁷ The WHO controls only little more than 30% of its own budget, as most resources go to what donors want rather than what the WHO requires.⁷⁸

Global governance for health, therefore, is characterized by struggling leadership and inadequate, volatile funding; poor coordination and shifting, skewed priorities; and little accountability and insufficient intersectoral influence. This is hardly a recipe for a breakthrough in health equity. Yet, dramatic improvement in the world's health and reduction of health inequalities are entirely possible with modest investments and smart, proven, policies.

The international community has taken halting steps in the right direction. The Monterrey Consensus, Paris Declaration on Aid Effectiveness, and the Accra Agenda for Action⁷⁹ established a new paradigm that became quickly accepted in principle. This paradigm includes clearer targets and indicators of success, harmonization among partners, alignment with country strategies, longer-term and more predictable international assistance, engagement with multiple stakeholders including civil society, and mutual accountability for development results.

Yet efforts to implement these principles have had setbacks. Consider the International Health Partnership and related initiatives (IHP+)— a partnership launched in 2007 consisting of developed countries (with the notable exceptions of the United States and Japan) and thirty developing countries primarily in Africa.⁸⁰ IHP+ has had successes in several areas as it has sought to put these principles into practice, including high-level alignment of partner plans with country plans, increased civil society involvement, and more timely disbursements of partner funding commitments. Yet “responsible and predictable financing” had “mixed results,” with funding levels still inadequate and limited progress towards multi-year funding commitments. Development

⁷⁷ Devi Sridhar & Lawrence O. Gostin, *Reforming the World Health Organization*, 305 J. AM. MED. ASS'N 1585-86 (2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1799432#; Stephanie Nebehay & Barbara Lewis, *WHO Slashes Budget, Jobs in New Era of Austerity*, REUTERS, May 19, 2011, available at <http://www.reuters.com/article/2011/05/19/us-who-idUSTRE74I5I320110519> (last visited Feb. 6, 2012). *WHO in overhaul as body faces losses*, THE NEW AGE (S. Afr.), May 16, 2011, available at http://www.thenewage.co.za/18030-1020-53-WHO_in_overhaul_as_body_faces_losses (last visited Feb. 6, 2012).

⁷⁸ Assessed contributions edged up from 21% of the WHO's 2010-2011 budget to 24% of its 2012-2013 budget. The remainder of contributions is voluntary. Most voluntary contributions are earmarked, though a small portion is highly flexible. In the 2012-2013 budget, assessed contributions and highly flexible voluntary contributions together comprised 34% of the WHO's budget. WHO, *Medium-Term Strategic Plan 2008–2013 and Proposed Programme Budget 2012–2013*, A64/7, Apr. 4, 2011, at 14-15, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf.

⁷⁹ Monterrey Consensus on Financing for Development, International Conference on Financing for Development, Monterrey, Mex. (Mar. 18-22, 2002), <http://www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf> (last visited Feb. 9, 2012); OECD, *The Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability*, OECD (2005), available at <http://www.oecd.org/dataoecd/30/63/43911948.pdf>; OECD, *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, OECD (2008), available at <http://www.oecd.org/dataoecd/30/63/43911948.pdf>.

⁸⁰ *Partners*, INT'L HEALTH PARTNERSHIP & RELATED INITIATIVES, <http://www.internationalhealthpartnership.net/en/partners> (last visited Feb. 8, 2012).

partner use and strengthening of country systems was “mixed,” and in a poor omen for accountability, only half of IHP+ partners participated in an independent review of IHP+ results.⁸¹

The Global Fund embodies several key principles of good global governance. It is driven by country demand and receives five-year funding proposals from Country Coordinating Mechanisms (CCMs), whose members include government officials – often from multiple sectors – civil society, development partners, and the private sector.⁸² Civil society from developed and developing countries, governments from the North and South, foundations, the private sector, and most significantly a community delegation sit as equals on the Global Fund Board. Transparent in its activities and progress in each country, the Fund also incorporates robust, independent measures to counter corruption.

Yet – as with the WHO – the Fund’s partners too often fail to act as shareholders. Several countries responded to reports of misuse of funds by suspending their contributions to the Fund, even as the Global Fund itself had uncovered this corruption, and responded aggressively, from strengthening grant oversight to suspending grants.⁸³ Worse, the purely voluntary funding has caused the Fund to fall well short of its needs,⁸⁴ forcing it to delay grants, limit support to middle-income countries, slow its pace of new funding around, and most dramatically cancel Round 11 after its launch. Beyond funding, whether non-governmental members are recognized and empowered to act as equal partners on CCMs varies significantly among countries.⁸⁵ Meanwhile, the Global Fund captures only a slice of health needs – though with its support for health systems strengthening and, indirectly, maternal and child health, is seeking to more fully align with the MDGs and country needs.⁸⁶

⁸¹ RE-ACTION, RESPONSIBLE ACTION UK & OXFAM, IHP+ RESULTS 2010 PERFORMANCE REPORT, at 3-6 (2011), available at http://www.internationalhealthpartnership.net/CMS_files/documents/ihpresults_annual_performance_re_E_N.pdf.

⁸² The Global Fund, *Country Coordinating Mechanisms*, THE GLOBAL FUND, <http://www.theglobalfund.org/en/ccm/> (last visited Feb. 8, 2012).

⁸³ John Zarocostas, *Donor Countries Have Responsibility to Root Out Corruption in Aid Flows*, 342 BRIT. MED. J. 714 (2011), available at <http://www.bmj.com/content/342/bmj.d714>; John Zarocostas, *Global Fund Tries to Lessen Impact of Corruption Cases With Reiteration of Zero Tolerance*, 342 BRIT. MED. J. 603 (2011), available at <http://www.bmj.com/content/342/bmj.d603>.

⁸⁴ At the UN MDG Summit in September 2010, countries committed to provide “adequate funding” for the Global Fund. Yet at the Global Fund’s 3-year replenishment conference the following month, the Fund received only \$11.7 billion in pledges, even as it had established a minimum need of \$13 billion, with a goal of \$20. United Nations General Assembly, *Keeping the promise: united to achieve the Millennium Development Goals*, A/RES/65/ 1, Sept. 22, 2010, <http://www.un.org/en/mdg/summit2010/pdf/mdg%20outcome%20document.pdf>. Donald G. McNeil, “Global fight against AIDS falters as pledges fail to reach goal of \$13 billion.” N.Y. TIMES, Oct. 6, 2010, <http://www.nytimes.com/2010/10/06/world/africa/06aids.html>.

⁸⁵ INT’L TREATMENT PREPAREDNESS COALITION, CCM ADVOCACY REPORT: MAKING GLOBAL FUND COUNTRY COORDINATING MECHANISMS WORK THROUGH FULL ENGAGEMENT OF CIVIL SOCIETY (Oct. 2008), available at http://www.itpcglobal.org/images/stories/doc/CCM_Advo_Rpt.pdf.

⁸⁶ *Enhancing Global Fund Support to Maternal, Newborn and Child Health*, Global Fund to Fight AIDS, Tuberculosis & Malaria, 22d Board Mtg., Decision Point GF/B22/DP15 (Dec. 13-15, 2010), available at http://www.theglobalfund.org/documents/board/22/BM22_DecisionPoints_Report_en/; *Strategic Approach to Health Systems Strengthening*, Global Fund to Fight AIDS, Tuberculosis & Malaria, 16th Board Mtg.,

In a deliberate effort to combine new global funding and strategic commitments to improved accountability, in 2011 the Commission on Information and Accountability for Women's and Children's Health laid out a strategy to enhance accountability in women's and children's health.⁸⁷ Its recommendations on strengthening health information systems and common indicators, regular reporting on spending and connections to results, improved oversight and transparency, and inclusive national accountability mechanisms are all important, deserve support, and provide standards that should extend throughout global health. The Commission also recognized the potential for information and communications technology to enhance information sharing and accountability. Yet there is little new here. Missing are recommendations on incentives or sanctions that might encourage compliance, a recommendation on local accountability mechanisms, capacity building for civil society and communities to hold their own governments to account, codification of commitments to open the potential for judicial enforcement, or other strategies that could help fundamentally improve accountability.

Deep reductions in health inequities will require stronger global governance for health than this. Governance must be capable of ensuring that principles captured in the Paris Declaration are fully implemented. And it must go beyond the focus of these principles to better address the overall volume of health financing, equity, and fundamental human needs. Far stronger forms of accountability are still required, and there remains the need for true global health leadership.

Global health law could play a role in all of these areas. Yet its scope – particularly in legally binding form – remains narrow. It has demonstrated its potential, yet remains highly underdeveloped.

The Scarcity and Inadequacy of Global Health Law

Along with the first global health treaty, the WHO Constitution, global health is populated by all of three major multilateral treaties: (1) two sets of international regulations binding on all WHO members under the terms of article 21 of the WHO Constitution: the World Health Organization Regulations No. 1 Regarding Nomenclature with Respect to Diseases and Causes of Death (the Nomenclature Rule) and the International Health Regulations (IHR); and (2) the first public health convention under article 19: the Framework Convention on Tobacco Control.⁸⁸ Binding global health law

Decision Point GF/B16/DP10 (Nov. 12-13, 2007), *available at* http://www.theglobalfund.org/documents/board/16/BM16_BoardMeeting_Decisions_en/.

⁸⁷ COMMISSION ON INFORMATION & ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH, KEEPING PROMISES, MEASURING RESULTS (2011), *available at* http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf.

⁸⁸ WHO const. (Apr. 7, 1948), *available at* <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>; WHO Reg. No. 1 Regarding Nomenclature (Including the Compilation and Publication of Statistics) with Respect to Diseases and Causes of Death (July 24, 1948 (formalizing a long-standing international process on the classification of disease), *available at* http://untreaty.un.org/unts/1_60000/2/38/00003899.pdf. International Health Regulations (2005), WHA58.3, May 23, 2005, *available at*

also encompasses certain stipulations found in other areas of law, such as the right to health and its accompanying obligations (discussed further below).⁸⁹

Non-binding or “soft” global health instruments are more abundant, including codes (e.g., the Global Code of Practice on the International Recruitment of Health Personnel), declarations (e.g., the UN Millennium Declaration, the Declaration of Commitment on HIV/AIDS, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases), frameworks (e.g., the Pandemic Influenza Preparedness Framework), and strategies (e.g., WHO’s Global Strategy on Diet, Physical Activity and Health).⁹⁰

The IHR and FCGH demonstrate the potential impact of binding global health law, even though they lack sufficient specificity, monitoring, and enforcement. An independent review of the IHR found that there were significant shortcomings in its first test, the 2009 H1N1 influenza pandemic, and the IHR alone were insufficient to enable the world to effectively respond to a severe pandemic. However, the “IHR helped make the world better prepared to cope with public-health emergencies.”⁹¹

http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf. WHO Framework Convention on Tobacco Control, *supra* note 6. In addition to these treaties are the *Protocol concerning the Office International d’Hygiène Publique* (dissolving the Office International d’Hygiène Publique, whose functions were integrated into the newly established WHO) and the *Agreement on the establishment of the International Vaccine Institute. Chapter XI: Health: Protocol concerning the Office International d’Hygiène Publique*, U.N. TREATY COLLECTION, available at http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-2&chapter=9&lang=en; *Archives of WHO, Archives of the Office International d’Hygiène Publique (OIHP)*, WHO, http://www.who.int/archives/fonds_collections/bytitle/fonds_1/en/index.html, (last visited Dec. 2, 2011); *Chapter XI: Health: Agreement on the establishment of the International Vaccine Institute*, U.N. TREATY COLLECTION, available at http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-3&chapter=9&lang=en.

⁸⁹ International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), at 49, U.N. Doc. A/63/16 (1966), available at <http://www1.umn.edu/humanrts/instree/b2esc.htm> [hereinafter ICESCR].

⁹⁰ WHO Code of Practice on the International Recruitment of Health Personnel, 63rd World Health Assembly, WHA63.16 (May 21, 2010), available at http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf [hereinafter Code of Practice]; U.N. Millennium Declaration, U.N. Doc. 55/2 (Sept. 8, 2000), available at <http://www.un.org/millennium/declaration/ares552e.htm>; Declaration of Commitment on HIV/AIDS, U.N. Doc. A/RES/S-26/2 (June 27, 2001), available at <http://www.un.org/ga/aids/docs/aress262.pdf>; Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases, U.N. Doc. A/RES/66/2 (Sept. 19, 2011), available at <http://www.un.org/en/ga/66/resolutions.shtml>; Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_8-en.pdf, adopted at 64th World Health Assembly WHA64.5 (May 24, 2011), available at http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R5-en.pdf. WHO Global Strategy on Diet, Physical Activity and Health, WHA57.17 (May 2004), available at <http://www.who.int/dietphysicalactivity/strategy/eb11344/en/index.html>.

⁹¹ Implementation of the International Health Regulations (2005), Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, 64th World Health Assembly A64/10 (May 5, 2011), at 11, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf (last visited Feb. 9, 2012).

The Framework Convention on Tobacco Control has demonstrated greater potential for addressing the major preventable cause of premature death. More than 60% of the 72 states party for more than five years (among those that have issued two implementation progress reports) has increased tobacco taxes and expanded smoke-free public places since ratifying the Convention. Measures that at least one-third of these 72 countries have taken include strengthening tobacco product health warning, protecting public health policies against tobacco industry interference, and prohibiting tobacco industry advertising, promotion, and sponsorship.⁹²

International health law demonstrates the potential of hard law to improve global health outcomes. Yet, existing treaties are deeply inadequate for the potent task of reducing global health disparities. As mentioned, the IHR and FCTC are flawed because their norms lack specificity, they have no concrete implementation and accountability provisions, and fail to ensure that developing countries gain the capacity to safeguard their own population's health, as well as contribute meaningfully to global health

Perhaps more importantly, these treaties address singular, even if important, areas of global health—health security from diseases of international health importance (the IHR) and tobacco prevention and control (FCTC). Neither treaty purports to deal with key determinants of health such as socioeconomic status, sanitation and hygiene, vector abatement, climate change, food security, as well as behavioral lifestyles (e.g., nutrition and physical activity) leading to chronic diseases. Nor do they build stronger sustainable health systems or ensure access to essential vaccines and medicines. A broad, cross-cutting treaty specifically targeted to the major determinates of health – a Framework Convention on Global Health – would be designed explicitly to reduce global health inequities contributing to millions of deaths annually.

Here we present four defining questions for the future of global health. Our claim is that, taken together, these questions represent the foundational issues for the future of global health. Their answers would offer clear pathways toward lasting and innovative solutions, based on the imperative of global health justice, while developing the foundation for the evolution of global health law in general, and an FCGH in particular: (1) What are the essential services and goods guaranteed under the international right to health? (2) What duties do all states have to meet the health needs of their own inhabitants? (3) What duties do states have to improve the health of people outside their borders? (4) What governance strategies are needed to create effective institutions and structures for global health improvement?

In reviewing these four critical questions, it should be readily apparent how important the law can be for the future of global health. Each major global health problem is shaped by the law's language of rights, duties, and rules for engagement, such as setting high standards, monitoring progress, and ensuring compliance. It is only through law that individuals and populations can claim entitlements to health services and

⁹² WHO, *Global Implementation of the WHO Framework Convention on Tobacco Control – Progress Note*, WHO (Sept. 2011), available at http://www.who.int/fctc/reporting/Progress_note_September2011.pdf.

corresponding state obligations can be established and enforced. And it is through law that norms can be set, fragmented activities coordinated, and good governance (e.g., transparency, stewardship, participation, and accountability) ensured.

Before offering preliminary answers to these four defining questions, we set out the moral and legal underpinning of our approach: that the concept of health aid as charity should be jettisoned, in favor of a justice-based commitment to mutual responsibility beyond state borders. Shared national and global responsibilities, social justice, and the right to health form the normative perspective that would properly guide global governance for health.

III. Reconceptualizing “Health Aid”: From Charity to Human Rights

Global health means different things to different people.⁹³ Often, it is used as shorthand for health assistance provided by the affluent to the poor in a donor-recipient relationship, as a form of charity—a concept we will refer to as “Health Aid.”

Framing the global health endeavor as Health Aid is fundamentally flawed,⁹⁴ as it implies that the world is divided between donors and countries in need. This is too simplistic. Collaboration among countries, both as neighbors and across continents, is also about responding to health risks together and building capacity collaboratively—whether it is through South-South partnerships, gaining access to essential vaccines and medicines, or demanding fair distribution of scarce life-saving technologies. New social, economic, and political alignments are evident, for example, in the emerging health leadership of countries such as Brazil, India, Mexico, and Thailand.⁹⁵

Likewise, the concept of “aid” both presupposes and imposes an inherently unequal relationship where one side is a benefactor and the other a dependent. This leads affluent states and other donors to believe that they are giving “charity,” which means that financial contributions and programs are largely at their discretion. It also means that donors decide the amount and objectives of global health initiatives. The level of financial assistance, as a result, is not predictable, scalable to needs, or sustainable in the long-term. These features of Health Aid could, in turn, mean that host countries do not accept full responsibility for their inhabitants’ health, as they can blame donors for shortcomings.

Conceptualizing international assistance as “aid” masks the deeper truth that human health is a globally shared responsibility, reflecting common risks and

⁹³ David Stuckler & Martin McKee, *Five Metaphors about Global-Health Policy*, 372 LANCET 95-97 (2008).

⁹⁴ See, e.g., Gorik Ooms & Wim Van Damme, *Impossible to ‘Wean’ When More Aid is Needed*, 86 WHO BULLETIN 893-94 (Nov. 2008); Gorik Ooms et al., *Financing the Millennium Development Goals for Health and Beyond: Sustaining the ‘Big Push’*, 6 GLOBALIZATION & HEALTH (2010), available at <http://www.globalizationandhealth.com/content/6/1/17>.

⁹⁵ Jennifer P. Ruger & Nora Y. Ng, *Emerging and Transitioning Countries’ Role in Global Health*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 253-90 (2010) (describing the role of the “BRIC” cluster of nations—Brazil, Russia, India and China— in global health, as the givers and recipients of aid).

vulnerabilities— an obligation of health justice that demands a fair contribution from everyone (North and South, rich and poor). Global governance for health must be seen as a partnership, with financial and technical assistance understood as an integral component of the common goal of improving global health and reducing health inequalities.

A Shared Obligation: The Right to Health and Reinforcing Frameworks

The right to the highest attainable standard of health is the most important health-related international legal obligation for all countries. What makes the right to health a compelling framework for holding states accountable is that it has wide international acceptance as binding law.

What does the right to health entail? The most authoritative interpretation, which has since been built upon by a series of reports by the UN Special Rapporteurs on the right to health⁹⁶ and supplemented by decisions of national courts, comes from General Comment 14 of the UN Committee on Economic, Social and Cultural Rights (CESCR). The right to health, which covers both health care and the underlying determinants of health, contains four “interrelated and essential elements,” requiring that health goods, services, and facilities be available and accessible to everyone (including being affordable and geographically accessible), acceptable (including culturally), and of good quality. States must respect, protect, and fulfill the right to health. That is, they must refrain from interfering with people’s ability to realize this right (for example, discrimination in access to health services is forbidden), protect people from violations of this right by third parties, and actively ensure the full realization of this right.⁹⁷

Although the right to health offers a critical framework for national and global responsibilities for health, it also suffers from obvious limitations: (1) the right to health contains broad aspirations, failing to structure obligations with sufficient detail to render them susceptible to rigorous monitoring and enforcement; (2) the oversight body – the CESCR – possesses few enforcement powers beyond reviewing state reports on treaty implementation and making recommendations; (3) the ICESCR requires states to deliver on the convention’s promises “progressively,” rather than immediately, leading to a staggered and uncertain path toward full realization; and (4) the legal duty falls primarily on the state (not the international community) to provide health services to its own people, even if the country has few resources and limited capacity.”

⁹⁶ Paul Hunt, Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, United Nations Economic and Social Council E/CN.4/2005/51 (Feb. 11, 2005); Paul Hunt, Promotion and Protection of all Human Rights, Civil, Political, Economic and Cultural Rights: Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, United Nations Economic and Social Council A/HRC/7/11 (Jan. 31, 2008); Paul Hunt, Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/64/263 (Aug. 11, 2008).

⁹⁷ General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, U.N. Committee on Economic, Social & Cultural Rights. E/C.12/2000/4 (Aug. 11, 2000).

Yet these structural limitations in the right to health framework can be overcome. The CESCR and the Special Rapporteur can continue to develop clear and enforceable standards and press states harder toward implementation. The duty to “progressively” realize the right to health could be interpreted to require states to meet precise “indicators” or “benchmarks” of tangible progress. The ICESCR’s text itself requires states “to take steps” immediately to achieve “the full realization” of the right to health. The CESCR affirms that states must “move as expeditiously and effectively as possible towards full realization.”⁹⁸ As we will discuss more below, an FCGH could further clarify ambiguities and respond to limitations.

The all-important capacity problem can be overcome through the treaty’s insistence that states use “the maximum of [their own] available resources,” and that the international community provide “assistance and co-operation, especially economic and technical.” As General Comment 14 explains, “If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, [its obligations].”⁹⁹ Taken together, the United Nations Charter, established principles of international law, and the Covenant itself, establish that “international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others.”¹⁰⁰ General Comment 14 states that international assistance is necessary to “enable developing countries to fulfill their core [obligations],” including immediate assurance of essential primary health care for all.¹⁰¹

The right to health – and related entitlements such as the right to food, clean water, and adequate sanitation – continues to evolve and gain international acceptance.¹⁰² Meanwhile, several other emerging paradigms join the human rights framework in recognizing global health as a shared responsibility, a partnership, and a priority that requires the cooperation of all countries. These complementary and mutually reinforcing approaches include health as a fundamental aspect of *human security*¹⁰³ as well as health

⁹⁸ General Comment No. 3, *The Nature of States Parties’ Obligations*, U.N. Committee on Economic, Social & Cultural Rights E/1991/23 (Dec. 14, 1990).

⁹⁹ General Comment No. 14, *supra* note 97.

¹⁰⁰ General Comment No. 3, *supra* note 98.

¹⁰¹ General Comment No. 14, *supra* note 97.

¹⁰² The Human Right to Water and Sanitation, G.A. Res. 64/292, U.N. Doc. A/RES/64/292 (July 28, 2010); The Human Rights to Safe Drinking Water and Sanitation, G.A. Res. 16/2, U.N. Doc. A/HRC/RES/16/2, (Mar. 24, 2011); The Right to Food, G.A. Res. 65/220, U.N. Doc. A/RES/65/220 (Dec. 21, 2010); The Right to Food, G.A. Res. 16/27, U.N. Doc A/HRC/RES/16/27 (Mar. 25, 2011).

¹⁰³ The concept of human security extends the notion of security far beyond traditional national security interests. The high-level Commission on Human Security, commissioned by the government of Japan, defined human security to mean “to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment,” including by protecting fundamental freedoms and “creating political, social, environmental, economic, military and cultural systems that together give people the building blocks of survival, livelihood and dignity.” Commission on Human Security, *Human Security Now* (Washington, DC: Communications Development Incorporated, 2003), at 4,

as a *global public good*.¹⁰⁴ Unlike the right to health, these two frameworks do not have the force of law, but they have gained international acceptance. With human rights benefiting from both widespread acceptance and firm legal grounding, even with its limitations it is a powerful platform upon which to base a new framework on shared global responsibility for health.

IV. Four Defining Questions for the Future of the World's Health

Having explained the moral and legal underpinnings of our approach, we now sketch preliminary answers to four questions, which, taken together, are critically important for the future of the world's health.¹⁰⁵

These questions, which seek to clarify national and international responsibilities towards vital goals rooted in human rights and the governance required to effectuate these responsibilities, may also be instructive for other legal regimes. For example, how should institutions and processes that bear on food production be structured to ensure food security for all, and what responsibilities do countries hold for achieving this goal, both with respect to their own populations and the global population? Similar questions might be asked with respect to meeting everyone's right to education and to social security.¹⁰⁶

1. What are the health services and goods guaranteed to every human being under the right to health?

Our first foundational challenge is to specify the essential health services and goods that make up the right to health. Answers on this front could guide national efforts to provide universal health coverage. Universal health coverage has become a clearly enunciated aim of an increasing number of countries, with some such as Thailand and

http://globalism.rmit.edu.au/files/SOI/Human_Security_Now.pdf. "Good health is both essential and instrumental to achieving human security." *Id.* at 96.

¹⁰⁴ Public goods traditionally share the features of being non-rivalrous (once supplied to one person, the good can be supplied to all other people at no extra cost) and (2) non-excludable (once the good is supplied to one person, it is impossible to exclude other people from the benefits of the good). Technically health does not share these features. For example, it is possible to supply one person with medicine but not another person, while supplying medicine to another person will have an additional cost. However, the collective action required to achieve global health, as well as its considerable positive externalities, such as preventing the spread of communicable disease and economic growth, have led scholars to apply this term to global health, or aspects of it. See WHO, "Global Public Goods," <http://www.who.int/trade/glossary/story041/en/index.html>, (last visited Dec. 12, 2011); Richard D. Smith & Landis MacKellar, *Global public goods and the global health agenda: problems, priorities and potential, Globalization & Health* 3:9 (2007), <http://www.globalizationandhealth.com/content/3/1/9>.

¹⁰⁵ See *Joint Action and Learning Initiative*, *supra* note 9; *National and Global Responsibilities for Health*, *supra* note 9.

¹⁰⁶ For more on an emerging approach to meet the right to social security, developing a social protection floor, see International Labour Office & WHO, *Social Protection Floor Initiative*, WHO (Nov. 2010), <http://www.issa.int/content/download/136762/2785842/file/2social%20protection%20floor%20initiative.pdf> [or Available through: <http://www.issa.int/Resources/Resources/Social-Protection-Floor-Initiative>]. Nicola Liebert, *No Justice Without Social Protection*, ILO (Sept. 2011), http://www.fes.de/gewerkschaften/common/pdf/Programme_NoSocialJustice.pdf.

Brazil making significant progress.¹⁰⁷ The international community, led by the WHO, has revived the goal of universal health coverage established in the 1978 Alma-Ata Declaration on primary health care.¹⁰⁸

A World Health Assembly resolution defined universal coverage “as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost.”¹⁰⁹ Clarifying the health services and goods to which everyone is entitled will help define those “key” health interventions, and give greater substance to a state’s core duties to meet the health needs of its inhabitants. Answers will also form the foundation for assessing the extent to which affluent states should enhance the capacities of low- and middle-income countries.

The WHO describes universal health coverage as a multi-dimensional, progressive process that entails increasing 1) the proportion of the population served; 2) the level of services, and; 3) the proportion of health costs covered by prepaid pooled funds.¹¹⁰ The core human rights principle of equality requires states to prioritize covering 100% of their populations. Although 100% coverage of all health services will not be possible immediately, full coverage of “key” health interventions should be an initial benchmark towards universal coverage. The right to health framework militates against a narrow definition of “key” services. Rather, they should encompass adequate health systems and services, cost-effective vaccines and medicines, and fundamental human needs:

¹⁰⁷ Claudia Jurberg & Gary Humphreys, *Brazil’s March Towards Universal Coverage*, 88 WHO BULLETIN 646-47 (2010), available at <http://www.who.int/entity/bulletin/volumes/88/9/10-020910/en/index.html>; Kannika Damrongplisit & Glenn A. Melnick, *Early Results From Thailand’s 30 Baht Health Reform: Something To Smile About*, 28 HEALTH AFF. w457-w466 (2009).

¹⁰⁸ The 1978 Alma-Ata Declaration set the goal of “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life,” with primary health care “key to obtaining this target.” Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 Sept. 6-12, 1978, at V, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf. Thirty years later, the WHO’s World Health Report refocused global attention on primary health care, while WHO’s 2010 World Health Report focused directly on universal health coverage. See WORLD HEALTH REPORT 2008, *supra* note 50. A 2005 World Health Assembly resolution urged member states “to plan the transition to universal coverage of their citizens.” Sustainable health financing, universal coverage and social health, World Health Assembly WHA58.33 (May 25, 2005), at para. 1(4), http://apps.who.int/gb/ebwha/pdf_files/WHA58-REC1/english/Resolutions.pdf. The G8 has acknowledged “the goal of universal access to health services, especially primary health care,” and the African Union’s health strategy Group of Eight, Responsibility Leadership for a Sustainable Future, L’Aquila Summit (Italy), July 8, 2009, at para. 121, <http://www.g8.utoronto.ca/summit/2009laquila/2009-declaration.html>. The African Union’s health strategy for 2007-2015 frames universal access as “the rallying point of the response to all health challenges.” African Union, *Africa Health Strategy 2007-2015*, CAMH/MIN/5(III), 3rd Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, Apr. 9-13, 2007, at 20, http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf (last visited Dec. 5, 2011).

¹⁰⁹ WHO, SOCIAL HEALTH INSURANCE: SUSTAINABLE HEALTH FINANCING, UNIVERSAL COVERAGE & SOCIAL HEALTH INSURANCE - REPORT BY THE SECRETARIAT, FIFTY-EIGHTH WORLD HEALTH ASSEMBLY (2005).

¹¹⁰ See PATH TO UNIVERSAL COVERAGE, *supra* note 71.

- a) *Health Systems and Services*. The WHO sets out essential building blocks of a well-functioning health system: health services, health workforce, health information, medical products and technologies, a financing system that raises sufficient funds for health and assures access, and leadership and governance. Health systems should ensure basic health care (e.g., primary, emergency, specialized care for acute and chronic diseases and injuries) and public health services (e.g., surveillance, laboratories, and response) for all inhabitants.
- b) *Essential Medicines and Vaccines*. “Essential medicines” refer to the WHO’s Model List of Essential Medicines, which include “the most efficacious, safe and cost-effective medicines for priority conditions.”¹¹¹ They are “selected on the basis of current and estimated future public health relevance, and potential for safe and cost-effective treatment.”¹¹² Vaccines and medicines can be highly cost effective in treating common infections and chronic diseases.
- c) *Fundamental Human Needs*. Reframing the approach to global health requires national and international health funding and activities to meet fundamental human needs—a traditional public health strategy vital to maintaining and restoring human capability and functioning. Fundamental human needs include sanitation and sewage, vector control, clean air, potable water, diet and nutrition (neither under- nor over-nutrition), and tobacco and alcohol reduction.¹¹³

Whatever the precise minimum health goods and services to which everyone is entitled under the right to health, states have an obligation to progressively and continually build upon that a minimum, to more fully realize the right to health. States, even wealthy ones, will need to continue to progress towards universal health coverage. Yet even a core set of essential goods and services – well within the capacity of countries to provide under a framework of mutual responsibility – could greatly improve the lives of vulnerable people.

What would be the cost of these health goods and services – which in their details would vary by country and should be determined with input from the public? The landmark 2001 report of the WHO Commission on Macroeconomics and Health estimated that a package of essential health interventions designed to eliminate much of the avoidable mortality in developing countries would cost \$34 per capita in 2007, rising to \$38 per capita by 2015 as coverage increases (though not yet to universal coverage).¹¹⁴ More recently, the High Level Taskforce on Innovative International Financing for Health Systems estimated that health interventions focused on achieving MDGs 4, 5, and

¹¹¹ WHO, THE SELECTION AND USE OF ESSENTIAL MEDICINES - WHO TECHNICAL REPORT SERIES NO. 920 (2010).

¹¹² WHO, *WHO Model List of Essential Medicines*, WHO, <http://www.who.int/medicines/publications/essentialmedicines/en/> (last visited Feb. 8, 2012).

¹¹³ Lawrence O. Gostin, *Meeting the Survival Needs of the World’s Least Healthy People: A Proposed Model for Global Health Governance*, 298 J. AM. MED. ASS’N 225-28 (2007).

¹¹⁴ WHO COMMISSION ON MACROECONOMICS AND HEALTH, *MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT* (2001). The Commission’s costing estimates of \$34 and \$38 per capita are equivalent to approximately \$42 and \$47, respectively, in 2010 dollars. Calculated using the Consumer Price Index inflation calculator. *CPI Inflation Calculator*, BUREAU OF LAB. STAT., <http://www.bls.gov/cpi/> (last visited Feb. 8, 2012).

6, along with a package of treatment and prevention interventions for chronic diseases (including asthma, cardiovascular diseases, mental illnesses, and neglected tropical diseases), would require states to spend, on average, a minimum of about \$60 per capita (2010 dollars). This could achieve near universal health care coverage for most of these interventions by 2015.¹¹⁵

The level of health services and goods to which everyone is entitled would have to extend well beyond the Commission and Taskforce per capita estimates, which for the most part are limited to medical care. Rather, the core goods and services must include all basic goods and services requisite for a functioning, and indeed, flourishing life.¹¹⁶

In considering costs, the economic benefits of health are worth bearing in mind. Health services contribute to increased productivity and other sources of economic growth—including, over the longer-term, by contributing to children’s education and healthy development as well as by maintaining a healthy workforce. Under-nutrition alone can lower a country’s GDP by 2%,¹¹⁷ while 30-50% of economic growth in Asia from 1965 to 1990 has been attributed to improved reproductive health, reduced infant and child mortality, and reduced fertility.¹¹⁸ HIV/AIDS slowed the rate of annual GDP growth across 33 countries in sub-Saharan Africa from 1992 through 2002 by an average of 1.1%.¹¹⁹ The World Bank found that compared to maintaining 2005 levels of tuberculosis treatment in sub-Saharan Africa, scaling up tuberculosis treatment and control interventions through 2015 in-line with the Stop TB Partnership’s Global Plan to Stop TB would require an additional of \$10 billion, but would bring \$88 billion in economic benefits.¹²⁰ More broadly, a year increase in life expectancy raises a country’s per capita GDP by approximately 4%.¹²¹ Meanwhile, prevention and control measures frequently more than pay for themselves through averted treatment costs. A dollar spent

¹¹⁵ See PATH TO UNIVERSAL COVERAGE, *supra* note 71; WHO & WORLD BANK WORKING GROUP 1, *supra* note 19.

¹¹⁶ AMARTYA SEN, DEVELOPMENT AS FREEDOM (1999); JENNIFER P. RUGER, HEALTH AND SOCIAL JUSTICE (2010).

¹¹⁷ United Nations Secretary-General Ban Ki-Moon, *Global Strategy for Women and Children’s Health* (2010), at 6, available at http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf (citing SUSAN HORTON ET AL., SCALING UP NUTRITION: WHAT WILL IT COST? (2010), available at <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/ScalingUpNutrition.pdf>).

¹¹⁸ *Id.* (citing WHO & The Partnership for Maternal, Newborn, & Child Health, *Investing in Maternal, Newborn and Child Health – The Case for Asia and the Pacific*, WHO (2009), available at http://www.who.int/pmnch/topics/economics/20090501_investinginmnch/en/index.html).

¹¹⁹ INT’L LABOUR OFFICE, HIV/AIDS AND WORK: GLOBAL ESTIMATES, IMPACT AND RESPONSE 77 (2004), available at http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_116379.pdf.

¹²⁰ Ramanan Laxminarayan et al., *Economic Benefits of Tuberculosis Control*, WORLD BANK, at 16-17 (Aug. 2007), available at <http://www.who.int/management/EconomicBenefitofTuberculosisControl.pdf>.

¹²¹ David E. Bloom et al., *Health, Wealth, and Welfare*, in HEALTH AND DEVELOPMENT: A COMPILATION OF ARTICLES FROM FINANCE & DEVELOPMENT 10-15 (Jeremy Clift ed., 2004), available at <http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf>.

on family planning typically will save at least four dollars in treatment costs of pregnancy-related complications, for example.¹²²

Determining a core package of essential goods and services requires ambition tempered by realism and moderation.¹²³ For if the answer is too ambitious, it will lead to unrealistic expectations about financial obligations and burden sharing—expectations that most developed countries, even those that are open to increased responsibility, will refuse to accept or fail to live up to. Yet if its level is not sufficiently ambitious, it will fail to meet the legitimate expectations and rights of all people, and to meaningfully advance the imperative of mutual responsibility for global health. The essential package must be sufficient to reduce health inequalities and offer a bulwark against transnational health threats. It must also need to be tailored to each country's particular and evolving circumstances, such as patterns of disease and people's expressed priorities.

2. What do states owe for the health of their own populations?

Individual states hold primary responsibility to uphold the right to health of their inhabitants. This requires states, within their capacity, to fund and ensure the delivery of all the essential goods and services guaranteed to every human being, and to progressively achieve the highest attainable standard of health. The elements of a state's duties to its inhabitants include, at least, the following:

- a) *Provide adequate health resources within a state's capacity.* Despite the undoubted need for expanded health services, developing country health expenditures as a proportion of total government spending are significantly lower than the global average (<10% compared with >15%).¹²⁴ This low spending comes even as African heads of state pledged in the 2001 Abuja Declaration to commit at least 15% of their government budgets to the health sector¹²⁵ – a pledge reaffirmed at their 2010 summit.¹²⁶ At the present rate of increase (from 2000 to 2008), it will not be until 2039 – nearly four decades after the Abuja Declaration – that average health sector spending among African countries will reach the 15% target.¹²⁷ Health spending in South East Asia, in both in absolute terms and relative to government budgets, is even lower.¹²⁸

¹²² See Ban Ki-Moon, *supra* note 117, at 6 (citing Jennifer J. Frost et al., *The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings*, 19 J. HEALTH CARE FOR THE POOR & UNDERSERVED 778–96 (2008)).

¹²³ By one estimate, at least 60 countries have developed some form of basic health package, at least for the poorest members of society. Pamela Das & Udani Samarasekera, *The Commission on Macroeconomics and Health: 10 years on*, 378 LANCET 1907, 1908 (2011).

¹²⁴ Jean-Pierre Poullier et al., *Health Expenditures: Ratios and Per Capita Levels by World Bank Income Group*, WHO (2002). See WORLD HEALTH STATISTICS 2011, *supra* note 65, at 136–37.

¹²⁵ Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Organization of the African Union Doc. OAU/SPS/ABUJA/3 (Apr. 24–27, 2001).

¹²⁶ Actions on Maternal, Newborn and Child Health and Development in Africa by 2015, African Union Assembly/AU/Decl.1 (XV) (July 25–27, 2010).

¹²⁷ African countries will need to spend, on average, an additional 5.4% of their budgets on the health sector to reach 15%, building on the increase from 8.2% in 2000 to 9.6% in 2008. See WORLD HEALTH

States' own health spending is influenced by foreign assistance, which accounts for 15% of total health expenditure in low-income countries on average, and can be as high as two-thirds in some low-income countries. Unfortunately, developing countries often reduce their domestic health spending in response to increasing international assistance—the so-called “substitution effect.”¹²⁹ It matters a great deal, of course, the purpose for which domestic health spending is being diverted. For example, certain essential non-health sector expenditures such as agriculture, education, or social security can improve health. Expenditures on infrastructure such as roads or electricity may similarly improve well-being.¹³⁰ Yet some governments will use these funds for purposes much less likely to improve health, such as the police or military, or might waste precious resources through corruption or inefficiency.

It is unrealistic to expect that affluent states will carry out their responsibilities if lower-income states do not provide necessary resources for health within their own economic constraints, and do so efficiently. A firm and realized commitment on the part of lower-income countries to make a clearly defined effort, consistent with their human rights obligations, could convince wealthier countries to accept their mutual responsibilities. It would therefore be beneficial to reach a global agreement on the minimum domestic effort to uphold the right to health. States that do not live up to that minimum will find it more difficult to claim assistance from the international community and the need to be the steward of that assistance. Furthermore, they would bear greater responsibility for ill health in their countries and for epidemics spilling over to other countries.

- b) *States have a 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 in the interests of those they serve. Sound governance is *honest*, in that it avoids corruption, such as public officials seeking personal gain or diverting funds from their intended purposes. It is *transparent*, in that institutional processes and decision-making are open and comprehensible to the people. It is *deliberative*, in that government engages stakeholders and the public in a meaningful way, giving

STATISTICS 2011, *supra* note 65, at 136. At the current pace of a 1.4% increase every eight years, it will be 31 years after 2007 before the average reaches 15%.

¹²⁸ Government spending on health in South East Asia is the lowest of any region in the world. It increased as a percent of total government expenditure from 4.7% in 2000 to 5.6% in 2008, and from \$7 per capita to \$20 per capita during the same timespan. See WORLD HEALTH STATISTICS 2011, *supra* note 5, at 136-37.

¹²⁹ Chunling Lu et al., *Public Financing of Health in Developing Countries: a Cross-National Systematic Analysis*, 375 LANCET Vol. 1375-87 (2010).

¹³⁰ Due to the increased access they provide to health services, greater road density in Africa is significantly associated with lower child and maternal mortality and greater access to improved sanitary facilities. Melina R. Platas, *Africa's Health Tragedy? Ethnic Diversity and Health Outcomes*, (Working Paper, Winter 2010 Working Group on African Political Economy, Dec. 17-18, 2010), available at http://www.sscnet.ucla.edu/polisci/wgape/papers/19_Platas.pdf (last visited Feb. 9, 2012).

them the opportunity to provide genuine input into policy formation and implementation. Good governance is also *accountable*, in that leaders give reasons for decisions and assume responsibility for successes or failures, and the public has the opportunity to disagree with and change the direction of policies. Good governance enables states to formulate and implement sound policies, manage resources efficiently, and provide effective services.

Despite the importance of good governance, health sector corruption is a significant problem in some developing countries. According to a World Bank survey of 22 developing countries, health was one of the most corrupt sectors.¹³¹ Health sector corruption includes fund leakage, drug diversion, informal payments to providers, accreditation and licensing bribes, and professional absenteeism. Foreign aid, in particular, is considered “ripe territory for corruption” because it theoretically permits “rent-seeking” behavior.¹³² In other words, local officials can profit from foreign aid, which is often allocated to governments with substantial discretion and little accountability. A vicious cycle of corruption related to foreign assistance can occur, as corrupt countries tend to perform poorly and therefore increasingly depend on aid.¹³³

- c) *States have a responsibility to equitably and efficiently allocate scarce 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 and enhancing- resources, often under conditions of scarcity. Derived from the principles of equal and non-discriminatory access and to equitable distribution under the right to health,¹³⁴ a state should fairly and efficiently distribute health goods and services for its entire population. This requires paying special attention to the needs of the most disadvantaged in society such as those who are poor, minorities, women and children, and people with a physical or mental disability. It requires that health services are accessible and acceptable irrespective of socioeconomic status, language, culture, religion, or locality (e.g., rural or urban).

3. What responsibility do states have for improving the health of people beyond their borders?

The duty of states should not be limited to their own people, but also to fostering a functioning inter-dependent global community, in which everyone recognizes that mutual survival is a matter of common concern. This responsibility includes but extends far beyond containing health threats that endanger other countries and regions.

¹³¹ *Corruption in the Health Sector: Causes and Consequences*, ANTI-CORRUPTION RESOURCE CTR., www.u4.no/themes/health/causesandconsequences.cfm (last visited Nov. 9, 2011); ANTICORRUPTION IN THE HEALTH SECTOR: STRATEGIES FOR TRANSPARENCY & ACCOUNTABILITY (Taryn Vian, William D. Savedoff & Harald Mathisen, eds., 2010).

¹³² Jakob Svensson, *Foreign Aid and Rent-Seeking*, 51 J. INT’L ECON. 437-61 (2000).

¹³³ JOSE TAVARES, DOES FOREIGN AID CORRUPT? (2001).

¹³⁴ The core obligations include “[t]o ensure equitable distribution of all health facilities, goods and services.” General Comment No. 14, *supra* note 97.

To be sure, increased globalization has compelled states to understand the broad need for collective action, but this still leaves a harder question unanswered: To what extent are states, particularly wealthier ones, responsible for the provision of health-related goods and services to the inhabitants of other countries? This is a particularly vexing problem because it is exceedingly difficult to enunciate sound principles demonstrating that State A has specific duties toward the people of State B. Even if a cosmopolitan perspective does point toward transnational obligations, it would remain unclear which states have duties, to whom, and for what.¹³⁵

Despite the conceptual complexity, it is imperative to find innovative ways of holding richer states accountable for a certain level of international assistance. Unfortunately, a tremendous burden of avoidable morbidity and premature mortality rests on those who have the least capacity to do anything about it. As described above, earlier WHO estimates suggest that a basic set of health services costs a minimum of \$60 per person annually, along with additional investments required to meet fundamental human needs. The national politics of taxation in the poorest states cannot realistically aim for government revenue above 20% of the gross national income (GNI).¹³⁶ If these states would furthermore allocate 15% of their government revenue to the health sector, as African heads of state promised in the Abuja Declaration, or at least 3% of their GNI if one combines both percentages, only states with a GNI of more than \$2,000 per person per year have the domestic capacity to provide the essential package of health-related goods.¹³⁷

The actual minimum GNI that would enable countries to have the capacity, using only internal resources, to provide the essential health package would need to be some level appreciably higher than \$2,000 per capita, given that this is based on an incomplete set of essential health services (in particular, including only a limited number of services for non-communicable diseases) and, more significantly, does not cover fundamental human needs such as vector control, adequate nutrition, and clean water. More than one-third of the world's people live in countries with the per capita GNI below \$2,000.¹³⁸ It will only be possible for these countries, and those with a somewhat higher per capita GNI, to provide their entire populations the essential health package with external support.

The Commission on Macroeconomics and Health calculated that affluent states would need to devote approximately 0.1% of GNI to international development assistance for health.¹³⁹ Other data suggest a similar¹⁴⁰ or somewhat higher proportion of

¹³⁵ NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* (2008).

¹³⁶ George J Schieber et al., *Financing Global Health: Mission Unaccomplished*, 26 *HEALTH AFF.* 921, 921-34 (2007).

¹³⁷ Gorik Ooms & Rachel Hammonds, *Taking up Daniels' challenge: The Case for Global Health Justice*, 12 *HEALTH & HUMAN RTS.* 29, 29-46 (2010), available at <http://www.hhrjournal.org/index.php/hhr/article/view/201/307>.

¹³⁸ *Id.* at 37.

¹³⁹ WHO Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: World Health Organization, 2001). While international assistance for

GNI may be necessary.¹⁴¹ In 2008, Official Development Assistance (ODA) for health care from traditional donor countries – members of the Development Assistance Committee of the OECD – was slightly below 0.05% GNI, or less than half of what is required by this measure.¹⁴²

Consequently, if low- and middle-income countries are to afford their inhabitants a reasonable standard of health services, wealthier states will have to ensure financing that is predictable, sustainable, and scalable to needs. The High Level Taskforce on

health has fallen short of the Commission's recommendations, domestic health spending in developing countries has, overall, been higher than the Commission believed necessary. The Commission called for national health spending to increase by \$23 billion by 2007. In fact, from 1995 to 2006, developing countries' health spending increased from \$128 billion to \$241 billion. Pamela Das & Udani Samarasekera, *The Commission on Macroeconomics and Health: 10 years on*, 378 LANCET 1907-08 (2011). However, as a percentage of GNI, developing countries have generally fallen short with respect to the Commission's recommendation of increasing health spending as a percentage of GDP by 1% by 2007 and 2% by 2015. For example, it increased from 5.5% to 6.0% of GDP in Africa from 2000 to 2008, while during those years, it dipped in South East Asia from 3.9% to 3.8% of GDP. *Id.* See WORLD HEALTH STATISTICS 2011, *supra* note 5, at 136. This suggests that the increased funding was more related to strong economic growth than to increased prioritization of funding for health. Most significantly, despite increased domestic health spending and genuine advances in health outcomes, the immense inequities we have described remain.

¹⁴⁰ The MDG Africa Steering Group estimated that an annual \$28 billion is required in external assistance to Africa by 2010 for health care to meet the MDGs on maternal and child health and major diseases. MDG Africa Steering Group, *Achieving the Millennium Development Goals in Africa: Recommendations of the MDG Africa Steering Group, June 2008*, U.N. (2008). At present, wealthy countries spend approximately 48% of their health assistance in sub-Saharan Africa (based on 2009 data). See KATES ET AL., *supra* note 66, at 6. To the extent that this reflects an appropriate regional distribution of health assistance, and not accounting for inflation or currency fluctuations, this suggests a global health assistance requirement of \$58 billion in 2010 (\$28 billion being 48% of \$58 billion). This is approximately 0.13% of high-income country GNI, based on a total \$43.4 trillion GNI for high-income countries in 2010. *Gross National Income 2010, Atlas Method*, WORLD BANK, <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNI.pdf> (last visited Feb. 6, 2012)

¹⁴¹ Another perspective on the figures from the MDG Africa Steering Group raises the possibility that a higher percentage of GNI might be required for health care. According to their calculations, the \$28 billion represents 39% of Africa's total MDG-related external assistance requirement. This is considerably higher than the 19% of MDG-related development assistance that would be used for health care if wealthy countries dedicated only 0.1% GNI towards health assistance out of a total of 0.54% GNI needed to meet the MDGs, according to calculations of the United Nations Millennium Project. U.N. MILLENNIUM PROJECT, *INVESTING IN DEVELOPMENT: A PRACTICAL PLAN TO ACHIEVE THE MILLENNIUM DEVELOPMENT GOALS* (2005).

¹⁴² Official development assistance for health was \$17.2 billion in 2009, excluding water and sanitation, which were not part of the estimate from the Commission on Macroeconomics and Health (nor included in the \$28 billion required from external sources to reach the health MDGs in Africa as estimated by the MDG Africa Steering Group). Total official development assistance (ODA) in 2009 was \$135.1 billion. See KATES ET AL., *supra* note 66, at 6. According to the OECD, which reports lower levels of total ODA (\$119.8 billion in 2009), OECD's Development Assistance Committee members spent 0.31% of their GNI on ODA in 2009. OECD, *Development Aid Rose in 2009 and Most Donors Will Meet 2010 Aid Targets*, OECD (Apr. 4, 2010), http://www.oecd.org/document/0,3746,en_2649_34447_44981579_1_1_1_1,00.html (last visited Feb. 9, 2012). The difference in total ODA is that the OECD figures provide net ODA (deducting loan repayments) while Kaiser Family Foundation reports gross ODA (without deducting loan repayments). Using proportion of ODA that went to health based on the Kaiser Family Foundation report (12.7%) the OECD's figure, the \$17.2 billion for health care was approximately 0.04% of GNI ($0.127 * 0.31$) for these countries.

Innovative International Financing for Health Systems reported in 2009 that health spending (from all sources) in 49 low-income countries alone had to increase from \$31 billion to \$67-76 billion annually to achieve the MDGs. And even this recommended level of funding largely excludes basic human needs such as clean water and adequate sanitation and hygiene.¹⁴³ However, the world is not on track to meet these and other funding requirements, and in the aftermath of the present global financial downturn, prospects for future growth in international health assistance appear grim. The world will likely see a retrenchment in the near-term.

Although the volume of international financial responsibility for global health certainly matters, it is not the only concern. Another critical concern is the long-term reliability of international financial responsibility. Financial assistance for health is typically provided in the form of grants with limited duration, generally three to five years. Along with domestic politics in wealthy countries – from election and appropriation cycles to changing geopolitical interests and national priorities – the international community seems to believe that short-duration grants will encourage poorer states to take their fate in their own hands, and mobilize additional domestic resources.¹⁴⁴

Paradoxically, the real effect might be quite the opposite. Donor commitments remain short-term and conditional, with funding that is volatile and unreliable, as highlighted by the Global Fund’s decision to cancel its Round 11 even after having already launched the Round. Governments, therefore, are “understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.”¹⁴⁵ But that does not mean they will refuse the financial assistance that is available. It is more likely that they will limit their own domestic health spending increases, possibly even flat-lining or decreasing their domestic health investments, to avoid increasing their health budgets to a level that they would not be able to sustain should the foreign assistance for health be reduced in the years ahead.¹⁴⁶ Furthermore, the short-term nature of assistance makes states reluctant to invest it in recurrent costs, creating an obstacle to overcoming one of the major health constraints many lower-income countries face—the severe shortages of health workers.

Financial assistance not based on an understanding of mutual responsibility, and unreliable in the long run, is therefore an inefficient expenditure of resources, as it is limited in its ability to improve the provision of health-related goods and services. This alone should be sufficient reason to consider a global agreement on norms that clarify national and the global responsibilities for health, transforming ineffective short-term financial assistance into effective sustained funding.

¹⁴³ TASKFORCE ON INNOVATIVE INT’L FINANCING FOR HEALTH SYSTEMS, MORE MONEY FOR HEALTH, AND MORE HEALTH FOR THE MONEY (2009).

¹⁴⁴ See Ooms et al., *supra* note 94.

¹⁴⁵ Mick Foster, *Fiscal Space and Sustainability: Towards a Solution for the Health Sector: Background Paper for the Third High-Level Forum on the Health MDGs* (Paris: World Health Organization and World Bank, 2005).

¹⁴⁶ Gorik Ooms et al., *Crowding Out: Are Relations between International Health Aid and Government Health Funding too Complex to be Captured in Averages Only?*, 375 LANCET 1403-05(2010).

International responsibility extends well beyond financing, as a range of policies, statutes, and bilateral or multilateral treaties outside the health sector have considerable impact on health. States and multilateral organizations adopt policies that often impede, rather than facilitate, health among the world's poor, including: intellectual property rules that reduce access to essential medicines and vaccines; trade and restrictive macroeconomic policies that limit government revenue or ability to invest in health; agricultural policies such as subsidies and biofuel production targets that impact global food markets, and; energy policies, including subsidies, targets, and investments, that will exacerbate climate change, with its numerous adverse effects on health. Even domestic workforce policies and international recruitment can accelerate the migration of trained doctors, nurses, and pharmacists out of developing countries already experiencing serious health worker shortages.

4. What kind of global governance mechanisms are required to ensure that all states live up to their mutual responsibilities to provide health goods and services to all people?

The preliminary answers to the questions above should be sufficient to understand that better global governance for health is needed, based on genuine global partnerships:

- a) Low- and middle-income states will be most likely to accept international norms for their domestic health challenges, including agreed upon priorities and domestic health-related spending levels, if they are part of a genuine partnership for a global common good, which confirms their duties towards their own people as well as towards the international community – but also the duties of the international community towards them.
- b) Individual affluent states will be reluctant to accept financial duties towards lower-income states without an agreed arrangement for equitable burden-sharing among all affluent states, agreed norms about how these financial duties will complement domestic duties, and agreed principles on the health-related goods, services, and capacities for which the funding will be used.
- c) Lack of adequate domestic health spending and misuse of global financial resources by national governments would seriously undermine the willingness of the international community to live up to its responsibilities.
- d) The collection, management, and coordination of the global financial duties for health will have to be governed in a way that reflects a genuine partnership. International financial assistance should be understood as part of a compact among states to provide essential health goods and services to all people and to adhere to good governance principles. Governance arrangements, moreover, should ensure the full participation of civil society, for where there are injustices, health advocates are the ones most likely to raise their voices and hold states, and others, accountable.

This paradigm shift to genuine mutual responsibility for global health grounded in the right to health will require more than an agreed set of responsibilities and principles. It will also require constructing a more forceful, purposeful, efficient, and accountable set

of institutions and arrangements. Work is underway to find answers to challenges of global governance for health. The UN General Assembly tasked the UN Secretary-General, in collaboration with the WHO, to report on ways that “foreign policy [can] contribute better to creating a global policy environment supportive of global health.” And in 2011, WHO launched a reform process to improve its own functioning and to create greater coherence and improved outcomes in global health.¹⁴⁷

A global governance structure that can at last make “health-for-all” a reality will have to successfully address at least seven “grand challenges” in global health:¹⁴⁸

1. *The lack of global health leadership.* Global health leadership is required to mobilize, coordinate, and focus a large and diverse set of actors around a clear mission, common objectives, effective approaches, sustained action, and mutual accountability. The WHO has the unique authority and legitimacy to assume this role, but it is experiencing a crisis of leadership.¹⁴⁹ Part of the reason is that the organization has proved reluctant to exercise its broad normative powers.¹⁵⁰ But, more importantly, with extra-budgetary funding consuming 77.3% of its budget (rich countries demanding highly-specific tasks), WHO has been transformed into a donor-driven organization, restricting its ability to direct and coordinate the global health agenda.¹⁵¹ Without leadership, the response to global health challenges has been ad hoc and fragmented. And without a global health advocate, other regimes, such as intellectual property and world trade, have dominated the agenda.
2. *The need to harness the creativity, energy, and resources for global health.* A shared sense of purpose and priorities, and greater coordination should complement, not supplant, the benefits that come from a proliferation of global health actors. These include civil society, with its ability to reach and represent disadvantaged populations, to advocate, and to hold governments accountable; the private sector, with its ability to develop new medical technologies, market safer food, and create safer and healthier workplaces; and foundations and philanthropists, with their ability and willingness to fund imaginative approaches

¹⁴⁷ Global Health and Foreign Policy, United Nations res. 63/33, United Nations A/RES/64/108 (Jan. 27, 2009). The future of financing for WHO: World Health Organization: reforms for a health future: World Health Assembly A64/INF.DOC./5 (May 12, 2011).

¹⁴⁸ Lawrence O. Gostin & Emily A. Mok, *Grand Challenges in Global Health Governance*, 90 BRITISH MEDICAL RECORD 7-18 (2009) (offering the first six grand challenges we describe). See also Devi Sridhar, *Seven Challenges in International Development Assistance for Health and Ways Forward*, 38 J. L. MEDICINE & ETHICS 459-69 (2010).

¹⁴⁹ Devi Sridhar & Lawrence O. Gostin, *Reforming the World Health Organization*, 305 J. AM. MED. ASS’N 1585-1586 (2011).

¹⁵⁰ Richard Dodgson, Kelley Lee and Nick Drager, *Global Health Governance: A Conceptual Review* (London and Geneva: World Health Organization and the London School of Hygiene and Tropical Medicine, 2002). David P. Fidler, “The Future of the World Health Organization: What Role for International Law?” *Vanderbilt Journal of Transnational Law* Vol. 31, No. 5 (1998): 1079-1126. Allyn Taylor, “Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health,” *American Journal of Law and Medicine* Vol. 18 (1992): 301-346.

¹⁵¹ Devi Sridhar & Ngaire Woods, *Trojan Multilateralism: Global Cooperation in Health* (Working Paper, Global Economic Governance Programme, Oxford 2011).

- to improving global health and meeting unmet needs. Public private partnerships (PPPs) based on and organized around a shared respect for human rights and health-for-all will be vital to success in these challenges.
3. *The lack of collaboration and coordination among multiple players.* Today's global health discourse is dominated by terms such as "fragmentation" and "duplication," with a proliferation of actors, pictorially represented as an incomprehensible, tangled web of agencies and programs. Such complexity reduces the efficiency of health spending, at times even pitting international actors and local service providers against each other. The proliferation of uncoordinated actors poses significant challenges to the stewardship role of ministries of health and misses opportunities for collaboration and synergy. A new global governance structure will need a simplified architecture that translates into a more coherent and manageable picture at the country level, with relationships rooted in collaboration that harmonizes global health actions and aligns with national strategies.¹⁵²
 4. *The neglect of essential health needs and health system strengthening.* Far-reaching health benefits would come from meeting such timeless human health needs as clean water and adequate nutrition, sanitation and sewage, tobacco control, and abating disease vectors such as mosquitoes and rodents, and from developing effective health systems that equitably and efficiently deliver known, effective health interventions. Giving heightened global priority toward meeting these human needs would more effectively reduce the diseases and injuries that are responsible for most of the world's suffering, morbidity, and premature mortality. Despite their demonstrable value in improving the public's health, basic needs have been largely neglected—although this is beginning to change with a new focus on health system strengthening. Reforming the global health architecture would prioritize health systems and fundamental human needs under a mutual responsibility framework.
 5. *Ensuring predictable, sustainable, and scalable funding, and cooperative priority setting.* Inadequate funding plagues global health. Most African governments have failed to fulfill their pledge to spend at least 15% of the government budget on the health sector. The proportion of GNI that OECD members allocated to ODA in 2010 (0.32% GNI)¹⁵³ is essentially the same as it was in 1970 (0.33% GNI)—the year that wealthy countries pledged to spend 0.7% GNI on ODA, though they have never come close to fulfilling that promise.¹⁵⁴ Meanwhile, too frequently geopolitical interests drive development assistance. Shifting priorities of wealthy countries can undermine country ownership, neglect basic needs, and enable diseases to resurge while progress is reversed. Consequently, coherent

¹⁵² OECD, PARIS DECLARATION ON AID EFFECTIVENESS: OWNERSHIP, HARMONISATION, ALIGNMENT, RESULTS AND MUTUAL ACCOUNTABILITY (2005).

¹⁵³ *Development Aid Reaches an Historic High in 2010*, OECD, http://www.oecd.org/document/35/0,3746,en_2649_34447_47515235_1_1_1_1,00.html (last visited Dec. 6, 2011).

¹⁵⁴ Helmut Führer, *The Story of Official Development Assistance* (Paris: Organization for Economic Cooperation and Development, 1994). For a historical perspective on foreign assistance, see Anup Shah, *Foreign Aid for Development Assistance*, GLOBAL ISSUES (June 5, 2011), <http://www.globalissues.org/article/35/foreign-aid-development-assistance> (last visited Feb. 2, 2012).

global governance for health must include sustainable funding and priority setting.

6. *The need for accountability, transparency, monitoring, and enforcement.* Basic principles of good governance are required not only at the national (and sub-national) level, but also at the international level. Yet the global health field is marked by a paucity of detailed targets with concrete plans to achieve them, along with a lack of accountability. There is insufficient transparency among states and international organizations, and inadequate monitoring and evaluation of health initiatives. Meanwhile, global health funding and activities are, in practice, voluntary, with few mechanisms to ensure compliance. A new global health architecture would include: clear targets to improve the public's health and reduce health inequalities; benchmarks and indicators of success that are rigorously monitored; incentives and enforcement mechanisms to ensure compliance; and civil society engagement, virtual and in-person interactive forums, and publicly provided reasons for decisions to improve transparency.
7. *The need for health and human rights leaders to influence multiple global sectors to promote health.* Health and human rights leaders must be empowered to influence sectors that profoundly affect the world's health such as trade, intellectual property, environment, development, and arms control. They need to collaborate and take an active role in transforming sectors that adversely affect health and human rights, or that need to be strengthened in their protection for health and human rights. Along with working to affect regimes on an individual basis they should work to develop a hierarchy of rules that uniformly gives priority to health and human rights. Otherwise, when policies in diverse regimes conflict, with few means of resolution, health and human rights may suffer. For example, trade and investment treaties may undermine state power to enact rigorous tobacco control laws as required under the FCTC. A narrow focus on the health and human rights sectors, without a positive influence on competing regimes, will not result in global health with justice.

These broadly imagined innovations in global governance for health are certainly ambitious and face powerful political and economic obstacles. There remains considerable distrust between the global North and South. It will be exceedingly difficult to convince wealthy states that they ought to bind themselves to sustainable levels of assistance, scalable to real needs. And it will be just as difficult to persuade poorer countries to move beyond their pledges to in fact fulfill their responsibilities for health assurance and good governance.

Yet, mutual responsibilities do come with reciprocal benefits. The global South would benefit from increased respect for their strategies, greater and more predictable funding from more accountable development partners, reform of international regimes that harm health, such as trade and agriculture, and improved health for their populations. The global North would benefit from greater confidence that development assistance is spent effectively, the prospect of reduced financing over time as host countries build sustainable health systems, and better protection for their populations from global public health threats. Developed countries would also achieve the diplomatic benefits that come

from their role in improving global health. All would benefit from lessons on shared health challenges and from the economic, educational, environmental, and security benefits that come from improved global health. And all would experience a sense of shared satisfaction from participating in a historic venture to make unprecedented progress towards global health equity.¹⁵⁵

For these reasons among others, an initiative to fill international law's most significant gap, however difficult, is possible. We now propose specific elements of a FCGH. The treaty would be designed along the four dimensions discussed above. It would create standards on universal health coverage, clarify national and global responsibilities towards securing universal health coverage and around the right to health more broadly, and structure a system of global governance for health that could effectively and efficiently effectuate these responsibilities. A worldwide civil society and academic-led initiative launched in 2010 – the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) – is campaigning for an FCGH, and conducting research to draft the convention.¹⁵⁶

V. A Framework Convention/Protocol Approach to Global Health

In April 2011, the United Nations General Secretary, Ban Ki Moon, asked political leaders “to commit to global solidarity, built on the tenets of shared responsibility, true national ownership and mutual accountability.... Let the AIDS response be a beacon of global solidarity for health as a human right and set the stage for a future United Nations Framework Convention on Global Health.”¹⁵⁷

Proposed originally in 2008,¹⁵⁸ a framework convention/protocol approach to global health, using a bottom-up inclusive process, would: (1) set globally-applicable norms and priorities for health systems and essential human needs; (2) do so while affording countries flexibilities to meet domestic needs and take “ownership” of national policies and programs; (3) establish a sustainable funding mechanism or framework scalable to needs; (4) effectively govern the proliferating number of actors and activities in a crowded global health landscape; (5) create methods for holding state and non-state actors accountable to the right to health obligations, including for monitoring progress and achieving compliance with the FCGH itself; and (6) devise a process for the international community to establish further commitments beyond those in the initial Convention.

¹⁵⁵ See *Joint Action and Learning Initiative*, *supra* note 9, at 4.

¹⁵⁶ See, e.g., the Joint Action and Learning Initiative on National and Global Health Responsibilities submission to Rio+20: United Nations Conference on Sustainable Development, Nov. 1, 2011, available at: <http://www.uncsd2012.org/rio20/index.php?page=view&type=510&nr=279&menu=20>. For more information about JALI, please see JALI's website: <http://www.jalihealth.org>.

¹⁵⁷ UN Secretary-General, *Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths: Report of the Secretary-General*, U.N. Doc A/65/979 (Mar. 2011), at ¶ 73, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/A-65-797_English.pdf.

¹⁵⁸ See *Meeting Basic Survival Needs*, *supra* note 9.

Normative Standards and Priorities

The central objective of the FCGH would be to improve health for all, with particularly attention to the least advantaged populations, thus seeking major reductions in health inequalities within and among states. Any legal intervention with this avowed aim can succeed only if it addresses the full gamut of major determinants of health—ranging from high quality health systems to fundamental human needs such as sanitation, hygiene, clean water, adequate nutrition, vector abatement and tobacco control, and even to broader social determinants such as employment, education, a healthy environment, and gender equity.¹⁵⁹

The entire scope of this task is more than any one treaty can be expected to accomplish, but the FCGH can be a milestone along the way to full health equity. It could firmly establish universal health coverage as a central goal of the post-MDG global health agenda and develop a normative framework for ensuring everyone both effective, accessible health systems and a broad array of public health services. And it could help ensure that countries have at least basic frameworks in place to address broader health determinants, building on the Rio Political Declaration on Social Determinants of Health of 2011.¹⁶⁰

An FCGH would go beyond establishing universal health coverage as a shared global health responsibility, but would also clarify the key elements that comprise universal coverage. Without a clear and detailed account of the critical features of universal coverage a plan for full financing, and ongoing monitoring and compliance, health coverage will remain a broad, unachieved aspiration.

The treaty would establish a richer definition of universal health coverage, encompassing the requirements for effective health systems ranging from primary care and human resources to essential medicines and vaccines. The treaty could delineate critical capacities and policies in each of the six health system building blocks that WHO has identified along with commitments for shared national and global efforts to develop these capacities and support these policies. It could, for example, build on the WHO Global Code of Practice on the International Recruitment of Health Personnel, such as turning guidance against recruiting health workers from countries facing critical health personal shortages into binding law.¹⁶¹

Further, the FCGH could specify a minimal proportion of national health costs covered by prepaid pooled funds, ensuring that out-of-pocket expenses do not exclude equal access by the poor. The proportion of health spending out-of-pocket and across

¹⁵⁹ See COMMISSION ON SOCIAL DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (2008), *available at*: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

¹⁶⁰ Rio Political Declaration on Social Determinants of Health, adopted at the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil, Oct. 21, 2011 [hereinafter Rio Political Declaration], *available at* <http://www.who.int/sdhconference/declaration/en/index.html>.

¹⁶¹ Code of Practice, *supra* note 90, at art. 5.1 (“Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers”).

socioeconomic groups could be a crucial indicator to monitor progress on universal health coverage.

The FCGH would redefine health systems to include fundamental human needs, and operationalize both long-standing and existing human rights norms, including the rights to food¹⁶² and to clean drinking water and sanitation,¹⁶³ and established principles and priorities of public health. It would establish the services that states must include within the ambit of health systems, whether by ensuring individual access, such as to clean drinking water, or by requiring all states to implement policies in the requisite areas, such as sanitation, mosquito abatement, and tobacco control, needed to satisfactorily meet these needs.

For some fundamental human needs, the FCGH could establish universal minimums based on the best scientific evidence, such as the minimum number of liters of clean drinking water must be available to each person every day, and the minimum number of calories and vital nutrients. The treaty could set floors for the annual pace towards ensuring clean water, decent sanitation, and nutritious food for all. Tobacco control measures could build on and incorporate obligations from the Framework Convention on Tobacco Control, subjecting them to the rigorous compliance mechanisms envisaged for the FCGH. Policies in other areas, such as vector control, alcohol reduction or diet and nutrition, could build on WHO global strategies¹⁶⁴ or other authoritative sources.

Even this expansive treaty vision of universal coverage would be narrower than the full range of determinants of health, which would require a variety of additional social and economic levers, such as education, housing, employment, the environment, a social safety net, and greater income equality. Many of the deeper causes of ill health are addressed by, or require, entire legal regimes focusing on gender equality, unequal distribution of power and resources, and more. The FCGH could offer pathways for addressing the broader socio-economic determinants of health, but could encompass only those with more direct health impact, such as health care and broader public health services captured by the idea of essential human needs.

The treaty could require countries to develop comprehensive public health strategies that encompass social determinants of health identified in the FCGH, along with benchmarked actions plans, with associated budgets and timelines, to implement these strategies. The Convention itself or a later protocol could establish processes for monitoring progress on and encouraging international support for these plans. A protocol might also extend commitments on universal health coverage to a broader set of social

¹⁶² The right to food is incorporated into the ICESCR as part of the right to an adequate standard of living and to be free from hunger. ICESCR, *supra* note 91 at art. 11.

¹⁶³ The human right to water and sanitation, U.N. G.A. Res. 64/292, U.N. Doc. A/RES/64/292 (adopted July 28, 2010).

¹⁶⁴ See, e.g., WHO, GLOBAL STRATEGY TO REDUCE THE HARMFUL USE OF ALCOHOL (2008) http://www.who.int/entity/substance_abuse/alcstratenglishfinal.pdf; WHO Global Strategy on Diet, Physical Activity and Health, WHA57.17 (May 2004), <http://www.who.int/dietphysicalactivity/strategy/eb11344/en/index.html>.

services, establishing for everyone a social protection floor.¹⁶⁵ Similarly, the FCGH could require countries to develop specific plans of action to ensure full health equity for women, and require these plans to remove obstacles women and girls face to health systems, fundamental human needs, and social determinants of health.

By establishing an agreed and obligatory roadmap to universal coverage, the treaty would help clarify, monitor, and incentivize compliance with the right to health, including specifying its core obligations¹⁶⁶ and elucidating its progressive realization requirement. An FCGH would set out principles, benchmarks, and processes for expanding the level of health services available to all under the human rights framework.

The norms that the FCGH affirms or establishes in international law would range beyond universal health coverage. It would elevate the right of people to participate in health-related planning¹⁶⁷ to a clearly articulated and legally enforceable principle of the right to health.

Perhaps most significantly, the FCGH would firmly embed in binding international law equality and non-discrimination as an immediate obligation of the right to health. Further, it would affirm that this obligation is not only a shield against malfeasance, but also a sword to cut away at inequality— in access to health services and fundamental human needs, and in securing broader determinants of health, such as employment and healthy environments. It is not enough that states protect all of their inhabitants from policies and practices that would undermine the health status of certain groups. States must also take affirmative measures to improve health outcomes for population groups that are being left behind.

In the remaining sections, we describe the aspects of an FCGH required to realize this expansive vision of universal health coverage and to significantly advance the right to health. We suggest types of targets for health system and fundamental human needs that the FCGH could include. We expand on the flexible process described above to balance global norms with country circumstances and how an FCGH could mobilize the funding required for universal health coverage. We outline how an FCGH could promote the global governance for health required to organize a multiplicity of international organizations and NGOs towards a common purpose of universal health coverage, and to ensure that other international legal regimes do not detract from – but rather contribute to – the right to health. Finally, we offer ways in which an FCGH could promote accountability, from that of the individual health worker and local health services to right to health norms to national accountability to its obligations under the FCGH.

Targets and Benchmarks

¹⁶⁵ Rio Political Declaration, *supra note* 160, at para. 11.2(x).

¹⁶⁶ General Comment No. 14, *supra note* 97, at para. 43.

¹⁶⁷ *Id.*, *e.g.*, at paras. 11 (stating that an important aspect of the right to health is “participation of the population in all health-related decision-making at the community, national and international levels”), (requiring a national public health strategy and plan of action to be developed “on the basis of a participatory and transparent process”).

Effective implementation of treaty obligations requires governments to set targets and benchmarks of success. Countries would establish strategies and targets that are achievable and consistent with their overall approaches to strengthening their health system. Within the health areas and in accordance to standards set by the FCGH, including on the participatory approaches to translating the FCGH mandates into nationally appropriate, desirable, and effective approaches, countries themselves would define the interventions guaranteed to everyone. They would establish the health workforce targets, and standards for developing their networks of health facilities, required to achieve universal coverage. Equity targets, such as to reduce disparities between urban and rural areas and between the highest and lowest income quintiles, could guide priorities and strategies in health systems strengthening. And they would ensure that financing is an obstacle to access neither for the poorest segments of the population nor for people who are above the poverty line but nevertheless will require substantial support to fully access health systems.

Countries typically already establish targets, timelines, and strategies in these areas. The difference now is that they will have to accord to certain standards and goals, backed by the necessary resources – as well as the assurance of international support to achieve these goals.

Similarly, the pathway to fundamental human needs for everyone might be tailored to country circumstances, establishing targets, timelines, and strategies. Consider clean water and decent sanitation. A country where only 75% of the population has access to safe drinking water cannot be expected to achieve universal access to safe drinking water by the same year as a country where 98% of the population already has such access. Conversely, it should not be acceptable for the country where coverage is already high to delay in achieving universal coverage until far poorer countries can achieve this goal.

Countries might have different benchmarks on the way to a rich form of universal coverage. The MDGs measure the proportion of the world's population with "improved" sources of water and sanitation.¹⁶⁸ Yet within these improved sources – which provide cleaner water and sanitation that is better than no technology at all, is a wide range of technologies, not all of which are equal in protecting health. Improved water sources range from a borehole or protected well that might be a kilometer away from a person's dwelling to clean water piped into one's home. Improved sanitation includes not only indoor toilets but also pit latrines.¹⁶⁹ Different countries may establish varying timelines to provide universal access first to "improved" sources of drinking water and sanitation, then to piped water and indoor toilets.

¹⁶⁸ UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 2011 53-55 (2011), *available at* http://www.beta.undp.org/content/dam/undp/library/MDG/english/MDG_Report_2011_EN.pdf.

¹⁶⁹ WHO, *WHO Statistical Information System (WHOSIS), Access to improved drinking water sources and to improved sanitation (percentage)*, <http://www.who.int/whosis/indicators/2007ImprovedAccessWaterSanitation/en/index.html> (last visited February 14, 2012).

A Flexible and Inclusive Process

A key strength of the Framework Convention/Protocol approach is that the treaty sets globally applicable norms that are needed in every society for good health and reduced inequalities, while launching an inclusive process for grassroots buy-in and specificity tailoring commitments to national and local population health needs. As specificity develops, states parties could adopt more detailed protocols on the key parameters of global health. Here is an illustration of how that bottom-up, inclusive process would operate.

As a treaty establishing the post-MDG global health agenda, and to promote accountability, the FCGH could include ambitious yet achievable global targets. The FCGH's targets would be refined locally through participatory, equitable processes that adapt them to local circumstances and ensure national and community ownership.¹⁷⁰ This local tailoring should enhance accountability, as the targets will truly be the country's own, and not viewed as externally imposed. Country ownership should promote not only government buy-in, but also is more likely to represent genuine national priorities for improved health. The nationally developed targets could be included in a treaty protocol, a codification that could affirm international support for these targets, while also subjecting countries to the various monitoring and compliance processes of the FCGH.

Civil society and community participation in developing the targets – as well as the strategies to achieve them – is critical, a role that the FCGH should reinforce. Participation can occur through a variety of forums, from national health assemblies, community consultations, and online input to being part of the teams that ultimately develop the targets and strategies.

Community and civil society involvement will help push against political boundaries and ensure that targets are ambitious, tuned to the demands of equity and the highest attainable standard of health. Their participation may create the pressure or provide the public health rationale for reluctant governments to address politically sensitive issues in their targets and strategies, including the needs – and rights – of disfavored populations, such as sexual minorities and drug users. Moreover, NGOs and community groups may bring knowledge – within communities, in rural or slum regions, at public health facilities – that many government officials might lack, and share the strategies that best work to connect marginalized populations with health services.

Protocols would have purposes beyond codifying nationally developed targets or other national commitments that have been established through bottom-up processes that the FCGH catalyzes. Protocols could also be used for agreements on issues that parties cannot resolve when negotiating the initial treaty, to address problems that arise during the course of treaty implementation, and to respond to changes in the global health

¹⁷⁰ See Jeff Waage et al., *The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015*, 376 LANCET 991-1023 (2010).

environment. Protocols, for example, could institute new forms of financing if the FCGH is not succeeding in securing required funding, or would expand the scope of areas covered under the treaty. Other protocols could include specific ways in which states parties will engage in other legal regimes in ways that promote health, bring additional social health determinants within the treaty's scope, or link the FCGH to broader initiatives, such as ensuring a universal social protection floor.

As compliance is vital for the treaty's success, but politically difficult to achieve, protocols could be needed to establish procedures for individuals or groups to bring complaints against governments not complying with FCGH requirements. For instance, a civil society coalition might assert that a government failed to include civil society and communities in health planning processes, or is failing to address the needs of marginalized populations.

Protocols could be binding on all parties or optional. They might be supplemented by amendments to the treaty, such as updating funding formulas, including responding to the rapid economic growth of many developing countries. The expectation of protocols will also help maintain a global focus and stimulate global discussion on health inequities.

Sustainable Funding Scalable to Needs

While increased global health spending has not reduced the global health equity gap, it has contributed to significant progress against AIDS and other diseases and causes of death that have their greatest impact in the global South. And even while efficiencies can contribute significantly to “more health for the money,” “more money for health” is also required if global health inequities are to be significantly reduced.¹⁷¹ The FCGH, therefore, would have to include a financing framework with clear funding benchmarks for governments' domestic health spending and for international health funding commitments.

The urgency of a framework to secure adequate funding is especially great now, as major economies from the United States to the European Union are plagued with debt and politicians look for ways to cut budgets, particularly expenditures for foreign assistance. The framework will have to ensure adequate funding, be backed by mechanisms to hold all partners accountable and otherwise guard against funding shortcomings, all the while achieving political buy-in and avoiding detrimental competition with other global financing demands, such as climate change mitigation and adaptation. This poses a particularly hard challenge for any international law regime.

Innovative financing mechanisms, support for countries' efforts to increase tax collection and prevent tax avoidance, private financing, and other measures could

¹⁷¹ TASKFORCE ON INNOVATIVE INTERNATIONAL FINANCING FOR HEALTH SYSTEMS, MORE MONEY FOR HEALTH, AND MORE HEALTH FOR THE MONEY (2009), http://www.internationalhealthpartnership.net//CMS_files/documents/taskforce_report_EN.pdf (last visited Feb. 6, 2012).

supplement ordinary government funding. With some creativity and the fortitude to resist entrenched interests (e.g., beverage industry opposition to taxes on sugary drinks, financial industry opposition to financial transaction taxes), substantial resources could be raised through these mechanisms.

New forms of taxes and fees, such as on unhealthy foods and medical tourism, could be implemented domestically and raise additional funds.¹⁷² Meanwhile, illicit capital flight from low- and middle-income countries has been estimated at approximately \$500 billion annually, representing enormous losses in tax revenue; tax havens for wealthy individuals alone may cost low- and middle-income countries \$50 billion annually in lost tax revenue.¹⁷³ The FCGH could facilitate these taxes, fees, and enhanced tax collection, such as through establishing information sharing, capacity building, and international cooperation responsibilities. Or, going beyond this, the FCGH could include more precise commitments, such as requiring taxes on unhealthy foods, increased tobacco taxes, or other sources of revenue.

Many countries will be unable through their own resources to ensure their populations universal health coverage, while also making the necessary investments in social determinants of health. International funding is also required. It should be based on the concept of global solidarity and an understanding that financial sustainability should encompass both domestic and international funds.¹⁷⁴

International funding would be provided directly to countries or channeled through a common funding mechanism, such as a Global Fund for Health,¹⁷⁵ to best ensure country ownership and simplify the landscape of health actors at country level. It could be that only wealthier nations provide international financing. Or, not unlike a highly progressive national system of social protection extended globally,¹⁷⁶ in line with the concept of global solidarity and to take into account the growing financial capacity of many developing countries, all countries would provide international health assistance, with levels based on economic capacity. Poorer countries would receive far more than they contribute, and wealthier countries contribute far more than they receive. Particularly if wealthier countries continue to provide much of their assistance bilaterally, supplementary measures may be necessary, such as to untie aid¹⁷⁷ and to encourage using local contractors and sources of technical expertise to make aid more efficient and effective.

¹⁷² See PATH TO UNIVERSAL COVERAGE, *supra* note 71, at 29.

¹⁷³ *Why do Tax and Capital Flight Matter for Health?*, ECON. GOVERNANCE FOR HEALTH (Apr. 1, 2009) <http://www.eg4health.org/get-informed/tax-capital-flight-and-health/> (last visited Feb. 8, 2012).

¹⁷⁴ See Ooms & Hammonds, *supra* note 137, at 29-46.

¹⁷⁵ Giorgio Cometto et al., *A Global Fund for the Health MDGs?*, 373 LANCET 1500, 1500-02 (2009); See Ooms et al., *supra* note 94.

¹⁷⁶ Gorik Ooms, *From the Global AIDS Response Towards Global Health?* (Stony Point Conference Paper, Jan. 2009), *available at* http://photos.pih.org/inforesources/IHSJ_Stony_Point_Conference_2009/From_the_Global_AIDS_Response_towards_Global_Health_G.Ooms.pdf (last visited Jan. 14, 2012).

¹⁷⁷ Tied aid is assistance that requires purchasing goods and services from the country providing the aid.

Much as the FCGH could encourage and facilitate innovative sources of domestic financing, it could also establish forms of innovative international financing for health, such financial transaction taxes. One review found eleven operational and three proposed novel international funding mechanisms for global health (and another twelve operational or proposed mechanisms to stimulate innovation and fund global health research).¹⁷⁸

These mechanisms could provide predictable sources of health funding, less dependent on state compliance to the FCGH. In addition, a trust fund or other mechanisms could guard funding volatility. For example, if several countries are failing to meet their international financing responsibilities, funding formulas could automatically adjust so that other countries cover the difference, or innovative mechanisms compensate through slightly higher fees or tax levels. Such an approach would need to be coupled with a treaty enforcement regime that effectively dissuades countries from being free riders, knowing that other sources of revenue will be found.

Any funding formula that the FCGH includes is unlikely to be nuanced enough to fully capture the many factors that go into determining whether a country is spending the maximum of its available resources,¹⁷⁹ particularly given that this requirement spans all economic and social rights, and cannot be viewed in isolation from them. Thus, the requirements in the FCGH would not obviate the more general obligations of the ICECSR. However, they could establish valuable benchmarks that serve as strong indicators of whether or not a country is meeting its obligation to spend “the maximum of its available resources.” It would also provide far greater clarity on what the ICESCR’s obligation on international assistance entails, as well as the comparable obligation in the UN Charter.¹⁸⁰

Global Governance for Health

One of the greatest deficiencies in global governance for health today is the lack of coherence among a multiplicity of global health actors, as well as among the multiple international legal regimes that impact health outcomes. A key priority for an FCGH is to gain greater rationality and cooperation among all actors and regimes around the central value of the right to health. This requires resolving both the fragmentation and poor coordination within the health sector and the tensions between health and other regimes.

With respect to the former, the global health landscape has poor partner alignment with national strategies and financing, insufficient coordination among development partners, and fragmentation of funding and programs. Ministers of health often are unaware of, or lack control over, multiple funders and service providers on the ground.

¹⁷⁸ JOSH MICHAUD & JEN KATES, INNOVATIVE FINANCING MECHANISMS FOR GLOBAL HEALTH: OVERVIEW & CONSIDERATIONS FOR U.S. GOVERNMENT PARTICIPATION, at 11 (2011), *available at* <http://www.kff.org/globalhealth/upload/8247.pdf>.

¹⁷⁹ RADHIKA BALAKRISHNAN ET AL., MAXIMUM AVAILABLE RESOURCES & HUMAN RIGHTS: ANALYTICAL REPORT (2011), *available at* <http://www.cwgl.rutgers.edu/globalcenter/publications/marreport.pdf>.

¹⁸⁰ Under article 56 of the U.N. Charter, states “pledge themselves to take joint and separate action in co-operation with the” United Nations to achieve “conditions of stability and well-being,” including universal observance of human rights and fundamental freedoms. U.N. Charter, art. 55-56.

Aid organizations compete with themselves for funding and programs. They even compete with local services. A local primary care health clinic, for example, cannot pay the salaries or maintain the level of equipment and services of a well-funded PEPFAR or Global Fund AIDS clinic.

The FCGH would empower host countries to take the lead in managing all funding and technical partners around a single national health strategy. The treaty could extend and strengthen present efforts, such as through the IHP+,¹⁸¹ to align international funding with national health strategies. Ministries of Health would be responsible for monitoring and evaluation frameworks by firmly embedding in international law the global health equivalent of the three ones (one national AIDS action framework used to coordinate the work of all partners, one national AIDS coordinating authority with a multi-sector mandate, and one agreed country monitoring and evaluation system).¹⁸²

The FCGH would require countries to report regularly on obstacles to adhering to these principles and to develop action plans to overcome them, to inform health ministries of any funding and programs outside the direct control of the ministries, and contribute to a national map of health activities to avoid duplication and gaps in coverage.

It is also necessary for the national plan itself to be rooted in the right to health, developed through participatory processes and prioritizing such principles as equality and accountability. Even the focus on a government-driven strategy should not preclude funding outside the strategy where it falls short with respect to the right to health – such as by failing to fully address the needs of marginalized populations. Similarly, funding outside of the plan to community-based and other civil society organizations might be required to bolster accountability. Funding outside the national strategy might also be appropriate in other limited circumstances, such as to non-state actors not adequately covered by the plan that are taking innovative approaches to meeting unmet health needs.

Although rationalization of health sector actors is important, so too is there a need for harmonization of widely diverse requirements in parallel international law regimes. The FCGH would have to seek greater consistency, and priority for human health, among non-health sectors, such as trade, environment, finance, and migration. It might provide that all clear conflicts that might arise between these regimes and the FCGH must be resolved in favor of the FCGH and the right to health. For example, a policy that another regime allowed or even encouraged that interferes with a country's capacity to ensure universal health coverage would be impermissible. Such a rule might not only alter the behavior of FCGH, but could also establish new norms applicable to all states.

The FCGH could offer specific actions that countries should take in non-health realms, and mechanisms to evaluate the adoption and effective implementation of these

¹⁸¹ For more information on the International Health Partnership and related initiatives (IHP+), see <http://www.internationalhealthpartnership.net/>,

¹⁸² UNAIDS, “*Three Ones*” *Key Principles* (2004), http://data.unaids.org/UNA-docs/three-ones_keyprinciples_en.pdf (last visited Feb. 6, 2012).

measures. For example, an FCGH could inform adaptation measures that will reduce the health impact of climate change, ensure that intellectual property agreements and laws do not interfere with public health, and regulate “land grabs”— the large-scale foreign purchase of land in developing countries, which can threaten food security.¹⁸³ An FCGH may be able to help manage potential resource competition among regimes, for example, if a Global Fund for Health and a Green Climate Fund were both mandated to raise some of their resources through financial transaction taxes.

Effective global governance for health requires institutional competence and leadership. Although it is currently going through a funding crisis of its own, the WHO, with expanded capacities, would be placed at the center of global governance for health. The WHO has the competence and institutional credibility to help ensure the priority of health in other regimes. The FCGH might include ways to formalize the WHO’s role outside the health sector. It could establish a WHO-led coordinating body that comprised key international organizations, such as the World Trade Organization, World Bank, Food and Agriculture Organization, International Labour Organization, UN Environment Programme, and UN Women. Such a body would develop and implement pathways for making health more prominent in multiple legal regimes, and could help develop a protocol to codify such measures.

The FCGH should also find ways to respond not only to regimes where health is not presently a central value, but also to non-state actors that that can powerfully impact – both for better and for worse – the right to health. The private sector, for example, has a substantial effect on the health of populations, ranging from food, beverages, alcohol, and tobacco to pharmaceuticals, energy, and consumer products. The treaty could define the responsibilities states to effectively regulate transnational corporations as they relate to health, and identify ways to incentivize compliance.

Accountability and Treaty Monitoring and Compliance

Greater accountability must be at the heart of improved global governance for health, and hence would be central to an FCGH, from government accountability for health services delivered to the communities they serve through to accountability for international obligations – in particular, compliance with the FCGH. To enhance accountability within countries, the FCGH could require countries to develop plans to support community-based strategies for monitoring and holding government responsible for local health services. These strategies might include, for example, community scorecards and functioning community health committees.¹⁸⁴

¹⁸³ Oakland Inst., *Special Investigation: Understanding Land Investment Deals in Africa*, <http://www.oaklandinstitute.org/special-investigation-understanding-land-investment-deals-africa> (last visited Feb. 6, 2012).

¹⁸⁴ For more on community scorecards see Agriculture Learning and Impacts Network, *Community Scorecards*, ALINE (UK), <http://www.aline.org.uk/community> (last visited Feb. 6, 2012). Community-based monitoring, such as scorecards, can have a powerful impact on health outcomes. A study in Uganda attributed a one-third drop in child mortality in certain communities to use of the scorecards and associated monitoring activities. See Martina Björkman & Jakob Svensson, *Power to the People: Evidence from a*

An FCGH could establish additional national and local accountability processes, such as maternal and child mortality audits.¹⁸⁵ And an FCGH could include targets, strategies, and mechanisms – or processes to develop them – to ensure an emphasis on equity and meeting the needs of poor, marginalized, and vulnerable populations, covering such areas as disaggregated data, funding, participation, and outreach. It could require states to assess stigma and discrimination in the health sector, implement strategies to reduce such attitudes and practices, and hold health workers accountable for mistreating patients.

The treaty could also provide new mechanisms and funding streams to support community-based and other civil society organizations that can hold their governments to account, as well as to ensure that health services reach even the poorest segments of the population. And it could require health worker education on the right to health, including rights in the FCGH and national constitutions, and how people can claim these rights. Moreover, the treaty could establish commitments and monitoring mechanisms to ensure that health plans, policies, and programs emphasize the health needs of traditionally discriminated against and underserved populations – to ensure that government accountability of its human rights and other health obligations and policies extend to their entire populations.

Accountability is closely linked to other aspects of good governance, such as transparency and deliberative, participatory processes. For example, states parties to the FCGH could commit to transparent and competitive bidding for ministry of health contracts, making publicly available information on the private assets of health ministry officials, and publishing and providing directly to communities information on health service funding that their local health services should receive. And the FCGH could establish or require countries to establish process that ensure civil society and community participation in planning, implementing, and evaluating local, national, and international partner-supported health plans, policies, and programs.

As with any treaty, an FCGH's success will depend on the difficult issue of compliance. States would regularly and transparently report on their compliance with the FCGH, including progress towards benchmarks. Civil society organizations and other non-state actors would be welcome to formally provide their own reports and data on

Randomized Field Experiment on Community-Based Monitoring in Uganda, 124 Q. J. ECON. 735, 735-69 (2009).

¹⁸⁵ Maternal, newborn, and child death audits are meant to capture the structural and systematic factors that must be addressed to reduce maternal, newborn, and child deaths. For more on these audits, see UN Special Rapporteur on Health, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Preliminary note on the mission to India, Addendum, A/HRC/7/11/Add.4 (Feb. 29, 2008), available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/preliminary_note_india.doc. Human Rights Watch, *No Tally of the Anguish: Accountability in Maternal Health Care in India* (Oct. 2009). Available at: <http://www.hrw.org/en/reports/2009/10/08/no-tally-anguish-0>. South Africa Every Death Counts Writing Group, "Every death counts: use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa." *Lancet* (Apr. 12, 2008) 371: 1293-1304.

state compliance, which would also be factored into determining state compliance. To further ensure the credibility and effectiveness of the compliance regime, the FCGH might also include a proactive mechanism to investigate state compliance if states fail to adhere to reporting requirements.

Effective compliance for the FCGH should also include an innovative regime of incentives and possibly sanctions. This regime could include certain forms of international support provided only to states meeting obligations, suspension of eligibility for WHO Executive Board membership or of other WHO rights, and encouraging or requiring states parties to grant national courts jurisdiction to hear cases brought by their populations involving FCGH violations.

VI. The Path Towards an FCGH

The architecture of a Framework Convention on Global Health would, therefore, encompass core normative standards for health systems and essential human needs; facilitate an inclusive participatory process for norm development suited to national needs and priorities; establish funding modalities to build capacity in low and middle-income countries to meet the broad health needs of their populations; prioritize and incorporate the right to health in other legal regimes; and strengthen health monitoring and accountability at community, national, and global levels.

This article's goal is to begin the vital task of constructing the norms and processes of an FCGH. Ultimately, a broad coalition of leading states, academic institutions, and civil society organizations will have to develop the ideas. Without a bottom-up, inclusive process, a treaty of this breathtaking scope and historic impact could never succeed politically. What is most important in formulating a treaty that successfully responds to the imperatives of human rights and global justice is that it captures the views and aspirations of the people whose health is most imperiled under current governance arrangements.

Traditionally, treaties are initiated and negotiated by states, but recent history suggests that bottom-up processes are not only possible, but also increasingly necessary. Civil society organizations, for example, led the International Campaign to Ban Land Mines, receiving the 1997 Nobel Peace Prize for successful international adoption of the Mine Ban Treaty. A coalition of NGOs proposed and successfully advocated for the Convention on the Rights of Persons with Disabilities.¹⁸⁶

An FCGH will need to follow this pathway as well. And like these other treaties, the role of civil society will be central at all stages, from developing the concept and populating the treaty to advocating for its adoption and ratification through to monitoring its implementation. The Framework Convention Tobacco Alliance, for example, has driven the implementation and expansion of the FCTC. As the nearly 20

¹⁸⁶ *History*, UNCPR INDIA, <http://uncrpdindia.org/about/history/> (last visited Feb. 9, 2012). Janet E. Lord, *NGO Participation in Human Rights Law and Process: Latest Developments in the Effort to Develop and International Treaty on the Rights of People with Disabilities*, 10 ILSA J. INT'L & COMP. L. 311 (2004).

million deaths attributable annually to global health inequities occur in the global South – even as innumerable more deaths attributable to internal inequities occur in nations of every income level – it is imperative that this process be driven by Southern civil society.

The initiative of which we are a part, JALI, is steering this broad consensus process. JALI places critical importance on an extensive, inclusive process of input, including through community, regional, and global consultations, online consultative processes, surveys, interviews, and targeted research. We invite readers to join the movement through <http://www.jalihealth.org>.

With global health justice as a core principle, JALI will enable and prioritize input of the people who suffer most from today’s national and global health inequities—marginalized communities, people who live in extreme poverty, women, persons with disabilities, and other disadvantaged populations. Although civil society participation is crucial, so too is input from communities— not only organizations working to advance the public’s health, but also the people living with AIDS, grassroots women’s networks, indigenous communities, and others whose rights to health are most severely compromised under extant national and international regimes.

A far-reaching process of developing an FCGH is needed not only to ensure the strongest possible treaty, but also to develop a social movement behind it. JALI faces overwhelming challenges in securing an FCGH from powerful governments in the North to influential transnational corporations. As much as progressive government leadership will be needed to navigate the FCGH from the conceptual realm to binding international law, the treaty’s adoption and widespread ratification will require pressure from below, in both the global South and North.

Like the FCGH itself, with a purview that extends far beyond health care services, the social movement behind an FCGH will need to encompass not only more traditional health movements, but also other social movements that intersect with the right to health, such as the labor movement, movements around the food security, the environment, and climate change, and movements for the rights of women, indigenous communities, and sexual minorities.

Most people understand that the defining issues of our time – climate change, food security, and global health – demand collective action, normative standards, and compliance mechanisms. It is hard to envisage fundamental change without the force of international law. With 54,000 deaths every day connected to global health inequities,¹⁸⁷ developing international legal solutions should become a global priority. The UN Secretary-General’s call to action for a UN Framework Convention on Global Health will test the international community’s oft-reiterated commitment to global health and human rights. The question remains, are states prepared to take the bold steps necessary to silence the daily drumbeat of preventable illness, suffering, and early death.

¹⁸⁷ See Garay, *supra* note 2.