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Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health

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Inaugural Lecture for the Investiture of the Linda D. and Timothy J. O'Neill Professor of Global Health Law, Georgetown University Law Center, Washington, D.C., April 19, 2007

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Opening Remarks for the Investiture of the O'Neill Institute

It is wonderful for me to have one of my dearest friends, Richard Diamond, say such warm words. It was because of Wendy Williams, Judy Areen, and Pat King that I came to Georgetown. And I have been happy every minute here, with the most talented group of colleagues and friends that I could possibly have on this terrific Georgetown faculty.

President DeGioia, Dean Aleinikoff, Mr. and Mrs. O'Neill, Faculty, and Students, thank you for this high honor. President DeGioia, your leadership exemplifies this great university. We are all fortunate to be in a place whose Jesuit spirit stands for justice and service to others. And your signature work on globalism, health, and AIDS is deeply important to our city, the nation, and the world.

Dean Aleinikoff, it was you, Dean Bette Kelner, and Kevin Conry who nurtured this idea and made it grow into the reality that it is today. The three of you deserve all the recognition for day and the Institute's bright future. And Mary Matheron has been a guiding and steady hand.

Linda and Tim O'Neill, thank you for making this dream come true. Your confidence in us has been humbling. Getting to know you and your family, and the values and principles you stand for, has inspired us and given me great happiness. I pledge to you that we will mightily pursue the mission of the O'Neill Institute of seeking innovative solutions to the world's most pressing health problems. We have a remarkable leadership team at the Institute, including Gregg Bloche, Bernhard Liese, David Vladeck, Tim Westmorland, and Ben Berkman. And to Wendy Perdue and James Hodge for our unique Global Health LL.M. program. We have an unbeatable partnership between the Law Center and the School of Nursing and Health Studies.

My family and closest friends from near and very far are surrounding me today, and that feels very good. My dear sister Judy and her husband Phil, and her lovely daughter Sari and her husband Aaron have come to share this special day. My father and mother, Joe and Lillian, have come from NYC. This Saturday, my father celebrates his 91st birthday, and I hope he will do what he did on his 90th, which is to ride his bicycle. (Talk about public health!).

One of Georgetown's best and brightest is here, but he also happens to be my eldest son Bryn. I am bursting with pride for the wonderful person Bryn is and the sheer joy that he and his brother give to Jean and I. My youngest son Kieran is taking exams at a rival law school. His Dad forbid him from coming today!

Many years ago, I held a very tense press conference when I chaired the UK's National Inquiry into the deeply contentious miners dispute. I frantically called my wife Jean and she said calmly: "My dear, I put your speech in your left hand pocket." Well, this summer my lovely English bride and I celebrate our 30th Anniversary. So, this Lecture is dedicated to you Jean—30 Years in Love.

Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health

Inaugural Lecture for the Investiture of the Linda D. and Timothy J. O'Neill Professor of Global Health Law April 19, 2007

Lawrence O. Gostin¹

This lecture searches for solutions to the most perplexing problems in global health—problems so important that they affect the fate of millions of people, with economic, political, and security ramifications for the world's population. No State, acting alone, can insulate itself from major health hazards. The determinants of health (e.g., pathogens, air, food, water, even lifestyle choices) do not originate solely within national borders. Health threats inexorably spread to neighboring countries, regions, and even continents. It is for this reason that safeguarding the world's population requires cooperation and global governance.

If I am correct that ameliorating the most common causes of disease, disability, and premature death require global solutions, then the future is demoralizing. The States that bear the disproportionate burden of disease have the least capacity to do anything about it. And the States that have the wherewithal are deeply resistant to expending the political capital and economic resources necessary to truly make a difference to improve health outside their borders. When rich countries do act, it is often more out of narrow self-interest or humanitarian instinct than a full sense of ethical or legal obligation. The result is a spiraling deterioration of health in the poorest regions, with manifest global consequences for cross-border disease transmission and systemic affects on trade, international relations, and security.

Suppose that States were convinced that amelioration of global health hazards was in their national interests or that they otherwise accepted the claim that they have an ethical or legal obligation to act. Would the consequent funding and efforts make a difference? If past history is any guide, the answer is no. Most development assistance is driven by high profile events that evoke public sympathy, such as a natural disaster in the form of a hurricane, tsunami, draught, or famine; or an enduring catastrophe such as AIDS; or politicians may lurch from one frightening disease to the next, irrespective of the level of risk ranging from anthrax and smallpox to SARS, Influenza A (H5N1), and bioterrorism.

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What is truly needed, and which richer countries instinctively (although not always adequately) do for their own citizens, is to meet what I call “basic survival needs.” By focusing on the major determinants of health, the international community could dramatically improve prospects for good health. Basic survival needs include sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines, and well-functioning health systems. Meeting everyday survival needs may lack the glamour of high-technology medicine or dramatic rescue, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disabilities across the globe.

If meeting basic survival needs can truly make a difference for the world’s population, and if this solution is preferable to other paths, then how can international law play a constructive role? Extant legal solutions have deep structural faults. The most glaring problem, widely debated by scholars, is whether international legal instruments and global institutions can effectively govern the diverse State and non-State actors that influence health outcomes. Setting normative standards and assuring follow-through are particular problems in health—more so than in other fields of international law. But even this governance debate does not address the hardest problem in global health. International law seems ineffective in creating incentives, let alone binding obligations, to provide funding, services, or protection for the world’s poorest people. But this is exactly what is required to solve the most intractable problems in global health.

If law is to play a constructive role, it will require an innovative way of structuring international obligations and this, in turn, will require States to accede to a new model. A vehicle such as a Framework Convention on Global Health (FCGH) could be a starting point. Such a Framework Convention would commit States to a set of targets, both economic and logistic, and dismantle barriers to constructive engagement by the private and charitable sectors. It would have to stimulate creative public/private partnerships and actively engage civil society stakeholders. A FCGH could set achievable goals for global health spending as a proportion of GNP; define areas of cost effective investment to meet basic survival needs; build sustainable health systems; and create incentives for scientific innovation. The World Health Organization (WHO) or a newly created institution could set ongoing standards, monitor progress, and mediate disputes.

A FCGH, or similar mechanisms would not be easy to achieve politically or provide an ideal solution. But, at least, a Framework Convention would go to the heart of the problem—finding creative ways to engage States, the private sector, and civil society to find sustainable solutions to improve prospects for a healthier and longer life for the world’s population.

This lecture first inquires why governments should care about serious health threats outside their borders, and explores the alternative rationales. Second, I examine the compelling issue of global health equity, and ask whether it is fair that people in poor countries and regions suffer such a disproportionate burden of disease, disability, and

premature death. Third, I describe how the international community focuses on a few high profile, heart-rending, issues while largely ignoring deeper, systemic problems in global health. By focusing on basic survival needs, the international community could dramatically improve prospects for the world's population. Finally, I explore the value of international law itself, and propose an innovative mechanism for global health reform—a Framework Convention on Global Health.

I. Global Health: A Matter of National Interest?

It is axiomatic that infectious diseases do not respect national borders. But this simple truth does not convey the degree to which pathogens migrate great distances to pose health hazards everywhere. Human beings congregate and travel, live in close proximity to animals, pollute the environment, and rely on overtaxed health systems. This constant cycle of congregation, consumption, and movement allows infectious diseases to mutate and spread across populations and boundaries. The global population is also vulnerable to bioterrorism—the deliberate manipulation and dispersal of pathogens. These human activities, and many more, have profound health consequences for people in all parts of the world, and no country can insulate itself from the effects. The world's community is interdependent and reliant on one another for health security.

This brief description about the inexorable spread of disease across countries and continents might well lead to the conclusion that global health is in every nation's interest. Indeed, a compelling case can be made that large-scale health hazards have such catastrophic consequences for the health of the populace, the economy, and national security that international cooperation is a matter of vital State interest. The relationship between extremely poor health and dire economic and political consequences is far too complex to be expressed in simple cause and effect terms. Instead, it can be explained by how poor health contributes to State instability and how State instability, in turn, creates the conditions for poor health.

A. National Interests in the Health of the Populace

Democratic theory holds that the common defense, security, and welfare of the population are among the State's primary obligations—goods that can be achieved only through collective action. The populace can tolerate even the most catastrophic events if they are unforeseeable and unpreventable. But if political leaders fail to take steps in advance that could have ameliorated a natural-occurring epidemic or bioterrorism, the political price would be high. The political consequences for failure to act early and decisively with respect to outbreaks of SARS, BSE and FME, for example, were evident in North America and Europe. The politics of infectious diseases can be seen in the fact that pandemic influenza planning has reached the highest levels of government, with enormous resources expended, even though Influenza (A) H5N1 has resulted in only a few hundred human deaths worldwide and none in the United States.

If governments have an obligation to ensure at least reasonable conditions of health, they have no choice but to pay close attention to health hazards beyond their

borders. DNA fingerprinting has provided conclusive evidence of the migration of pathogens from less to more developed countries. In fact, more than thirty infectious diseases have newly emerged over the last 2-3 decades, ranging from Hemorrhagic Fevers, Legionnaires Disease, and Hanta virus to West Nile Virus and monkeypox. Vastly increased international trade in fruits, vegetables, meats, and eggs has resulted in major outbreaks of foodborne infections caused by Salmonella, E. coli bacteria, and Norwalk-like viruses.

Not only do emerging and re-emerging diseases increasingly affect the wealthiest countries, but also they are less able to ameliorate these harms through technologies such as vaccines and pharmaceuticals. Resurgent diseases such as tuberculosis, malaria, and HIV have developed extreme resistance to front-line medications. As microbes change genetic form, existing vaccines and pharmaceuticals become inapt. The therapeutic challenges are not limited to exotic infections, as WHO has warned that many pathogens are gaining resistance to therapies, including common respiratory, diarrheal, and ear infections.

The State's response to disease epidemics also has profound domestic costs. Disease control measures such as travel restrictions, school closures, and quarantines can cause personal detachments, disrupt social and economic life (education, trade, business), and infringe individual rights. Powerful reasons, therefore, exist for governments to pay close attention to global health, not only for the sake of people in far away places but to prevent potentially catastrophic social, economic, and political consequences for their own citizens.

B. National Economic Interests: Trade and Commerce

Even the most powerful countries have a narrow interest in preventing the migration of large-scale health threats to their shores. But beyond narrow self-interest, are there broader, "enlightened" interests in redressing extremely high rates of disease and premature death in the world's poorest regions? There is a strong case that a forward-looking foreign policy would seek to reduce enduring, intractable diseases in developing countries.

Epidemic disease dampens tourism, trade, and commerce, as the 2003 SARS outbreaks demonstrated. Animal diseases such as FMD, BSE, and avian influenza similarly had severe economic repercussions on trade and commerce, with mass cullings of flocks and herds, and provoked trade bans on beef, lamb, or poultry. Massive economic disruption would ensue from a pandemic of human influenza, with a projected loss of up to 6% in global GDP.

In regions with extremely poor health, economic decline is almost inevitable. HIV/AIDS in sub-Saharan Africa accounts for 72% of global AIDS deaths. Average life expectancy in this region is now 47 years, when it would have been 62 without AIDS. For some of the worst affected countries such as Botswana, life expectancy has declined from 75.7 to 34.2 years of age. Most of the excess mortality is among young adults aged

15-49, leaving the country without entrepreneurs, a skilled workforce, parents, and political leaders. The World Bank estimates that AIDS has reduced GDP nearly 20% in the hardest-hit countries. AIDS, of course, is only one disease in countries experiencing multiple epidemics, starvation and massive poverty, and regional conflicts that devastate the population.

Countries with extremely poor health become unreliable trading partners without the capacity to develop and export products and natural resources; pay for essential vaccines and medicines; repay debt; and require increased financial aid and humanitarian assistance. In short, a foreign policy that seeks to ameliorate health threats in poor countries can benefit the public and private sectors in developed, as well as developing, countries.

C. National Security

Extremely poor health in other parts of the world can also affect the security of the United States and its allies. Research shows a correlation between health and the effective functioning of government and civil society. The CIA, for example, finds that high infant mortality is a leading predictor of State failure, and the State Department called AIDS a national security threat. States with exceptionally unhealthy populations are often in crisis, fragmented, and governed poorly. In its most extreme form, poor health can contribute to political instability, civil unrest, mass migrations, and human rights abuses. In these States, there is greater opportunity to harbor terrorists or recruit disaffected people to join in armed struggles. Politically unstable States require heightened diplomacy, create political entanglements, and sometimes provoke military responses.

Diseases of poverty overwhelming are concentrated in sub-Saharan Africa, and it is no surprise that many of these political and military entanglements occur in that region. The rest of the world, however, has largely been insulated from the devastation wrought by these endemic diseases. The explanation for this “awful dissonance” may lie in the region’s marginal strategic importance. Sub-Saharan Africa has weak political, military, and economic power.

The same cannot be said about the burgeoning health crises emerging in pivotal countries in Eurasia, such as China, India, and Russia. These countries are in the midst of a “second wave” of HIV/AIDS, which mirrors the earlier explosion in Sub-Saharan Africa. The HIV prevalence in the Ukraine and the Russian Federation, for example, have risen twenty-fold in less than a decade. In the decades ahead, the center of the global HIV/AIDS pandemic is projected to shift from Africa to Eurasia.

The HIV/AIDS crisis in Eurasia is exacerbated by additional emerging health problems. Recall that infant mortality is a prime predictor of State instability. Russia’s official infant mortality rate (which is thought to be vastly under-reported) is 3-4 times higher than in North America and Western Europe, and similar levels are found in parts of India and China. Of children who are born alive, nearly two-thirds will be unhealthy,

many suffering lifelong illness and disability. Women's reproductive health is also poor, with nearly half of all pregnant women being malnourished and sick, many losing their babies before term.

Eurasia is a region of high strategic importance in terms of its population, economic and military prowess, and political influence. It has more than 60% of the world's inhabitants; one of the highest combined GNPs; and at least four massive armed forces with nuclear capabilities. But due to extreme health hazards, Eurasia will suffer economic, political, and military decline. Political instability in a region with such geostrategic importance will have major international ramifications.

D. Do States Perceive Global Health to be in Their National Interests?

Governments, therefore, have powerful reasons based on narrow or enlightened self-interest to ameliorate extreme health hazards beyond their borders. But do political leaders acknowledge, and act on, this evidence? The answer may be that States are beginning to understand, but their engagement in global health is relatively limited. And the sad truth is that the coincidence of interests is narrower than activists, and even scholars, have suggested. As U.K. Chancellor Gordon Brown said when launching the International Finance Facility for global health in 2003, rich countries "just don't care enough."

There is little doubt that developed countries are beginning to see global health as essential to their national interests. OECD countries have increased development assistance for global health over the last two decades, rising from nearly \$2 billion in 1990 to \$12 billion in 2004. At the same time, philanthropic organizations have devoted historic sums to global health. The Gates Foundation alone will donate up to \$3 billion per year. This development assistance may appear substantial, but sits modestly beside the annual \$1 trillion spent on military expenditure and \$300 billion on agricultural subsidies.

The increase in development assistance, moreover, is largely attributable to extensive resources devoted to a few high profile problems: AIDS, pandemic influenza, and the Asian tsunami. Even factoring in these new investments, most OECD countries have not come close to fulfilling their pledges of giving 0.7% of Gross National Income (GNI) per annum. OECD countries would have to invest an additional \$100 billion by 2015 to close the vast investment gap. With these additional expenditures, WHO projects that tens of millions of lives would be saved every year.

Rather than a general commitment to global health, States often prefer "targeted engagements" to prevent only those hazards deemed most likely to affect their own citizens. National security assessments and international agreements offer relatively narrow justifications for State action on global health. Governments frame the problem as one of averting direct threats of infectious diseases reaching their borders, and not to reduce extremely poor health in impoverished countries.

In many respects, States may be correct that true global engagement does not serve their interests. Richer countries almost always have relative health advantages over poorer countries. The technological capacity to produce drugs and vaccines, the sophisticated health systems, and the simple fact that their populations generally are richer and healthier, means that developed countries usually can safeguard their citizens by looking inward. One need only examine the historical and current data on health disparities discussed next to understand that highly developed countries can, and will, maintain comparatively high levels of population health by focusing the bulk of their resources on domestic needs.

II. Global Health Disparities: Are Profound Health Inequalities Fair?

Perhaps it does not, or should not, matter if global health serves the interests of the richest countries. After all, there are powerful humanitarian reasons to help the world's least healthy people. But even ethical arguments have failed to capture the full attention of political leaders and the public.

It is well known that the poor suffer, and suffer more than the rich. Unfortunately, this is also true with respect to global health. What is less often known is the degree to which the poor suffer unnecessarily. The global burden of disease is not just shouldered by the poor, but disproportionately so, such that health disparities across continents render a person's likelihood of survival drastically different based on where she is born. These inequalities have become so extreme and the resultant effects on the poor so dire, that health disparities have become an issue no less important than global warming or the other defining problems of our time.

The current global distribution of disease has led to radically different health outcomes in developed and developing countries. Disparities in life expectancy among rich and poor countries are vast. Average life expectancy in Africa is nearly 30 years less than in the Americas or Europe. Life expectancy in Zimbabwe or Swaziland is less than half that in Japan; a child born in Angola is 73 times more likely to die in the first few years of life than a child born in Norway; and a woman giving birth in sub-Saharan Africa is 100 times more likely to die in labor than a woman in a rich country. While life expectancy in the developed world increased throughout the twentieth century, it actually decreased in the least developed countries and in transitional States such as Russia. As little as one concrete example offers a sense of perspective on the global health gap. In one year alone, 14 million of the poorest people in the world died, while only four million would have died if this population had the same death rate as the global rich.

A. Diseases of Poverty: Preventable Suffering

The diseases of poverty are endemic in the world's poorest regions, but barely get noticed among the wealthy. Diseases such as elephantiasis, guinea worm, malaria, river blindness, schistosomiasis, and trachoma are common in poor countries, but are largely unheard of in rich countries. Beyond morbidity and premature mortality, the diseases of

poverty cause physical anguish, for example, when a two-foot long guinea worm parasite emerges from the genitals, breasts, extremities, and torso with excruciating pain; or filarial worms cause disfiguring enlargement of the arms, legs, breasts, and genitals; or river blindness leads to unbearable itching and loss of eyesight.

B. Who Has the Responsibility to Ameliorate the Vast Disparities in Global Health?

A core insight about health disparities is that there are multiple causal pathways to numerous dimensions of disadvantage. The causal pathways to disadvantage include poverty, poor education, unhygienic and polluted environments, and social disintegration. These, and many other causal agents, lead to systematic disadvantage not only in health, but also in nearly every aspect of social, economic, and political life. Inequalities of one kind beget other inequalities, and existing inequalities compound, sustain, and reproduce a multitude of deprivations in well-being.

Human instinct tells us that it is unjust for large populations to have such poor prospects for good health and long life simply by happenstance of where they live. Although almost everyone believes it is unfair that the poor live miserable and short lives, there is little consensus about whether there is an ethical, let alone legal, obligation to help the downtrodden. When are health inequalities between different societies unjust, and what do wealthier societies owe as a matter of *justice* to the poor in other parts of the world? Even if reasonable people believed that health disparities were morally wrong, they would be hard pressed to answer the difficult questions: *Why* are inequalities unfair? *Who* is responsible for ameliorating the high rates of illness and death? And *what level* of assistance is ethically warranted?

Are disparities ethically wrong? A Theory of Human Functioning

Many scholars and activists simply assert that global health disparities are unethical, suggesting that inequalities are self-evidently wrong or that they violate fundamental human rights. But, stating that inequalities are unfair, without more, does little to explain why it is so. Nor is an appeal to human rights convincing because, used in this way, “rights discourse” is just another rhetorical device without explanatory power. The internationally recognized “right to health,” as explained further below, principally focuses on States’ obligations to meet the health needs of their own populations. In any event, the text of an international legal instrument cannot be read as a principled *ethical* argument that State A owes a duty to improve the health of State B’s population.

Perhaps the strongest claim that health disparities are unethical is based on what I call a theory of human functioning. Health has special meaning and importance to individuals and the community as a whole. Health is necessary for much of the joy, creativity, and productivity that a person derives from life. Individuals with physical and mental health recreate, socialize, work, and engage in family and social activities that bring meaning and happiness to their lives. Every person strives for the best physical and mental health achievable, even in the face of existing disease, injury, or disability.

Perhaps not as obvious, health also is essential for the functioning of populations. Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, and provide for the common security. A safe and healthy population builds strong roots for a country's governmental structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public's welfare—social, political, and economic.

Amartya Sen famously theorized that the capability to avoid starvation, preventable morbidity, and early mortality is a substantive freedom that enriches human life. Depriving people of this capability strips them of their freedom to be who they want to be and “to do things that a person has reason to value.” Under a theory of human functioning, health deprivations are unethical because they unnecessarily reduce one's ability to function and the capacity for human agency. Health, among all the other forms of disadvantage, is special and foundational, in that its effects on human capacities impact one's opportunities in the world.

Does a duty exist to rectify these disparities?

Not everyone accepts the claim that health has a special value because it is necessary for human functioning, agency, and opportunity. But even if this theory were sufficient, it would still not answer the harder question about the corresponding obligation to do something about global inequalities. First and foremost, what creates such a duty? Whose duty is it? And what is the scope of that duty, if there is one?

Even liberal egalitarians who believe in just distribution, such as Nagel, Rawls, and Walzer, frame their claims narrowly and rarely extend them to international obligations of justice. Their theories of justice are “relational” and apply to a fundamental social structure that people share. States may owe their citizens basic health protection by reason of a social compact. But positing such a relationship among different countries and regions is much more difficult. Those arguing for a non-statist view of health obligations might point to an increasingly interdependent world—social, political, and economic. They see a global community that sets norms regarding world health, and a network of international organizations and rule making. But, whether this international order requires fair terms of cooperation, let alone wealth transfer to poorer States, is far from well accepted outside activist circles.

Perhaps there is no principled ethical argument because it is so hard to craft. A way forward might be to use international law, so that States can accede to a set of shared responsibilities, with a fuller understanding of what they are agreeing to, and why. I will propose a FCGH later in this Lecture, but before doing so it is necessary to explain more precisely the kind of obligation that I think is necessary to enshrine in a Framework Convention.

III. Basic Survival Needs: Ameliorating Suffering and Early Death

Global health is fashionable these days, with expressions of sincere concern and increased funding by political leaders, humanitarians, activists, and even celebrities. But is all this funding and interest likely to be successful in reducing extremely poor health? The answer is that most international aid is ineffective, even counterproductive. Undoubtedly, the current spate of support will wane, as the international community has only a limited attention span and resources. And when it does, it is conceivable that the least healthy people in the world will be in the same, or worse, position.

Admittedly, there are no clear solutions to complex problems in global health. But, we do know how to ameliorate much of the suffering and early death. The answer is disarmingly simply, if only it could rise on the agendas of the world's most powerful countries. Mobilizing the public and private sectors to meet basic survival needs, comparable to a Marshall Plan, could dramatically transform prospects for good health among the world's poorest populations.

A. Reframing the Approach to Development Assistance

Currently, international development assistance is often driven by emotional, high visibility events such as large-scale natural disasters, diseases that capture the public's imagination, or diseases with the potential for rapid global transmission. These funding streams, however, skew priorities, and divert resources from building stable local systems to meet everyday health needs.

A relatively small number of wealthy donors currently wield considerable influence in setting the global health agenda. Although well meaning, this small group of wealthy countries and philanthropists often sets priorities that do not reflect local needs and preferences. Sometimes donors exert control over the use of funds that discourages local leaders from taking ownership. For example, the Bush Administration's insistence on abstinence, fidelity, and faith-based programs undermines effective HIV prevention. Similarly, development banks have encouraged or required poor countries to "cap" internal spending on health as a condition of loans or debt relief. Donors often fund politically popular projects, rather than what is most likely to improve global health, leading experts to conclude, "Funding is skewed towards what people in the West want to deliver."

International health assistance, moreover, is fragmented and uncoordinated. Relief agencies and NGOs often establish programs that compete with each other and, still worse, compete with local government and businesses. Rather than integrating policies and programs within local hospitals, clinics, and health agencies, they set up state-of-the-art facilities that overshadow and detract from governmental and private enterprises. Foreign philanthropists can offer salaries and amenities that are far more generous than those that can be offered locally. As a result, local innovation and entrepreneurship are stifled; talented individuals in business, health care, and community development migrate to foreign-run programs; and the local health industry cannot profit or easily survive.

Many humanitarian initiatives also set narrow, short-term goals that do not improve basic infrastructure and create sustainable systems. Donors want quick, observable, and quantifiable results. By focusing so narrowly, often donors fail to see the long-term benefits of building human resources and sustainable health systems.

Finally, and perhaps most importantly, the massive infusion of humanitarian assistance into a very poor countries can lead to reliance and dependency. If charity is the main vehicle for health improvement, it means that local government and businesses lose the desire and ability to solve problems on their own. One day, the foreign cash, clinics, medicines, and aid workers will leave. And when that happens, the least healthy will be no better off, and perhaps worse off, unless they gain the capacity to meet their own basic health needs.

It is important to stress that host countries also bear responsibility for the failure of international development assistance. Many poor countries spend a minute percentage of their GDP on health, preferring to spend on the military or other perceived needs. At the same time, some governments misappropriate foreign health assistance, whether by excessive bureaucracy, incompetence, or corruption. The World Bank estimates that roughly half of all foreign health funds in sub-Saharan Africa do not go for health services on the ground, but are spent on payments for non-existent services, counterfeit drugs, equipment diverted to the black market, or bribes.

B. Defining Basic Survival Needs as a Measure of International Health Assistance

Reframing the approach to international developmental assistance requires interventions that substantially improve the health and wellbeing of the world's least healthy people. I propose shifting assistance to what I call basic survival needs, namely those needs essential to restoring human capability and functioning. Basic survival needs include immunizations, essential medicines, nutritional foods, potable water, sanitation, pest abatement, public health infrastructures, primary health care, and health education.

Vaccines are the most cost effective means of preventing infectious diseases that we know. Vaccine-preventable diseases are virtually extinct in developed countries but still kill millions of children and adults annually in poorer regions. Activists fervently lobby for universal access to anti-retroviral (ARV) medications for AIDS, as they should. ARVs now cost hundreds of dollars annually per person, down from thousands, but they must be taken daily and for a lifetime. In contrast, a single annual dose of Mectizan costing a couple of dollars rids the body of intestinal worms, relieves the unbearable itching of river blindness, and prevents loss of eyesight. Basic sanitation and water systems would vastly reduce improve global health at minimal cost, such as clean water kits costing as little as \$3. An insecticide-treated bednet, which costs roughly \$5, is highly effective in reducing malaria, river blindness, elephantiasis, and other insect-borne diseases among children. But only about one in seven children in Africa sleep under a net, and only 2% of children use a net impregnated with insecticide.

Consequently, something as simple as a vaccine, a generic drug, basic engineering, or sanitation can result in remarkable benefits for the health of the world's poorest people. It does not take advanced biomedical research, huge financial investments, or complex programs.

C. Health Systems: Basic Infrastructure and Capacity Building

There is little doubt that the single most important way to ensure population health is to build enduring health systems in all countries. States and local communities must possess well-functioning public health and health care systems with sound infrastructures and skilled human resources. If the vast preponderance of international assistance went into helping poor States develop and maintain health systems, it would give them the tools to safeguard their own populations. What poor countries need is not foreign aid workers parachuting in to rescue them. Nor do they need foreign run state-of-the-art facilities. Rather, they need to gain the capacity to provide basic health services themselves.

Health systems include public health agencies with the ability to identify, prevent, and ameliorate health risks in the population—disease surveillance, laboratories, data systems, and a competent workforce. They also include primary health, bringing basic medical services as close as possible to where people live and work—maternal and child health, family planning, and medical treatment. Primary care promotes individual and community self-reliance and participation in the planning, organization, operation and control of health services, making fullest use of local and national resources.

Human resources are critically important for well functioning health systems. But the availability of skilled health workers is dangerously low in developing countries. In a cruel twist of fate, countries with the highest burden of disease also garner the lowest proportion of the global health workforce. Southeast Asia, which shouldered the largest share of the global disease burden, has only 12% of the world's health workforce. Africa has only 3% of health workers worldwide. In contrast, North America and Europe command a far larger share of health and medical professionals than their need would indicate.

Poor countries often do not have the public health, medical, pharmacy, and nursing schools necessary to train sufficient numbers of HCWs. But, even when developing countries do train HCWs, many leave for more lucrative positions in richer countries. For example, in Ghana and Liberia, 30% and 60%, respectively, of the country's physicians are working in the U.S. or U.K. Physicians in middle income countries such as India and Pakistan are similarly moving to the West in droves. The migration of HCWs is caused by a "push" from depressed working conditions and opportunities in poor countries and a "pull" from more attractive conditions elsewhere. North America and Europe represent an overpowering lure for doctors and nurses, offering salaries and career opportunities that far surpass what could be offered in a poorer country. The problem is not simply due to diffuse global market forces. Rather,

OECD countries are aggressively recruiting HCWs, even as they acknowledge the resulting dire situation in poor countries.

This “brain drain” is leaving poor countries – as many as 57 by WHO calculations – unable to meet the MDGs because of a shortage of HCWs. Africa would need at least an additional one million health workers just to offer the services that could meet the MDGs.

IV. Global Governance for Health: A Proposal for a Framework Convention on Global Health

To ensure effective and well-functioning health systems in poor countries, and to meet basic survival needs, the international community, in partnership with host countries, must invest in health system infrastructure. It is not simply the amount of money spent that is important, but how those resources are invested and used. This requires a structured approach that sets priorities, ensures coordination, and monitors results. The innovative use of international law could provide just such a vehicle for change. But extant global health governance has been inadequate, and a fresh approach is badly needed.

A. International Health Law: WHO’s “Thin” Record of Law Making

The WHO Constitution grants the agency extensive normative powers, which it has never fully exercised. The agency can adopt binding conventions which, unlike normal treaties, affirmatively require States to “take action” within 18 months. The WHO also possesses quasi-legislative powers to adopt regulations. WHO regulations, unlike most international law, are binding on Member States unless they proactively “opt out.” Despite WHO’s impressive normative powers, modern international health law is remarkably thin, with only one significant regulation and one treaty in 60 years of existence. The International Health Regulations (IHRs), until they were revised in 2005, applied only to cholera, plague, and yellow fever—the same diseases originally discussed at the first International Sanitary Conference in Paris (1851). The IHRs, therefore, historically and politically, were intended to prevent trans-migration of disease, rather than to improve health in poor countries. To be sure, this international instrument is far more expansive and bold than its predecessors, but it is unlikely to do the work that is needed in global health—namely, to dramatically improve the plight of the world’s least healthy people.

The WHO did not create a health convention until 2003, when the WHA adopted the Framework Convention on Tobacco Control (FCTC). The FCTC declares the bold objective of protecting present and future generations from the devastating consequences of tobacco consumption and exposure. Although a laudable achievement, the FCTC is almost sui generis because it regulates the only lawful product that is uniformly harmful. The FCTC was politically feasible because the industry was vilified for denying scientific realities, engineering tobacco to create dependence, engaging in deceptive advertising, and targeting youth, women, and minorities.

B. An Expanded Sphere of International Health Law: The Influence of Trade and the Human Right to Health

Although international law under WHO's auspices is sparse, there is a much larger body of international law that powerfully affects global health in areas ranging from food safety, arms control, and the environment to trade and human rights. The WHO should be a leader in creating, or at least influencing, these norms, but that has not happened. The agency has shied away from the "high politics" of international law because it has seen itself principally as a scientific, technical agency. Thus, WHO is comfortable developing technical standards for food safety under the Codex Alimentarius Commission, but it has not ventured into the harder terrain of WTO rule making and dispute resolution. It ought to have a great deal to contribute, and have some sway over, matters of trade in goods and services; sanitary and phytosanitary measures; and intellectual property rights in vaccines and medicines. Yet, its influence is nowhere to be found.

It might not matter whether WHO was a prime mover on matters of global health if extant international norms were adequate, but they are not. International institutions and social activists increasingly have turned to the language of human rights to articulate their fondest dreams for global health. And, the international right to health resonates with bold-sounding obligations for the "highest attainable standard of physical and mental health." The WHO Constitution defines health so broadly to be simply unachievable: "a state of complete physical, mental and social well-being."

These high-minded declarations have had little normative force, as they lack the basic features of a "right": What exactly does the right entail and what obligations do States, and others, have to conform? When is the right violated? And what are the mechanisms to enforce the entitlement? Despite considerable progress, recasting the problem of extremely poor health as a human rights violation does not help for a number of reasons. First, the legal obligation falls primarily on each State to "respect, protect, and fulfill" the right to health for its own population. Although the ICESCR posits that all States have duties to assist and cooperate in achieving economic and social rights, the obligation to assist other States' populations cannot become primary. Second, the right to health itself is expressed as "progressively realizable," so there can be little agreement as to when a State has breached an obligation to its people, let alone to people in far away places. Finally, even if some obligation to offer financial and technical assistance could be read into human rights instruments, there is no systematic method of implementation and enforcement. This leaves us with the very problem posited in this Lecture—the duty to improve the health of the world's most disadvantaged people falls primarily on those who lack the means to do so. This is undoubtedly an untenable position if global health is to be taken as a serious issue of international concern.

C. Toward a Framework Convention on Global Health

The problem of global health governance has perplexed scholars, and for good reason. International health law has a number of structural inadequacies—e.g., vague standards, ineffective monitoring, weak enforcement; and a “statist” approach that insufficiently harnesses the creativity and resources of non-State actors and civil society more generally. The question of whether international law can, or should, govern the diverse entities that influence global health is the subject of intense debate in the literature. Indeed, modern cutting edge global health governance initiatives eschew formal international legal regimes, such as the Global Fund, Global Health Security Initiative, and the International Finance Facility.

If law is to play a constructive role, new models will be required and here I make the case for a Framework Convention on Global Health. I am proposing a global health governance scheme incorporating a bottom-up strategy that strives to: build health system capacity; set priorities to meet basic survival needs; engage stakeholders to bring to bear their resources and expertise; harmonize the activities among the proliferating number of actors operating around the world; and evaluate and monitor progress so that goals are met and promises kept.

The framework convention-protocol approach is becoming an essential strategy of powerful transnational social movements to safeguard health and the environment. Two prime illustrations are the Kyoto Protocol to the U.N. Framework Convention on Climate Change and the Framework Convention on Tobacco Control. These framework conventions recognize that a collective effort is necessary to mitigate the threat that humans pose to health and the environment. Although far from perfect, environmental and health conventions offer inventive approaches to global governance, including “common but differentiated responsibilities” for developing and developed countries, multilateral funding mechanisms, and incentives to facilitate compliance.

A FCGH would represent an historical shift in global health, with a broadly imagined global governance regime. The initial framework would establish the key modalities, with a strategy for subsequent protocols on each of the most important governance parameters. It is not necessary, or perhaps even wise, to specify in detail the substance of an initial FCGH, but it may helpful to state the broad principles:

- 1) *FCGH mission*—Convention Parties seek innovative solutions for the most pressing health problems facing the world in partnership with non-State actors and civil society, with particular emphasis on the most disadvantaged populations;
- 2) *FCGH objectives*— establish fair terms of international cooperation, with agreed-upon mutually binding obligations to create enduring health system capacities, meet basic survival needs, and reduce global health disparities;
- 3) *Engagement and coordination*—finding common purposes and process among a wide variety of State and non-State actors, setting priorities, and coordinating activities to achieve the mission of the FCGH;
- 4) *State Party, and other stakeholder obligations*—incentives, forms of assistance (e.g., financial aid, debt relief, technical support, subsidies,

tradable credits), and levels of assistance, with differentiated responsibility for developed, developing, and least developed countries;

- 5) *Institutional structures*—conference of Parties, secretariat, technical advisory body, and financing mechanism, with integral involvement of non-State actors and civil society;
- 6) *Empirical monitoring*—data gathering, benchmarks, and leading health indicators, such as maternal, infant, and child survival;
- 7) *Enforcement mechanisms*—inducements, sanctions, mediation, and dispute resolution;
- 8) *Ongoing scientific analysis*—processes for ongoing scientific research and evaluation on cost effective health interventions, such as the creation of an Intergovernmental Panel on Global Health, comprised of prominent medical and public health experts; and
- 9) *Guidance for subsequent law-making process*—content, methods, and timetables to meet framework convention goals.

The framework convention-protocol approach has a number of advantages resulting from the incremental nature of the process, and its ability to evolve over a longer time horizon. The framework agreement allows for the initial codification of normative parameters, with the expectation of building detailed standards in the future. The incremental nature of the governance strategy allows the international community to focus on a problem in a stepwise manner, avoiding potential political bottlenecks over contentious elements.

The creation of international norms and institutions provides an ongoing and structured forum for States and stakeholders to develop a shared humanitarian instinct on global health. A high-profile forum for normative discussion can help educate and persuade Parties, and influence public opinion, in favor of decisive action. And it can create internal pressure for governments and others to actively participate in the framework dialogue. The creation of such a normative community, therefore, may be an essential element of building an international consensus. The imperatives of global health have to be framed not just as a series of isolated problems in far-off places, but as a common concern of humankind. Just as the normative process can shape values, it can also serve as a forum for experts and policymakers to collect and analyze health data and scientific evidence.

The really interesting and vital aspect of a FCGH is not merely how it governs inter-State responsibilities. The critical challenge is how to make it do the really hard work of mobilizing the diverse drivers of health, including NGOs, private industry, foundations, public/private hybrids, researchers, and the media. It is essential to harness the ingenuity and resources of these non-State actors. The FCGH, therefore, should actively engage major stakeholders in the process of negotiation, debate, and information exchange, as well as reducing barriers for them to actively engage in capacity building.

A FCGH offers an intriguing approach, potentially creating a process and structure for an innovative international mechanism for ameliorating complex problems

in global health. It will not, however, be a panacea, and there are multiple social, political, and economic barriers to the creation of such a framework convention. The framework convention-protocol approach cannot easily circumvent many of the seemingly intractable problems of global health governance: the domination of economically and politically powerful countries; the deep resistance to creating obligations to expend, or transfer, wealth; the lack of confidence in international legal regimes and trust in international organizations; and the vocal concerns about the integrity and competency of governments in many of the poorest countries.

But given the dismal nature of extant global health governance, a FCGH is a risk worth taking. It will, at a minimum, identify the truly important problems in global health. Solutions will not be found solely in increased resources, although that is important. Rather, an FCGH can demonstrate the imperative of targeting the major determinants of health, prioritizing and coordinating currently fragmented activities, and engaging a broad range of stakeholders. It also will provide a needed forum to raise visibility of one of the most pressing problems facing humankind.

V. A Tipping Point

I have sought to demonstrate why politically and economically powerful countries should care about the world's least healthy people. It may be a matter of national interest, so that helping poor States makes everyone safer and more secure. Or, global health assistance simply may be ethically the right thing to do to avert an unfolding humanitarian catastrophe. Or, there may be a growing sense of legal obligation, whether through WHO treaties and regulations or the international right to health. Although no single argument may be definitive in itself, the cumulative weight of the evidence is now overwhelmingly persuasive. Whatever the reasons, perhaps we are coming to a tipping point where the status quo is no longer acceptable and it is time to take bold action. Global health, like global climate change, may soon become a matter so important to the world's future that it demands international attention, and no State can escape the responsibility to act.

If that were the case, States would need an innovative international mechanism to bind themselves, and others, to take an effective course of action. Amelioration of the enduring and complex problems of global health is virtually impossible without a collective response. No State or stakeholder, acting alone, can avert the ubiquitous threats of pathogens as they rapidly migrate and change forms. If all States and stakeholders voluntarily accepted fair terms of cooperation through a FCGH, then it could dramatically improve life prospects for millions of people. But it would do more than that. Cooperative action for global health, like global warming, benefits everyone by diminishing collective vulnerabilities.

The alternative to fair terms of cooperation through a Framework Convention is that everyone would be worse off, particularly those who suffer compounding disadvantages. Absent a binding commitment to help, rich States might find it politically or economically easier to withhold their fair share of global health assistance, hoping that

others will take up the slack. Major outbreaks of infectious disease, including extensively drug resistant forms, would become increasingly more likely. Even if the economically and politically powerful escaped major health hazards, they would still have to avert their eyes from the mounting suffering among the poor. And they would have to live with their consciences knowing that much of this anguish is preventable.

What is most important is that if the global community does not accept fair terms of cooperation on global health soon, there is every reason to believe that affluent States, philanthropists, and celebrities simply will move on to another cause. And when they do, the vicious cycle of poverty and endemic disease among the world's least healthy people will continue unabated.