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The Joint Action and Learning Initiative on National and Global Responsibilities for Health

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Georgetown Public Law and Legal Theory Research Paper No. 10-70

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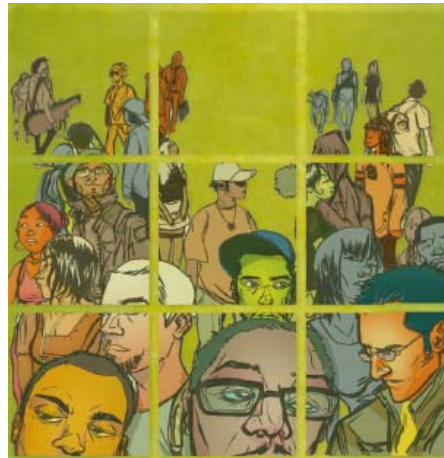
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Abstract

A population's health and wellbeing is primarily a national responsibility. Every state owes all of its inhabitants a comprehensive package of essential health goods and services under its obligations to respect, protect, and fulfil the human right to health. Yet health is also a global responsibility. Every state has a duty to ensure a safe and healthy world, with particular attention to the needs of the world's poorest people. Improving health and reducing unconscionable health inequalities is both an international obligation under the human right to health and a matter of global social justice.

The mutual obligations of states to safeguard the health of their own inhabitants and the health of people everywhere are poorly defined, with serious adverse consequences for world health. These obligations must be better understood. Central questions of vital importance to the health of the world's population include: What are the duties of all states to ensure the right to the highest attainable standard of health for all their inhabitants? What are the components of a comprehensive package of essential goods and services under the right to health to which people everywhere are entitled? How specifically can states' duties to govern well be incorporated into and realized through the health system?

One of the most inadequately understood obligations is the responsibility of the international community to augment the capacity of low- and middle-income states to ensure their population's health, with the specific contours of this obligation ill-defined. Indeed, international financial assistance is framed as "aid," rather than an expression of mutual responsibility, leaving the flawed impression that international health assistance is a matter of charitable discretion rather than an international human rights obligation. The approach to health assistance as charity rather than as an obligation also means that this assistance is unreliable over the longer-term, leading to the reluctance of low- and middle-income countries to use it for recurrent public health expenditures.

Continued and accelerated improvements in global health will require significant and reliable funding at a time of extended economic uncertainty and budget belt-tightening in many countries. Progress on global health therefore risks stagnating unless states have clarity on, accept, and adhere to national and international obligations to respect, protect, and fulfil the human right to health.

Translating state obligations into improved health will also require building a more robust and effective global health governance structure. Current global health initiatives are too often undermined by a host of now well-recognized weaknesses: Global health actors do not sufficiently coordinate their activities with each other or the host countries, leading to fragmentation, nor do they make and keep longer-term funding commitments, leading to unpredictability. Development partners do not set the priorities required to meet all human health needs, and lack accountability for their own global health commitments. Host countries are not empowered to take "ownership" of health planning and programs. And the international community does not adequately monitor and evaluate programmatic effectiveness.

Our aim is to propose a coherent global health governance framework for the post-MDG period that will clarify national and global responsibilities for health, enable countries to effectively carry out these responsibilities, and create accountability around them. In order to achieve this, we are establishing the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI). The primary purpose of the JALI is to catalyze and facilitate research, broad consultations, and campaigns that will lead to a global compact. Towards this end, the JALI will rigorously and systematically address the following issues:

- Clarify the essential package of health goods and services to which all human beings are entitled as part of their right to health;
- Clarify the responsibility of all states, even the poorest, to provide this essential package of health goods and services to all of their inhabitants;
- Assess the gap between the conditions (financial and others) for the provision of an essential package of health goods and services, and the domestic capacity of and use of that capacity by poorer countries—the gap for which the international community should take responsibility;
- Clarify the international responsibility to build the capacity of low- and middle-income states to provide an essential package of health goods and services to their inhabitants;
- Clarify the principles of good governance, both nationally and globally, including transparency, honesty, and accountability.
- Propose a coherent global health governance architecture to ensure robust national and global responsibilities for health.

In particular, the JALI will answer the following four key questions:¹

1. What are the essential services and goods guaranteed to every human being under the human right to health?
2. What is the responsibility that all states have for the health of their own populations?
3. What is the responsibility of all countries to ensure the health of the world's population?
4. What kind of global health governance is needed to ensure that all states live up to their mutual responsibilities?

Introduction

“In the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defense against transnational threats,” declares the World Health Organization (WHO).² Both elements of this statement—a shared responsibility for equitable access to essential services, and a shared responsibility for collective defense against transnational health threats—require global leadership, sustainable and scalable resources, collaboration, and mutual support among states, businesses, philanthropy, and civil society. As stated in the Global Strategy for Women's and Children's Health, “Global partnership and the sufficient and effective provision of aid and financing are essential.”³ In other words, global health urgently requires enhanced global health governance.

A coherent system of global health governance can be built, founded on the common interests of states and their partners. All states have self-interests in fostering global health governance as a collective defense against transnational health threats, containing infectious diseases where they emerge and avoiding the international spread of health hazards. States also have self-interests in ensuring equitable access to essential services—health systems, including cost-effective drugs and vaccines, and other human health needs (e.g., safe water, nutrition, sanitation, vector control, and tobacco reduction) to all people. Ensuring essential health services and goods makes all countries safer, more secure, and more prosperous, and a foreign policy based on global health improvement is an effective form of diplomacy.^{4,5}

Every person has a fundamental human right⁶ to the highest attainable standard health⁶ and, therefore, holds a legitimate expectation that the state, however resource constrained, will ensure essential health goods and services for all its inhabitants, and expand beyond this core as resources permit. Honoring the right to health is a necessary condition for any community to function. If individuals cannot gain access to health goods and services necessary to function and attain wellbeing, they cannot contribute to social and economic wellbeing—generating wealth, educating children, creating art, providing for the common security—and they will feel abandoned by their community, national and international. The right to health is central to ensuring human security and protecting people from “critical and pervasive threats to human lives, livelihoods and dignity, and to [enhancing] human fulfillment.”⁷

The responsibility for ensuring the right to health for all lies not only with states and their obligations to their own people, but also with the international community. More than half of the Millennium

Development Goals (MDGs) address fundamental human needs, reflecting an understanding that all states have an interest in ensuring that critical needs are met for all human beings everywhere.⁸ As the Millennium Declaration states: “We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world’s people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs.”⁹

However, more than a decade after the adoption of the MDGs – despite advances, such as the reduction in child mortality¹⁰ and expansion of AIDS treatment¹¹ – the international community has not achieved fundamental improvements in global health or significantly reduced health inequalities. It has failed to effectively meet fundamental human needs. There are deep structural reasons for the lack of significant progress, such as the absence of leadership, fragmentation and lack of coordination of multiple actors, persisting inadequate levels of domestic and international health spending, and foreign aid and programs that do not match national priorities.

The international community has made progress in addressing these challenges. The Paris Declaration on Aid Effectiveness¹² and the Accra Agenda for Action,¹³ for example, call for clearer targets and indicators of success for harmonization among partners, alignment with country strategies, and mutual accountability for development results. The International Health Partnership and related initiatives¹⁴ seeks to put these principles into practice. The Global Fund to Fight AIDS, Tuberculosis and Malaria is driven by country demand and receives funding proposals from inclusive Country Coordinating Mechanisms, whose members include government officials, civil society, development partners, and the private sector.¹⁵ Meanwhile, both domestic and international health investments have increased. From 2000 to 2007, governments in sub-Saharan increased their health sector spending from 8.7% to 9.6% of their budgets, leading to more than a doubling of their per capita health spending, increasing from an average of \$15 to \$34 per capita (in nominal dollars and including external assistance).¹⁶ Official development assistance for health increased from \$7.6 billion in 2001 to \$26.4 billion in 2008 (in nominal dollars and including water and sanitation).¹⁷

But even these innovative approaches and the increased spending have not achieved fundamental shifts in global health. Preventable and treatable injuries and diseases continue to overwhelm sub-Saharan Africa, the Indian subcontinent, and other impoverished areas of the world. Healthy life expectancy in sub-Saharan Africa is 45 years, a full quarter-century less than in high-income countries.¹⁸ As we will briefly

review, the diseases and health issues that are the focus of the MDGs – child and maternal mortality, and major diseases include AIDS, tuberculosis, and malaria – persist as major health threats, as do neglected tropical diseases. New infectious diseases continue to emerge, while the tremendous burden of non-communicable diseases, including mental illness, as well as of injuries, continues to grow.

While the number of children dying has fallen by approximately half since 1970, this still leaves far too much room for parents' tears that ought not have to be shed and undersized coffins that ought not have to be assembled, as nearly 8 million children under five die every year.¹⁹ More than 3 million of them 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.²⁰

Like their children, women too face intolerable risks, including of dying in childbirth. During the course of her lifetime, a woman in sub-Saharan Africa is almost 140 times more likely to die during or shortly after pregnancy than a woman in an industrialized country, with 99% of the approximately 350,000 maternal deaths in 2008 occurring in developing countries.²¹ And for each of these deaths, at least twenty times as many women²² – and possibly thirty times as many²³ – suffer severe complications from pregnancy and childbirth, including acute and long-term disabilities. Most of these deaths and disabilities, most of this suffering, is entirely avoidable by providing skilled birth attendants and known, inexpensive interventions.

Infectious diseases continue to causes millions of death in developing countries, while threatening all of us. More than 4 million people die annually from AIDS, tuberculosis, and malaria – approximately 2 million from HIV/AIDS, 1.3 million from tuberculosis, and 863,000 from malaria.²⁴ Despite progress, including a falling global incidence of HIV and more than 5 million people in developing countries on HIV/AIDS treatment by the end of 2009, approximately 10 million people still need treatment but are not receiving it,²⁵ and five people are newly infected with HIV for every two people who begin treatment.²⁶

Neglected tropical diseases, meanwhile, are by their very definition primarily infectious diseases – 17 in all, such as Chagas disease, trachoma, leprosy, schistosomiasis, lymphatic filariasis, and dengue – that thrive in impoverished, especially tropical, settings. They are often transmitted by insects or the eggs of worms, and infect more than 1 billion people. Many of these diseases “blind, debilitate, deform, or maim” their victims, while impairing cognitive development and diminishing people’s economic productivity.²⁷ As the first UN Special Rapporteur on the right to health observed, they “cause immense suffering and

lifelong disabilities among the poorest populations in developing countries, in particular those living in rural areas...[contributing] to the entrenched cycle of poverty, ill health, stigmatization and discrimination experienced by neglected populations.”²⁸ They also kill more than half a million people per year.²⁹

Even emerging infectious diseases, such as SARS and novel influenza strains such as H1N1, which threaten people wherever they live, pose the greatest risk to people in developing countries. The health systems in poorer countries are least prepared to detect and contain these emerging diseases. And absent a global agreement on sharing the vaccines and medications needed to prevent and treat them, people in developing countries will have – as they now have – the least access to the essential medical technologies needed to control and treat these diseases.

The terrible toll of infectious diseases has overshadowed a fast growing and even more substantial cause of mortality and morbidity in lower-income countries, non-communicable diseases (NCDs), such as cardiovascular disease, cancer, diabetes, and chronic respiratory diseases. Popularly conceived of as primarily affecting people in wealthy countries, today’s truth is different. In 2005, 80% of deaths from NCDs occurred in developing countries.³⁰ Such diseases are on track to cause fully 70% of all deaths in developing countries by 2020.³¹ Also by 2020, 60% of new cancer cases will occur in developing countries – which already account for 70% of cancer deaths worldwide, due to higher death rates than in wealthier countries.³²

Such statistics have become too daunting and disconcerting to ignore. In May 2010, the UN General Assembly passed a resolution to convene a high-level meeting on non-communicable diseases in September 2011.³³ This will be only the third high-level summit to address a particular health issue. The other two were on HIV/AIDS, which transformed the global response to the AIDS pandemic. The NCD Alliance – a global network of individuals and organizations devoted to combating diseases such as cancer, diabetes, cardiovascular disease, respiratory disease, and stroke – is calling for the UN to include NCDs in the MDGs.

If non-communicable diseases have, overall, received relatively little attention in developing countries, one category of such diseases has been particularly marginalized, as are those who suffer from these diseases: mental illness. 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 2020.³⁴ Most of the burden of depression 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 found. More than 75% of people in most of these countries have no access to treatment,³⁵ in part because many developing countries have an extreme paucity of mental health workers.³⁶

Also frequently overlooked is the impact of injuries in developing countries. More than 90% of deaths from unintentional injuries occur in these low- and middle-income countries.³⁷ Poverty and other conditions in developing countries contribute to people's heightened risks of injury, such as 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 maintained roads and motor vehicles, lack of safety equipment such as seatbelts, and frequently chaotic road conditions contribute to horrific crashes, which are often fatal. While low- and middle-income countries have only 48% of the world's registered vehicles, they experience 91% of traffic fatalities.³⁸

Already terribly grim, the current state of disease in lower-income countries stands to be exacerbated by climate change, which is now responsible for 300,000 deaths annually.³⁹ Climate change will negatively affect many of the existing health problems in poorer – and wealthier – countries. It will increase the intensity and range of climate-sensitive diseases such as malaria. Extreme weather events will kill both directly and indirectly, including by causing droughts and floods that destroy crops, contaminate water sources, displace people, and expand habitats for mosquitoes, contributing to malnutrition, hunger, and water-borne and vector-borne diseases, including malaria. Changing temperatures and rain patterns, along with rising sea levels, will affect the supply of food and clean water, leading to increased hunger and water-related diseases such as diarrhea. Climate change will also degrade air quality and cause severe heat waves, contributing to cardiovascular and respiratory illnesses.^{40,41} Further, the stress, trauma, and displacement climate change causes will likely negatively affect mental health.

Aggregate figures of the death, disease, and disability that continue to plague the world's poorer regions must not mask the disparities within these regions, and the extra burdens faced by poor and other disadvantaged populations, such as indigenous peoples and people with disability. In Nairobi, Kenya, the death rate for children under five is less than 15 per 1,000 children in the wealthiest neighborhood, but 254 per 1,000 in a poor one.⁴² Coverage of skilled health personnel during delivery is a meager 30% for women in the poorest quintile in 38 countries with among the highest levels of maternal death, compared with more than 80% coverage for women in the wealthiest quintile in these countries.⁴³

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 for all income quintiles. And the gap in Brazil between the prevalence of stunting among children in the richest and poorest quintiles fell from 35-37% in 1989 (40% prevalence among children in the poorest quintile and 3-5% prevalence among children in the wealthiest quintile) to 5-7% in 2007 (10% prevalence among children in the poorest quintile and a continued 3-5% prevalence among children in the wealthiest quintile).⁴⁴ Yet vast inequalities remain today's pervasive reality.

As Brazil's experience demonstrates – and there are many other pockets of progress, sometimes quite significant, throughout the developing world – the still extreme level of avoidable death and disease in developing countries is just that – avoidable. Effective interventions exist, but many people cannot access them. There is no single reason for this, but one overarching concern is insufficient political attention to ameliorating the suffering among the poor in both the global North and South.

The inadequate levels of health funding demonstrate this lack of political will, with the increases in national and international funding still leaving considerable financing gaps. The High Level Taskforce on Innovative International Financing for Health Systems reported in 2009 that annual health spending (from all sources) in 49 low-income countries alone had to increase from \$31 billion to \$67-76 billion annually by 2015 to achieve the MDGs. And even this recommended level of funding largely excludes fundamental human needs such as clean water and adequate sanitation and hygiene.⁴⁵ However, the world is not on track to meeting these and other funding requirements for the investments that are critical to improving health worldwide.

A Proposal

Here, we propose a *Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)* to stimulate fresh thinking and catalyze greater understanding and acceptance of national and international responsibilities. What essential health services and goods do individuals need to live a healthy and safe life, and what are their legitimate expectations based on human rights? What are the fundamental domestic responsibilities of all states, including the poorest, towards providing these health goods and services? To what extent should affluent states (i.e., those that can help others without undermining the survival needs of their own inhabitants) assist states that lack the capacity to do so? What

changes should be made to the global health architecture to better ensure states' mutual responsibility and create incentives for innovation by philanthropy, business, and civil society?

The answers to these questions are inherently political. They entail the provision of public goods and services for health, sustainable financing, and state-level assurance of essential services, as well as health and safety regulations in accordance with internationally accepted standards. All of this requires global cooperation and governance. By creating new norms and rules for all states to follow, global governance entails a diminution of state sovereignty to benefit the world's population. The justification is found in international human rights agreements, which define the limits of state sovereignty.⁴⁶

The future of global health is one based on mutual responsibility, the assurance of fundamental human health needs, and the right to health for everyone. The WHO has the constitutional responsibility to lead the way in developing the roadmap towards this future – and mobilizing countries to follow this map. The Joint Action and Learning Initiative aims to support and enhance WHO leadership.

The Joint Action and Learning Initiative will be structured around four critical issues that the international community must address: 1) defining a core package of essential health services and goods; 2) clarifying the duties that all states owe to their own inhabitants; 3) exploring the responsibilities all states have for improving the health of the world's poorest people; and 4) proposing a global health governance architecture to improve health and reduce inequalities. Before we offer preliminary guidance, it is important to understand the moral and legal underpinning of our approach, particularly the need to move beyond the concept of health aid as charity and toward mutual responsibility beyond state borders.

Reconceptualizing 'Health Aid'

Global health means different things to different people.⁴⁷ Often, it is used as shorthand for the aggregate of health aid provided by the affluent to the poor in a donor-recipient relationship as a form of charity, together with the volume and the modalities of this assistance. We call this concept 'Health Aid.'

Framing the global health endeavor as Health Aid provided by the affluent to the poor is fundamentally flawed. This suggests that the world is divided among donor states 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, with the emergence of health leadership from countries such as Brazil, India, Indonesia, Mexico, and South Africa.

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 make decisions about how much to give and for what health-related goods and services. The level of financial assistance, therefore, is not predictable and sustainable, often failing to meet domestic needs and priorities. As a result, Health Aid often has not been scalable to needs or sustainable in the long term. These unwelcome features of Health Aid could, in turn, mean that host countries might not accept full responsibility for their inhabitants’ health, as they can blame the poor state of health on the shortcomings of aid, rather than any failures of their own.

Conceptualizing global health as aid masks the greater truth that global health is a globally shared responsibility reflecting common risks and vulnerabilities—an obligation of health justice that demands a fair contribution from everyone—North and South, rich and poor. Global health governance 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

Central to obligations towards improving health in all countries is the right to the highest attainable standard of health. All countries have ratified at least one treaty that recognizes the right to health,⁴⁸ including 160 of which have ratified the seminal treaty guaranteeing the right to health, the International Covenant on Economic, Social and Cultural Rights.⁴⁹ Notably, the African Charter of Human and Peoples’ Rights, to which all African Union members are party, also contains this right,^{50,51} as do at least 135 national constitutions.⁵²

Beyond ratification of human rights treaties, the UN Charter obliges all UN members “to take joint and separate action in co-operation with the Organization for the achievement of... [the] purposes” of the UN, including to “promote universal respect for, and observance of, human rights and fundamental freedoms

for all.”⁵³ The content for these human rights have been interpreted to come from the Universal Declaration of Human Rights,⁵⁴ which includes the right to health.⁵⁵ Further, in 1993, at the World Conference on Human Rights, 171 countries adopted the Vienna Declaration and Programme of Action,⁵⁶ which affirms the duty of all states “to promote and protect all human rights and fundamental freedoms.”⁵⁷

What does the right to health entail? The most authoritative interpretation of the right to health, which has since been built upon by a series of reports by the UN Special Rapporteurs on the right to health^{58,59,60} and supplemented by decisions of national courts, comes from General Comment 14 of the UN Committee on Economic, Social and Cultural Rights.⁶¹ The right to health, which covers both health care and the underlying determinants of health – similar to what we refer to as fundamental human needs – contains four “interrelated and essential elements,” namely that health goods, services, and facilities must be available, accessible to everyone (including being affordable and geographically accessible), acceptable (including culturally), and of good quality.⁶² States must respect, protect, and fulfill the right to health. That is, they must themselves refrain from interfering with people’s ability to realize this right such as by denying non-discriminatory access to health service, protect people from violations of this right by third parties, and actively ensure the full realization of this right, including by providing health services and through legislative, administrative, and other measures.⁶³

This right, like other economic, social, and cultural rights, includes certain “minimum core obligations.” The Committee on Economic, Social and Cultural Rights explains that these are “minimum essential levels of each right” that are so basic that, if they did not exist, would “largely [deprive the ICESCR] of its *raison d’être*.”⁶⁴ The core obligations of the right to health, including primary health care⁶⁵ will, as discussed below, provide a launching point for the JALI’s exploration into the essential health services and goods to which all people are entitled. The core obligations also include the equitable distribution of health facilities, goods, and services.⁶⁶

Key principles of the right to health include non-discrimination and equity, participation, and accountability.^{67,68} States must ensure equitable and non-discriminatory access to health facilities, goods, and services, and place a special emphasis on meeting the needs of marginalized and vulnerable populations. People have the right to participate in health-related decision-making, including developing national and local health plans, policies, and programs. And the government must be accountable for its health plans, policies, and services, ensuring accessible, effective, and transparent mechanisms to enable

people to monitor and evaluate the conduct, performance, and outcome of the health system. These principles will inform the JALI's understanding of national and international obligations with respect to the right to health, as well as of appropriate global health governance structures.

Furthermore, the ICESCR itself requires states "to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the" right to health and other human rights.⁶⁹ The progressive realization requirement is not an excuse to move slowly or fail to move beyond the core obligations. Rather, states must "move as expeditiously and effectively as possible towards" the full realization of each right.⁷⁰ And they must do so within the context of the "maximum of [their] available resources." 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."⁷¹

The above requirement incorporating international assistance and cooperation has significant implications for mutual responsibility. As the Commission on Economic, Social and Cultural Rights has emphasized, "in accordance with Articles 55 and 56 of the Charter of the United Nations, with well-established principles of international law, and with the provisions of the Covenant itself, 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 in this regard."⁷² General Comment 14 states that "it is particularly incumbent on States parties and other actors in a position to assist, to provide" this assistance to "enable developing countries to fulfill their core and other" comparable obligations.⁷³

An important development in the human rights field since the promulgation of the ICESCR and General Comment 14 is the explicit recognition of the international community to protect people from gross human rights abuses wherever they live, as captured in the 'responsibility to protect' doctrine. At the UN 2005 World Summit, states adopted this responsibility, specifically accepting the responsibility of the international community "to use appropriate diplomatic, humanitarian and other peaceful means...to help to protect populations from genocide, war crimes, ethnic cleansing and crimes against humanity." Further, states agreed "to take collective action, in a timely and decisive manner...in accordance with the [UN] Charter, including Chapter VII...should peaceful means be inadequate and national authorities are

manifestly failing to protect their populations from genocide, war crimes, ethnic cleansing and crimes against humanity.”⁷⁴

The International Commission on Intervention and State Sovereignty had earlier stated the responsibility to protect in still more forceful terms, describing it as “the idea that sovereign states have a responsibility to protect their own citizens from avoidable catastrophe – from mass murder and rape, from starvation – but that when they are unwilling or unable to do so, that responsibility must be borne by the broader community of states.”⁷⁵ We contend that the mass death that persists in many states as a result of preventable and treatable diseases and injuries is just such an “avoidable catastrophe.”

Several other paradigms join the human rights framework in recognizing that global health is 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 part of *human security* as well as global health as a *global public good*.

Health and Human Security⁷⁶

Human security offers a complementary emerging paradigm for understanding global vulnerabilities, holding a people (rather than state)-centered view of security, with health as a cornerstone of human security. The Commission on Human Security defines the concept to mean, “creating political, social, environmental, economic, military and cultural systems that together give people the building blocks of survival, livelihood and dignity.” As the Commission recognizes, “Good health is both essential and instrumental to achieving human security.” Health is essential to human security because it is required for survival, helping people to function as members of their societies – local, national, and global – and taking responsibility for others.

Global Public Goods for Health^{77,78,79}

The shared benefits of global health reposition the provision of health goods and services from being outside the technical criteria of public goods into the realm of global public goods.

As commonly defined, a public good has two characteristics: 1) once supplied to one person, the good can be supplied to all other people at no extra cost (non-rivalness), and; 2) once the good is supplied to one person, it is impossible to exclude other people from the benefits of the good (non-excludability). Looking at their essential nature – apart from the external benefits they produce – essential health goods and services would not seem to qualify as public goods. For example, there is an additional cost to supplying medicine to additional people (rivalry exists), and it is possible to provide medicine to one person but not another (people can be excluded).

However, the positive externalities of ensuring essential health and services for all people, everywhere, have a transformative effect on these goods and services. There are many such benefits. The success of infectious disease control and prevention in one country will impact spread of disease to other countries, particularly in a globalized world, and successes in addressing a health threat in one country can inform effective approaches in other countries.

Furthermore, providing basic health goods and services to all fosters global social cohesion, contributes to economic growth and prosperity, enhances the capacity of all to function as dignified members of society and to contribute to the human security of all others, and increases the credibility and value of the body of international human rights standards.

These benefits show why essential health goods and services should be understood as global public goods. If some of us are to receive these benefits, we will all receive them. Like other global public goods, global health has significant positive externalities that extend beyond national borders, yet the goods and services required for global health are likely to be undersupplied by individual countries – especially as many countries do not have adequate means to ensure everyone a full complement of essential health goods and services.

Achieving these benefits will require recognizing that global health is a global public good, and accordingly, cooperating globally to ensure global health, and the provision of essential health goods and services for all people.

The JALI's approach will be explicitly rooted in human rights, as these are international legal obligations incumbent upon all states. Its analysis, however, stands to inform issues of responsibility that are highly pertinent to the human security and global public goods perspectives. Those perspectives also offer important additional justifications on why we must adopt a mutual responsibility framework for addressing global health. And if the JALI is successful, it will contribute not only to advancing human rights, but also to improving human security and to providing global health as a public good.

The Joint Action and Learning Initiative: Four Critical Challenges

The Joint Action and Learning Initiative will seek solutions to the four critical challenges discussed below. As the Initiative evolves, it will also encompass related themes of high importance, including: (i) power relationships through unequal access to, and participation in, the development of knowledge and evidence, including research priorities; (ii) resources, roles, and obligations of intergovernmental organizations (e.g., WHO, the World Bank, and UNICEF) and public/private partnerships (e.g., Global Fund and GAVI Alliance), and the importance of multilateral engagement in global health;⁸⁰ and (iii) foreign policy, global health diplomacy, trade, intellectual property, macroeconomic policies, and health worker migration as critical factors affecting global health. In pursuing these and other vital questions, we will learn from innovative national, bilateral, and multilateral approaches that have led to significant health improvements.

The JALI will explore other fundamental questions of health responsibility as well, such as whether national obligations are defined by resource level/financial contributions to health (input), the provision of a package of essential health goods and services (output), or the achievement of a certain population health status (outcome), or some combination of these.

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

A foundational question for the Initiative is to determine the essential health services and goods that every person has a right to expect. This analysis will be central to determining what states have a core duty to provide to their inhabitants and the extent to which affluent states should enhance capacities of low- and middle-income countries to ensure this package to their entire populations.

The question of what an essential health package entails raises the question of cost and the affordability of this package. We recognize that health resources—even in a world where some individuals and countries have great riches—are limited. We do not argue for a vast increase in global health assistance. More resources are necessary for improved health, but they are well within the reach of states in partnership with others. And even at current total global resources for health, improved global health governance (e.g., leadership, coordination, effective programs, and clear priorities) would save many lives and avoid much suffering.

Based on the 2001 landmark report of the WHO Commission for Macroeconomics and Health, the WHO estimates that a basic set of health care services costs a minimum of US\$40 per person per year, which varies depending on the socioeconomic conditions and the burden of disease.⁸¹ The Commission for 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).⁸² This is equivalent to approximately \$42 and \$47, respectively, in 2010 US dollars.⁸³ More recently, the High Level Taskforce on Innovative International Financing for Health Systems estimated that by 2015, an additional \$24-29 per capita will be required to achieve the MDGs, on top of the \$25 per capita already spent, on average, in the 49 low-income countries the Taskforce examined.⁸⁴

The health care elements of the essential health package would be more comprehensive than a package aimed primarily at health services associated with the MDGs. Such MDG-focused services are at the core of the cost estimates from the Commission for Macroeconomics and Health and the High Level Taskforce. A more complete package would also address non-communicable diseases and injuries. The higher estimate of the Taskforce (i.e., an additional \$29 per capita required) did include costs for tobacco control, salt reduction, and treatment of select non-communicable diseases including cardiovascular disease, asthma, and mental illness, as well as neglected tropical diseases.⁸⁵

Although the cost of interventions for NCDs varies greatly,⁸⁶ for some interventions they are quite modest. For example, a package of mental health services for schizophrenia, bipolar disorder, depression, and hazardous use of alcohol would cost only an initial \$0.20 per capita in low-income countries, rising to \$2 per capita as coverage expands, and \$3-4 per capita in lower-middle income countries.⁸⁷ Measures to implement the Framework Convention on Tobacco Control and reduce salt consumption would cost less than \$0.40 per capita in low- and lower-middle income countries. And in the same set of countries, the

per capita investment required for screening and treatment in people with at least a 15% of dying of cardiovascular disease averages \$1.10 per capita.⁸⁸

Significantly, the Commission and Taskforce per capita estimates include only health care, and with very limited exceptions, not also such fundamental human needs as potable water, nutrition, sanitation, and vector control, which would also be part of an essential health package, and thus add to its cost. The WHO and the World Bank Group in 2008 calculated the annual investments required over a ten-year period to expand coverage in line with the MDG target of halving the number of people without access to safe drinking water and basic sanitation. It found that \$4 billion annually was required to extend coverage of clean water, along with \$14 billion per year to extend coverage of adequate sanitation. Recurrent costs – maintenance and operations, as well as surveillance and education – for both the new coverage and for maintaining existing water and sanitation coverage would add \$52 billion annually to the required investments. Together, total spending required on water and sanitation in developing countries would be approximately \$12 per capita per year.⁸⁹ Separately, the MDG Africa Steering Group, comprised of major multilateral organizations, estimated that \$5.8 billion would be required annually in development assistance to countries in Africa by 2010 to meet the Millennium Development Goal targets on water and sanitation.⁹⁰

The UN's Food and Agriculture Organization (FAO), meanwhile, has called for \$44 billion annually in development assistance to agricultural development.⁹¹ (This does not include emergency spending required to address humanitarian crises.) This is well within the capacity of wealthy countries to provide as part of their overall commitment to development assistance of 0.7% of their gross national product. And as the Director-General of FAO observed, it is only a small fraction of the \$365 billion that rich countries spent in 2007 to support agriculture in their own countries⁹² – even as such subsidies harm some of the world's poorest people. The MDG Africa Steering Group had a lower estimate of funding required to address food and nutrition needs in Africa: \$8 billion in external financing annually by 2010 to improve agricultural productivity, and \$4 billion annually to address stunting and chronic malnutrition, in particular for universal access to critical nutrients, comprehensive school feeding programs, and de-worming.⁹³

Whatever the precise minimum package and its cost, this is just that, a minimum, one that states have an obligation to progressively build upon to more fully realize the right to health. Yet even such an essential package, well within the capacity of countries to provide under a framework of mutual responsibility, could achieve great strides in improving the lives of the world's least healthy people.

It is also worth bearing in mind that most or all of the investments that would be included in an essential health package would more than pay for themselves. They will contribute to increased productivity and other sources of economic growth (including, over the longer-term, by contributing to children's education and cognitive development by reducing cognitive impairment and absence from school), and in the case of prevention and control measures, through averted treatment costs as well.

Determining a core package of essential goods and services is a task that requires ambition tempered by realism and moderation. For if the answer is too ambitious, it will lead to unrealistic expectations about financial obligations and burden sharing, expectations that most states, even those that might otherwise accept increased responsibility for global health, 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. It will, like the selective primary health care approach that took hold shortly after the landmark Declaration of Alma Ata of 1978 on primary health care, undercut rather than advance the goal of health for all, of realizing the right to health for all people.⁹⁴ It would fail to meaningfully advance the imperative of mutual responsibility for global health. The essential package must be sufficient to remove the unconscionable inequities in health that exist today. It should also offer a bulwark against transnational health threats.

General Comment 14's delineation on states' core obligations and comparable priorities, augmented by a report of the UN Special Rapporteur on the right to health, provides an important starting point for defining this essential package. All people should have, at least:⁹⁵

- Access on a non-discriminatory basis to health facilities, goods, and services;
- Essential medicines;
- Access to the minimum essential food, which is nutritionally adequate and safe;
- Access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- Maternal, child, and reproductive health care, including family planning and emergency obstetric care;
- Immunizations against major infectious diseases occurring in the community;
- Education on the main health problems occurring in the community;
- Access to measures to prevent, treat, and control epidemic and endemic diseases.

The Initiative will use this right to health framework as a starting point because it is grounded in international law and consistent with the MDGs. However, the General Comment on the right to health will need elaboration and adaptation. Although there is certainly a core of goods and services necessary to ensure the conditions of health everywhere, human needs and socioeconomic conditions differ from one country to the next. Consequently, the essential package of health goods and services will not be the same in all countries, requiring flexibility and state authority (through inclusive processes) to define priorities, but still within acceptable standards. Nor will the essential package be static over time. It will have to reflect shifting epidemiology and evolving health needs. It should be a forward-looking package that addresses today's health needs while establishing the foundation for good health tomorrow, such as by addressing the deepening burden of injuries and NCDs, and the intensifying impact of climate change.

The core goods and services include all those necessary for people to lead lives in which they can function and gain the capacity for human agency.⁹⁶ People's health impacts their capacities and hence their opportunities in life, meaning that health must be preserved to ensure equality of opportunity.⁹⁷

The core health goods and services include adequate health systems and services, cost effective vaccines and medicines, and fundamental human needs:

- a) *Health Systems and Services*. The WHO sets out six essential building blocks of a well-functioning health system: health services; health workforce; health information; medical products, vaccines, and technologies; a financing system that raises sufficient funds for health and assures access; and leadership and governance. Health systems 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 Drugs, Vaccines and Technologies*. '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."⁹⁸ They are "selected on the basis of current and estimated future public health relevance, and potential for safe and cost-effective treatment."⁹⁹ Vaccines and medicines can be highly cost effective in treating common infections and chronic diseases. Other essential technologies, including medical devices and procedures, should also be included as part of the core package, based on comparable criteria as essential medicines. The WHO is planning to assist countries in developing advisory lists, focused on devices and related procedures for primary care delivery that would contribute to the greatest health improvements. These lists could be adapted to local conditions.¹⁰⁰

c) *Fundamental Human Needs*. Reframing the approach to global health requires a shift in national and international health funding and activities in the direction of fundamental human needs—a traditional public health strategy vital to maintaining and restoring human capability and functioning. Fundamental human needs include sanitation and sewage, pest control, clean air, potable water, diet and nutrition (neither under- nor over-nutrition), and tobacco and alcohol reduction.¹⁰¹ These “fundamental human needs” are neither minimal nor do they suggest a ceiling of services. Rather, whenever any person on the planet – rich or poor, or in the global North or South – turns on a tap, clean water should flow; whenever she uses a toilet, it should flush properly and maintain sanitary conditions; whenever she is hungry, adequate nutritionally-balanced food should be on the table; and whenever she goes out to play or goes to bed, she should not live in fear of disease-carrying insects, rodents, or parasites. Cigarettes and alcoholic beverages should not be marketed by for-profit companies or available cheaply and easily. These are traditional functions of public health departments, and are critically necessary to maintaining healthy populations. By focusing on these, and other, major determinants of health, the international community could dramatically improve prospects for good health precisely because they deal with the major causes of common disease and disabilities across the globe. As WHO Director-General Margaret Chan observed when launching the Commission on Social Determinants of Health, “the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one.”¹⁰²

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

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

a) *Provide adequate health resources within a state's capacity.* Despite the vast 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%).¹⁰³ 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 sector,¹⁰⁴ a pledge reaffirmed by African heads of state at their 2010 summit.¹⁰⁵ At the present rate of increase (from 2000 to 2007), it will not be until 2049, nearly half a century after the Abuja Declaration, that average health sector spending among African countries reaches 15% of their budgets.¹⁰⁶ The current inadequate health spending is also, on its face, at odds with the obligation in the ICESCR that countries spend “the maximum of [their] available resources” towards progressively realizing rights including the right to health, as well as with the entitlements in many national constitutions to health, life, and a safe environment that require the provision of essential health services.

Importantly, while we focus here on securing an essential health package for all, as part of the core obligations of the right to health, such a package is a starting point to, not the end of, state obligations. States, as explained above, have the obligation to spend the maximum of their resources towards the full realization of the right to health and other rights, not only towards achieving the core content of the right to 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,’ or ‘fungibility,’ or ‘crowding out.’¹⁰⁷ It is uncertain to where this domestic health spending is being diverted. It makes an enormous difference under the right to health whether governments shift the funds to other sectors addressing essential health needs, or indeed the education sector given its positive impact on health, or whether the funding is moved to support, for example, the military or large infrastructure projects. Nevertheless, these data suggest, particularly in conjunction with overall low levels of health spending as a percent of budget and compared to commitments, that low-income countries should do much more to ensure the right to health for their inhabitants. Certainly, all states should help build each other's capacity, but this does not obviate the responsibility of government do its utmost to meet its own population's health needs.

On the contrary, it is unrealistic to think that affluent states will carry out their responsibilities if lower-income states do not provide necessary resources within their own constraints, meeting their obligations to spend the “maximum of [their] available resources” towards fulfilling their human rights obligations, and doing so in an efficient manner. By contrast, a firm and realized commitment on the part of lower-income countries to make a clearly defined effort, consistent with their human rights obligations, towards providing an essential health package (and more, for those able) 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 provide the essential package of health-related goods and services. States that do not live up to that minimum domestic effort will have a weaker case to claim assistance from the international community and to be the steward of that assistance. Furthermore, they would bear greater responsibility for the 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’—introduced by the World Bank—sets consistent standards for national management of economic and social resources for development. Those who exercise authority to expend resources and make policy have a duty of *stewardship*—a personal responsibility to act on behalf, and in the interests, of those whom they serve. Sound governance is *honest*, in 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 them the right 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.

The principles of good governance can also be derived from the right to health. The right’s emphasis on equality means that transparent government must be accessible to all people, including efforts to reach people with physical or mental disabilities and individuals who do not speak the dominant language. For example, a radio announcement in the country’s dominant language is inaccessible to those who are deaf or do not speak that language. And the deliberative process must include active outreach to facilitate the participation of members of vulnerable and marginalized populations. And

indeed, the centrality of equality and non-discrimination to the right to health mean that another basic tenant of good governance must itself be equality and non-discrimination, meaning that the government works to respect, protect, and fulfill the rights of all people regardless of race, religion, sex, national origin, disability, sexual orientation, or other such status,¹⁰⁸ and must ensure the equitable distribution of resources. Government must also ensure equality before the law and enforce laws and policies that protect against discrimination—all essential to compliance with the rule of law.

c) *States have a responsibility to equitably and efficiently allocate health resources.* States should have the authority and discretion to set their own health priorities. Yet, in doing so, they have a responsibility to ethically allocate life-sustaining and enhancing- resources, often under conditions of scarcity. Deriving from the emphasis on equal and non-discriminatory access and to the equitable distribution under the right to health, and part of this right's core obligations,¹⁰⁹ states must equitably 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 language, culture, religion, or geography.

3. What is the responsibility of all countries to ensure the health of the world's population?

To what extent are states, particularly wealthier ones, responsible for the provision of health-related goods and services to the inhabitants of other countries? The answers to the first and second JALI questions above will inform the answer to this third question. An agreed understanding of essential health-related goods and services and on the limits of the capacity of states to provide them will offer a clearer picture of the financial and technical assistance that wealthier states will have to provide. This does not mean that health-related assistance should necessarily be limited to ensuring the essential health package, and that there are not further responsibilities to assist countries in achieving the full realization of the right to health, including fulfilling the wider determinants of health. However, given that a vast number of the world's people lack access to even basic health services and survival needs, the appropriate focus and priority at present – ours and that of health assistance – is to enable all people access to the type of comprehensive essential health package described above.

Unfortunately, a tremendous burden of avoidable morbidity and premature mortality rests on those who have the least capacity to adequately address it. As described above, earlier WHO estimates suggest that a basic set of health services costs a minimum of US\$40 per person per year, along with additional investments required to meet fundamental human needs. George Schieber and colleagues argue that the national politics of taxation in the poorest states of the world cannot realistically aim for government revenue above 20% of the gross domestic product (GDP).¹¹⁰ 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,¹¹¹ or at least 3% of their GDP if one combines both percentages, only states with a GDP of more than US\$1,333 per person per year have the domestic capacity to provide the essential package of health-related goods. The actual minimum GDP 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 US\$1,333 per capita, given that this is based on a low-end estimate of the cost of an incomplete set of essential health services and, more significantly, does not cover fundamental human needs such as adequate nutrition and clean water. About one-third of the world's people live in countries where the per capita GDP is less than US\$1,333. It will only be possible for these countries, and even those with a somewhat higher per capita GDP, to provide their entire populations the essential health package with external support.

The Commission for Macroeconomics and Health calculated that approximately 0.1% of the GNP of affluent states will be needed as international development assistance for health.¹¹² Other data suggest a similar¹¹³ or slightly higher proportion of GNP may be necessary.¹¹⁴ Additional assistance will be required to meet fundamental human health needs. These needs were not included in the Commission's 0.1% GNP estimate, other than tobacco control, which the Commission assumed to be self-financing.¹¹⁵

And even apart from human needs, the essential health package would be more comprehensive than that of the Commission (e.g., including NCDs) and would have higher coverage levels, with the package ensured for all inhabitants. This greater comprehensiveness and universality further increases the level of development assistance required.

While 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 factors that may be more internal to wealthy countries – from election and

appropriation cycles to changing geopolitical interests and inadequate national priority to global health – 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.

Paradoxically the real effect might be quite the opposite. As Mick Foster explains: “donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable. Governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.”¹¹⁶ 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.¹¹⁷ 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, severe shortages of health workers.

Financial assistance that is not based on an understanding of mutual responsibility, and is 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 reason alone should be sufficient to consider a global agreement on norms that clarify national and the global responsibilities for health, as it would transform ineffective short-term financial assistance into effective sustained financial contribution.

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

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

- 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.

- 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 and services for which the funding will be used.
- 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.
- The collection, management, and coordination of the global financial duties for global health will have to be governed by a body that reflects a genuine global partnership. International financial assistance should be understood as part of a compact with states themselves to provide a essential health-related goods and services to all people, and adherence to good governance principles, and vice versa. This body should be one in which all states are equally represented, and in which civil society of all states have a meaningful voice.

The challenge of the task ahead – both with respect to the goal and the paradigm shift to one of 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 begin to find answers to challenges of global health governance. For example, the UN General Assembly tasked the UN Secretary-General, in close collaboration with the WHO, to report on ways that “foreign policy [can] contribute better to creating a global policy environment supportive of global health.”¹¹⁸

A global health governance structure that can at last make “health for all” a reality will have to successfully address the six “grand challenges” in global health:¹¹⁹

1. *The lack of global health leadership.* Such leadership is required to mobilize, coordinate, and focus the large and diverse set of global health 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, including with its constitutional power to adopt conventions and promulgate binding regulations. Its leadership, resources, and normative role must be enhanced in an improved global health governance structure.

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, and not supplant, the benefits that come from a proliferation of various entities involved in global health. These include civil society and its ability to reach and represent disadvantaged populations, to advocate, and to hold governments accountable; the private sector and its ability to develop new medical technologies, market safer food, and create safer and healthier workplaces; and foundations and philanthropists, and their ability and willingness to fund imaginative approaches to improving global health and meeting unmet needs. Public private partnerships (PPPs) that are based on and organized around a shared respect for human rights and the goal of improving public health will be important to succeeding in these challenges.
3. *The lack of collaboration and coordination between multiple players.* Today's global health discourse is dominated by terms such as "fragmentation" and "duplication," and pictorially represented as an incomprehensible array of boxes and lines to portray the proliferation of actors involved in a country's health system. This cumbersome complexity reduces the efficiency of health spending, at times even pitting elements of the health system against each other. This proliferation of often-uncoordinated actors poses significant challenges to the stewardship role of the ministry 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 picture at country level, with relationships rooted in coordination and collaboration that successfully translate into action such principles as harmonization among various actors and alignment with national strategies, as prescribed by the Paris Declaration on Aid Effectiveness.¹²⁰
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, and controlling disease vectors such as mosquitoes and rodents, and from developing effective health systems that equitably and efficiently deliver known, effective health interventions. Shifting global health priorities 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 its demonstrable value in improving population health, the basic needs approach has been largely neglected, although this is beginning to change. Indeed, the past several years have seen new focus on these areas, particularly expanding HIV-related initiatives to also strengthen health systems, and recognizing health system strengthening as key to achieving the MDG 5 target on reducing maternal mortality. Prioritizing health systems strengthening to enable equal access to quality health care and meeting

outside the health sector would become a top priority of global health under the type of mutual responsibility framework that we have described. This should be integral to a new global health architecture.

5. *Ensuring predictable, sustainable, and scalable funding, and cooperative priority setting.* As described above, inadequate funding plagues global health. We have noted that at the present rate of increase, it will not be until nearly half a century after the Abuja Declaration that African countries fulfill their pledge to spend at least 15% of the government budget on the health sector. The proportion of gross national income (GNI) that members of the Organization of Economic Cooperation and Development allocated to official development assistance in 2009, 0.31% GNI,¹²¹ while presently on the rise,¹²² is essentially the same as it was in 1990 (0.34% gross national product [GNP]), 1980 (0.33% GNP), and 1970 (0.33% GNP), the year that wealthy countries pledged to spend 0.7% GNP on official development assistance.¹²³ Meanwhile, too frequently geopolitical concerns rather than need drive development assistance. Within the health sector, shifting priorities of wealthy countries can undermine country ownership, neglect basic needs, and enable diseases to resurge and progress in fighting disease to be reversed. As for the previous global health governance challenge, funding and priority setting would be central to the right to health-based mutual responsibility framework.
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 global 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 where clear targets do exist (such as universal access to HIV/AIDS prevention, treatment, care, and support by 2010, and indeed, the MDGs). There is insufficient transparency in inter-organizational and state health-related decision-making, and inadequate monitoring and evaluation of various health initiatives – though as with such issues as coordination, global health initiatives are making greater efforts to improve monitoring and evaluation.

Meanwhile, most actions in the global health field are, in practice, voluntary – the right to health obligations notwithstanding. Global health law presently lacks enforcement mechanisms, with the exception of limited international enforcement capacity regarding domestic human rights violations through regional institutions and several international human rights committees that adjudicate cases brought under human rights treaties (such as through the Optional Protocol of the ICESCR,¹²⁴ which allows for individual and group complaints).

The global health governance structure that should emerge in the coming years should embody the principles of accountability, transparency, monitoring, and enforcement. It will require clear targets with sufficiently detailed, benchmarked, budgeted strategies to achieve them, with strong health information systems that can monitor progress in real time. The Internet, mobile phones, and social media, as well as traditional media, can be used to improve transparency and accountability, and through virtual and in-person interactive forums, decision-makers should be available to explain their decisions. Accountability will also benefit from incentives created under a mutual responsibility framework.

Enforcement, ever a challenge under international law, will be aided by the development of binding commitments, and specific adjudication and other enforcement mechanisms that may be created under them. Funding could be channeled around rather than through governments that fail to meet their commitments, perhaps under institutionalized international stewardship to facilitate coordination. And as the global health governance structure is revamped, it is possible to imagine greater linkages with other areas of international law, such as trade and intellectual property law, given the unusually strong enforcement powers of the World Trade Organization. Could economic interests of states be challenged if they fail to meet global health obligations? Or might such failure to comply lead to other sanctions, such as suspension from regional organizations or other forms of formal state stigmatization?

Furthermore, along with various forms of pressure applied internationally, communities and local civil society are also central to any enforcement regime. Through greater technical and financial support, and creative North-South and South-South partnerships, the global community should prioritize strengthening communities and local civil society organizations that can hold their governments to account, and enforce obligations through domestic political and legal channels.

In addition to these six “grand challenges,” global health governance will need to address an issue that threatens to break trust in the structures of global health: how to distribute vaccines and medicines required to prevent and treat public health emergencies, such as a virulent new strain of influenza.¹²⁵ Will such technologies be developed and retained in wealthy countries, leaving the people of poorer countries far more exposed to the impact of such a threat, or will they be equitably distributed, offering protection and relief to people wherever they live? Failure to address this issue – along with its potentially

devastating health impact in the event of the emergence of a highly infectious and novel disease agent – could lead the people and governments of lower-income countries to view the global health governance structure and its lead actors as biased or even illegitimate, severely undermining its effectiveness.

A global health governance structure that can deal with this issue as well as the six global health “grand challenges” outlined above should be able to earn the confidence of both higher- and lower-income states, as well as non-state actors. This would enable it to have the legitimacy and authority to assess lower-income states’ health plans, domestic contributions, and adherence to principles of good governance. It will need to be able to provide or mobilize technical support to assist countries to strengthen health plans and increase domestic health spending. And it will need the ability to provide or readily mobilize the agreed level of international support to lower-income states that have sound plans to ensure coverage of (at the least) essential health services for all their people, follow principles of good governance, and have met their domestic health funding obligations. It will also require trust, including so that it can respond flexibly to country-specific circumstances, such as exceptional situations impacting states’ abilities to meet their commitments.

Such an entity will also need the means to channel support even to those lower-income countries that have failed to meet their funding responsibilities, placing their people at risk of not being covered by the essential health package, a possibility that a new global health governance regime should be structured to avoid. International responsibility extends to states that prove not only unable but also unwilling to meet their own domestic resource obligations towards an essential health package and their right to health obligations more broadly, even as wealthier countries will likely be inclined to avoid funding for states that have failed to meet their end of mutual responsibility. Creative approaches will be required to enable people in these countries to have their right to health met in ways that do not create a free rider problem – where lower-income countries fail to adequately fund health because they assume the international community will do so – that can garner support from wealthy countries, and critically, that does not undermine the accountability of governments to their own people.

Although this may be ambitious, there are precedents for each of the key elements of a global health governance architecture as we imagine it. The International Health Regulations create binding norms on all countries, imposing minimum efforts all governments must make to control emerging epidemics.¹²⁶ And the Framework Convention on Tobacco Control holds states accountable for reducing the supply and demand for tobacco products. Why would something similar not be possible for essential health goods and

services? The idea is beginning to interest governments. The Norwegian Directorate of Health hosted a stakeholder meeting on a framework convention approach to global health in March 2010, and the German Bundestag Committee on Economic Cooperation and Development met in September 2010 to discuss the challenges and opportunities of such a possibility.

African heads of state have committed and re-committed themselves to allocate a minimum level of domestic resources to the health sector. Would it not be possible to clarify and expand upon this commitment, and to encourage all countries of the world to adhere to this principle? There are several precedents of agreed burden sharing of international assistance, such as for the International Development Association of the World Bank¹²⁷ and the regular and peacekeeping budgets of the United Nations. Why not also an agreed approach to dividing the international funding responsibilities for something as vital as essential health needs?

New partnerships for global health like the Global Fund to Fight AIDS, Tuberculosis and Malaria have adopted innovative governance bodies, in which states providing the financial assistance and states providing the operational efforts for a common good are equally represented, and in which civil society has a serious voice. Can we learn lessons from this, and apply them on a wider scale?

We believe that this is not only achievable, but also necessary to achieve, to bring an end to the inequalities in global health based on the happenstance of one's birth, and to develop and sustain the structures required to ensure that these inequalities do not resurface.

Our Intention

We believe it is possible to build global health governance on the foundation of international human rights law, and through a broad consultative process to address the key issues that we have identified: the essential health-related goods and services; national and international obligations; and an architecture that monitors progress, evaluates effectiveness, and holds all states accountable.

We propose a Joint Action and Learning Initiative that will seek an international consensus around a broadly imagined global health system that meets the needs of the world's least healthy people and closes unconscionable health gaps between the global rich and poor.¹²⁸ It represents a stepwise process, which through its analyses and stakeholder involvement will be an important contribution to the improvement of

the “global health system.” We aim for a more formalized, highly effective global compact, which might take the form of a Framework Convention on Global Health,^{129,130,131} or a Global Plan for Justice,^{132,133,134} with resources devoted through, for example, a Global Fund for Health.^{135,136} A global compact would clarify and enhance accountability around national and international responsibilities to ensure the realization of the right to health, and would create the framework for post-MDG global health goals and commitments.

We intend for the Initiative to drive a broad, inclusive participatory process, particularly among communities and civil society in the South, while also actively engaging Northern civil society, governments, multilateral organizations, academic institutions and think tanks, foundations, and public/private partnerships. Broad engagement from all the world's regions will ensure acceptance and legitimacy. And it will be vital to engage the WHO at all levels and all regions.

The most transformative changes in global health have come from ‘bottom-up’ social movements, such as campaigns to rid the world of landmines and fight HIV/AIDS.^{137,138} Civil society is now moving rapidly toward a broad health rights and social justice agenda, characterized by the People’s Health Movement and the South African AIDS movement.^{139,140} Civil society is embracing the human right to health as a focal point for understanding the entitlements that everyone has the right to receive, and the corresponding obligations of states and the international community. The right to health is a global commitment. It is time to make it a global reality.

During the coming months, we will further elaborate the plan for a participatory process, including a list of essential stakeholders, a timeline, budget, and deliverables. We will further refine key questions for research, begin the research and consultation process, develop material to aid advocacy, and launch a website. We will seek to develop support for the goals that animate this Initiative, and accelerate our efforts to develop the partnerships that will be vital to success. For this we need different forms of support from innovative states and philanthropies, together with funding for a secretariat (perhaps a South-North partnership). This could be modeled, for example, on the influential Global Health and Foreign Policy initiative launched by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand.¹⁴¹ The investment of economic and political capital in this Initiative is modest compared with the potential benefits of dramatically improving the health of the world’s poorest people.

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¹ Clarifying and building support around the answers to these questions will also make important contributions to achieving meaningful universal health coverage. Looking through the lens of universal coverage, our first key question explores its underlying content, the health goods and services for which universal coverage should be ensured for people in even the poorest of countries. The next two questions address the ways in which governments should be accountable for universal coverage, both with respect to their own populations and to people everywhere. And the fourth question moves beyond the more micro level of the particular financing systems for universal coverage to explore an overarching global health architecture within which these systems are most likely to be fully, effectively, and equitably implemented.

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