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ARTICLE DRAFT:

Examining the Global Health Arena: Strengths and Weaknesses of a Convention Approach to Global Health Challenges

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Strengths and Weaknesses of a Convention Approach to Global Health Challenges

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The article comprises a conceptual framework to analyse the strengths and weaknesses of a global health convention. The analyses are inspired by Lawrence Gostin's suggested Framework Convention on Global Health. The analytical model takes a starting-point in events tentatively following a logic sequence: Input (global health funding), Processes (coordination, cooperation, accountability, allocation of aid), Output (definition of basic survival needs), Outcome (access to health services), and Impact (health for all). It then examines to what degree binding international regulations can create order in such a sequence of events. We conclude that a global health convention could be an appropriate instrument to deal with some of the problems of global health. We also show that some of the tasks preceding a convention approach might be to muster international support for supra-national health regulations, negotiate compromises between existing stakeholders in the global health arena, and to utilize WHO as a platform for further discussions on a global health convention.

Introduction

Global health is a concept which in recent years has evoked a lot of interest from both academics, politicians, celebrities, and the media. The term "global health" implies a globally shared responsibility to provide health as a public good through an expansive number of initiatives. This emerging era of consciousness about our international interdependence, regardless of a problem's geographic location or type of disease, may be a good moment for exploring the strengths and weaknesses of an international law approach to global health challenges: a global health convention.

The most prominent global health initiatives are the Millennium Development Goals (MDGs)(1), the 2005 Paris Declaration Process on Aid Effectiveness on need for alignment and coordination (PDP)(2), and the 2008 Accra High Level Forum on Aid Effectiveness (AHLF)(3). These instruments have yet to prove their value(4), and the funds annually disbursed, approximately $25 billion in 2009(5), could have better effect if the negotiated principles from the PDP and the AHLF were followed. However, these agreements are not legally binding. They also can also be perceived as solutions that have been negotiated in a top-down manner, and thus only seem to be respected as long as they are suited to a particular problem. Thus, there are several barriers to advancing global health that could be addressed with a unified and coordinated legal instrument, such as:

- funding problems (prioritization of resources)
- coordination of stakeholders
- access to health services (strengthening of country health systems)
- allocation of aid (cost of delivery, corruption)
- accountability of stakeholders
- enforcement of binding international health regulations

Our analysis is inspired by Lawrence Gostin's proposal for a Framework Convention on Global Health (FCGH)(6). In this article we use the acronym FCGH when commenting on Gostin's proposal, in other cases we use the more generic terms 'global health convention', 'convention', or 'binding regulations'.

The Proposal for a Framework Convention of Global Health

Gostin proposed a global health convention in his article *Meeting Basic Survival Needs of the World's Least Healthy People Toward a Framework Convention on Global Health,* published in 2007(6). In short, he argues that a FCGH:

"*...could powerfully improve global health governance [...] by committing States to a set of targets, both economic and logistic, and dismantle barriers to constructive engagement by the private and charitable sectors.*"

The framework convention-protocol approach refers to a process of incremental regime development where states could commit in a step by step manner. Specific protocols would be developed to achieve the objectives that are stated in a previously agreed upon framework of principles. The aim of a FCGH would be to ameliorate the most common causes of disease, disability, and premature death in the developing world, and thus to grant a majority of the world's poorest and most marginalized people a legal framework on which they could base their rightful claims for basic health care services(6). According to Gostin a FCGH should include the following:

- Mission and objectives –establish fair terms of international cooperation;
- Engagement and coordination –find common purposes and process, set priorities, and coordinate activities;
- Stakeholder obligations –e.g. incentives, forms and levels of assistance;

- Institutional structures –e.g. secretariat, technical advisory body, and financing mechanisms;
- Empirical monitoring –data gathering, benchmarks, and health indicators;
- Enforcement mechanisms –inducements, sanctions, and dispute resolution;
- Ongoing scientific analysis –processes for ongoing scientific research and evaluation on cost effective health interventions;
- Guidance for subsequent law-making process –content, methods, and timetables to meetframework convention goals by developing subsequent protocols.

These suggested principles do not in themselves represent any novelty in the global health arena. Each is already, either fully or in part, integrated in the priorities of a number of global health stakeholders. What is new is Gostin's suggestion to create a unified and coordinated *legal* framework for all these concepts.

Inherent Issues in an International Law Approach to Global Health Challenges

Incremental Regime Development

According to the sovereignty principle states reign supreme in any question that regards global or transnational issues. Thus, states formally have absolute power to commit or oblige. However, most states have surrendered some of their sovereignty, and abide by the most important legal instruments that promote the sake of humanity, e.g. the Geneva Conventions. Understandably, such transfer of national power to international governing bodies does not come without controversy. Some of the problems pertaining to globally

binding regulations are: How to create international legal regimes? How to assure compliance? How to grant them with legitimacy and timeliness?

In order to address the latter, Gostin proposes a "framework convention-protocol approach"; a mechanism capable of setting key objectives, defining means, methods and interventions, as well as ensuring compliance. The approach refers to a process of incremental regime development where stakeholders agree to negotiate broad principles for global health governance. Subsequent stages facilitate development of protocols including detailed legal norms, structures, and processes to achieve the objectives in the original framework(6). The strength of this gradual approach is that nation states' binding to more controversial obligations can happen progressively as actors try out any new positions, and as consequences are better explored. A weakness is that some states will be sceptical because of the uncertainty inherent in this approach.

Gostin's proposes that the protocol approach constitutes a bottom-up strategy. Supporting the claim is that the idea renders *possible* empowerment of stakeholders behind grass-roots initiatives. However, the proposal assumes that a convention should set priorities, coordinate activities, and evaluate and monitor progress(6). Such activities undoubtedly involve elements of top-down governance, or will at least easily be perceived as such by traditional recipient-states. In a true bottom-up regime, should not stakeholders themselves set priorities? And could not coordination be seen as self-organization between grassroots enterprises? Indeed, there is still a danger that many recipient-countries will still perceive such regulation as a troublesome top-down initiative.

Compliance with International Regulations

Will a global health convention make a difference? The same question with regards to human rights treaties was addressed in a large-scale quantitative analysis of the relationship between ratification of such treaties and countries' human rights practices. The analysis showed that noncompliance with treaty obligations is common, and that treaty ratification appears to be associated with worse practices than otherwise expected(7). Such findings can be explained in part by the dual nature of treaties as both instrumental and expressive instruments; treaties not only create binding law, but also declare or express the position of countries that ratify them. Because human rights treaties tend to be weakly monitored and enforced, countries that ratify may enjoy the benefits of this expression –including, perhaps, reduced pressure for improvements in practices– without bearing significant costs.

However, despite what one would believe, sanctions and threats are not considered the main success factors for ensuring compliance with international binding regulations. Treaty compliance(8) is sometimes considered to arise from reciprocity (mutual advantages)(9), transparency(10), legitimacy(11), social learning(12), mobilization (through the crafting of the agreement), and internalization (integration of treaty rules into states' legal systems and bureaucracies)(13). Accordingly, analyses of previous international agreements served as patterns when adopting the Framework Convention for Tobacco Control (FCTC). Among the features that were highlighted in terms of what could make the FCTC more effective in achieving its goals were: clear, precise rules;

financial support where states lack the capacity to comply; and regular meetings among member states for information exchange and ongoing negotiation(14).

Another problem somewhat in relation to compliance is the conflict between national and global responsibilities for health. Such conflicts could easily occur if one sets out to design a legal framework which is fit to blur that border. Indeed, for some the idea of a legal framework for global health could even be perceived to challenge the sovereignty principle and undermine national responsibilities. At the far end of such perceptions lie some dire consequences, namely that a global health convention could lead to circumstances where:

- Global responsibility would displace national responsibility, thereby extinguishing any domestic initiatives that work towards e.g. increasing tax revenues for subsequent health spending
- International assistance, by providing default funding to government budgets, would undermine community initiatives towards self-help financial arrangements, like the grassroots promotion of community health insurance.
- A nonexistent distinction between the national and global sphere where the world's total tax revenues allocated to health, in principle, should be spread evenly across the world. Thus, public health budget per capita per annum in Burundi, for example, would increase from US$0.7 to US$639, and in Norway would decrease from US$4,508 to US$639(15).

Indeed, if any of these arguments were true, neither donors nor recipients would feel very tempted to comply by global standards. However, as for human rights, there seems to be a global consensus that the primary responsibility for health lies with each country's government. Only if the government of a country is willing, but unable to achieve the minimum standards necessary for the enjoyment of the right to health, an obligation for other governments to provide international assistance sets in. Of course, potential donor countries can always argue that such international assistance is too costly on the grounds that they have an obligation towards their own inhabitants to achieve their *highest* attainable level of health. If such an argument is to be heard, one would have to disregard the fact that, according to The UN Committee on Economic, Social and Cultural Rights' (CESCR) General Comment 14(16), any core obligations to assist those that have nothing must be given priority over other rights. However, if countries do not disregard the core rights in General Comment 14, this is again an argument for a supra-national regime to which it is hard to obtain compliance.

On the other side, if one should accept the high-cost argument above, the right to health would in fact be a privilege and not a right. Thus, the recourse to human rights arguments inevitably leads to a "Catch 22-situation" where core obligations are not possible to realize without a supra-national governance regime. By analogy, a similar comprehension would have to be maintained for a global health convention; any rights that guarantee basic survival needs will by nature have to be supra-national. Alas, the problem of compliance with supra-national versus national regulations is still real, and a conundrum that must be solved before embarking on a new global health governance scheme.

Assessment of Rule-Making Processes

In global health there seems to be a drive towards adopting legally binding instruments, and the examples of recent international regulations are numerous (e.g. 2006 United Nations Convention on Disabilities, 2005 International Health Regulations (IHR), 2003 WHO Framework Convention on Tobacco Control, Medical Research and Development Treaty (current proposal being discussed as a follow up of the Commission on Intellectual Property Rights, Innovation and Public Health), United Nations Framework Convention on Climate Change, and further back 1990 Convention of the Rights of the Child, 1979 United Nations Convention on the Elimination of All Forms of Discrimination Against Women). Thus, there already is quite substantial experience in establishing instruments based on the rule of law. Questions could be raised, however, as to whether the implementation of voluntary guidelines would be just as effective as binding legislation. Hence, one could ask what are the strengths and weaknesses of the rule-adoption-processes in formal rights-based processes compared to "soft law" processes.

Indeed, when analyzing the adoption of a supra-national legal instrument, it is clear that a chosen procedure can be more or less in harmony with different countries legal traditions and negotiations cultures. In international legislative negotiations parties regularly attend with increased vigilance in the face of committing to wide-ranging responsibilities, and countries' legal traditions often clash as country-specific legislative strategies surface. Indeed, some nations have traditions of dynamic legislative processes where new rules are regularly set into action as a result of ongoing political processes. Consequently, it

becomes impossible to treat all regulatory initiatives with the same vigilance. In other countries, legal commitments are generally of a non-declaratory nature, and legislators thus display a more conservative attitude during adoption processes.

Such differences undeniably would play a part in the negotiations foregoing a global health convention, and need to be addressed before settling on a final approach. Whether Gostin's FCGH proposal encompasses mostly informal or formal procedures is not clear at the moment. However, we will briefly examine one prominent global health regulatory initiative, the Framework Convention on Tobacco Control (FCTC), and by this assess the main drivers and obstacles to its adoption processes. Other regulations that would have deserved attention are the IHR, the United Nations Framework Convention on Climate, and the Convention on the Rights of the Child.

It is regularly perceived that the major public health challenge that the use of tobacco causes was the carrying force of the process. It is also speculated that momentum was gained by fact that the countries of the world, in the face of tobacco related disease, could confront one common enemy that had no justifiable cause for its ultimately harmful actions. Thus, WHO could, without much controversy, take on the whole tobacco industry, its products, and its business strategies.

In the case of global health, no common enemy can be identified, and there are already numerous stakeholders combating disease and poverty, all defending their established

turfs. Comprehensive regulations for the global health field thus challenge the legitimacy and justification of existing global health initiatives, fostering political discord.

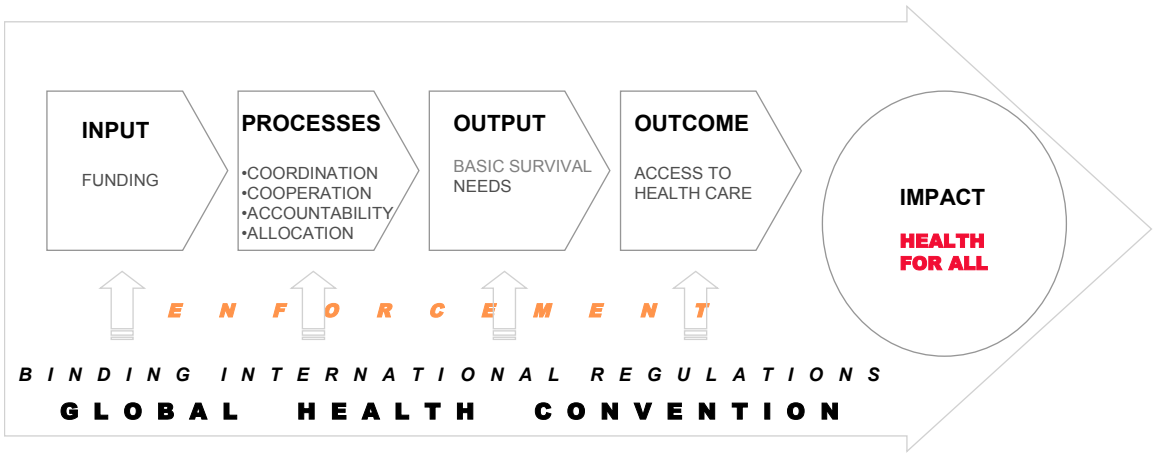
Observing that previous important advances in the global arena have emerged as mainly rights-based initiatives, it appears that the most viable strategy for supporters of a global health convention would be to aim for the creation of clear, concise and easily verifiable rules that have been negotiated in integrative and empowering processes. To avoid controversy, supporters should early on propose principles that all parties can agree on, and if possible, highlight areas of relative value. This would contribute both to establish healthy relations between stakeholders, and to expand the outlook towards possible gains. Such an approach appears to be concurrent with the process used by the WHO when adopting the FCTC, which is regularly perceived to have consisted of two main phases, namely:

- Initial brainstorming by a technical working group on the potential parties, principles, and contents of a convention
- Establishment of an intergovernmental negotiating body to draft and negotiate the proposed FCTC and possible related protocols(17)

Each phase presents procedural challenges, and convention facilitators would do wise in making sure there is in place a coherent framework for analysis of the whole negotiation system.

Conceptualizing the Complexity of the Global Health Arena

In this article, we attempt to conceptualize the convention approach to the global health arena by introducing a simplistic model. The model illustrates a tentatively logical sequence of events, and how a global health convention could impose order on such a system (see figure). However, we also acknowledge the underlying complexity of the global health arena, with self-organizing, tightly intertwined, ever changing, and both linear and nonlinear elements.



Thus, the sections below will analyze the following issues in sequence:

- Input –funding for global health
- Processes –coordination, cooperation, accountability, allocation of aid
- Output –basic survival needs
- Outcome –access to health services
- Impact –health for all
- Enforcement

The analysis does not discuss what would be the intended impact of a convention. The impact, health for all, preferably manifest as a general improvement in public health or population health amongst the world's poorest and least healthy people, is rather regarded as a possible emergent quality once binding regulations are in place.

Input

Funding

One of the main conundrums in global health is how to assure sufficient, sustainable and adequate funding for necessary and essential global health investments. Another problem is how to administer the vast sums of money that are already channelled into global health every year. Also, a challenge especially in relation to a global health convention is to obtain enough funds to create, implement and enforce a comprehensive regulatory regime. Mainly the two first problems will be examined in this article.

Global funding for health has increased in the recent years. According to commentators, private and public institutions' combined development assistance for health (DAH) grew from US$5.6 billion in 1990 to almost US$21.8 billion in 2007(5). This increase is mainly comprised of public development assistance which soared from US$4.15 billion in 1990 to just over US$14 billion in 2007(5). In addition, there has been a substantial increase in private funding for global health, which is now regarded to constitute a fourth of all development aid for health(18).

Although there is evidence of increased funding, McCoy at al. argue that there is insufficient evidence to describe the precise volume of expenditures, the sources of this

funding, and importantly; how it is managed and spent(18). There is thus still a need for a detailed account of global health funding mechanisms to improve the efficiency, accountability, performance, and equity impact of the many actors that populate the global health arena. Some researchers have even argued that there is a need for a single Global Health Fund to increase and coordinate available resources for health aid; according to Ooms, such a fund could be based on the design of the GFATM(19). Ooms gives ten reasons why a single global health fund would be practical, most importantly that it would:

- simplify bilateral aid relationships and harmonize global health initiatives
- help align health aid with national priorities
- improve long-term reliability of international health aid
- create a "fiscal space" for health
- avoid conditionality as part of obligation for recipient countries
- fight corruption and misuse of funding(19)

In addition, a sustainable funding mechanism could contribute towards this goal through preparing the grounds for sustainable health workforce development(20).

As is evident from this list of advantages, a comprehensive financing mechanism could contribute substantially towards uniform management of global funding for health. Subsequently, such efforts could even spark the development of a more coordinated global health regime that guarantees basic survival needs to the world's least healthy

people. It could also be a key factor in coordinating the constructive cooperation of nation states, intergovernmental organizations (IGOs) and non-governmental organizations (NGOs) towards such a legally binding global health initiative. However, a single global fund for health would necessarily have to build on a multitude of already established structures, and would thus represent a major challenge with respect to the cooperation, coordination and final merger of a number of large organizations. Questions could also be raised as to who should govern the fund, how one intends to assure accountability, and how to enforce any binding regulations. From a free market perspective a concern would moreover be the extinction of healthy competition between stakeholders, which could consequently lead to stagnation in innovation and business development. Such issues would need to be analyzed in detail before a final merger could come in place.

It is worth noting that African civil society activists are using the Abuja Declaration as a lobbying tool by pressing for governments to be held accountable to their commitment to spend 15% of their GDP on the health sector(21). Also, the grassroots people's organization People's Health Movement in its 2005 Cuenca Declaration has called upon governments to implement universal health care financing mechanisms, corresponding to at least 15% of the total budget, in all African countries(22). In the north, and especially in Europe, civil society groups with widely differing global health priorities call upon the EU and member states to ensure funding for health official development assistance (ODA) through the allocation of 0.1% of GDP in the case of donor countries, and through a 15% offset from national budgets in the case of recipient countries(23). In the USA,

civil society groups call upon significantly expanded investments by doubling U.S. aid for global health to approximately $16 billion per year in 2011(24), a number which, coincidentally or not, represents 1.0 % of U.S. GDP.

According to Gostin, the suggested FCGH could contribute towards financing global health reform by setting attainable goals for global health spending as a proportion of GNP(6). As such, it could come to provide an arena that both facilitates and legitimizes the creation of innovative financial instruments towards global health strengthening, as well as procuring agreed upon principles for sound financial governance. Interestingly, the proposal for a single global fund is rooted in the same idea: creating a common framework for sustainable global health spending. Thus, the idea of a global health convention would be supported by the advent of a single fund and vice versa. The two ideas have different starting points: the need for binding commitments regarding financing versus the need for coordinated investments when funding is secured.

Processes

Coordination

Global health challenges cannot be solved unilaterally by governments, private parties, NGOs, or supra-national conglomerations. In some way or another, at all levels, parties must find ways to cooperate constructively and purposefully. However, existing cooperation within the global health arena is regularly thought to be based on incomplete information, or even withstanding competing interests and goals. It is on this basis that global health can be perceived to be in demand of a powerful new strategy for resource utilization.

Since year 2000 the international society's main response to emerging health disparities caused by a few, but fatal diseases, has been several large global health initiatives (GHIs), e.g. the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), PEPFAR, UNAIDS, Polio Plus, World Bank Multi-Country AIDS Program (WBMAP). Such initiatives have rapidly established themselves within the existing international aid network, and have shown remarkable success in raising funds and driving the technical development towards more targeted health interventions. As a result of these disease specific interventions, there has been a continuous incentive towards the development of separate independent health service delivery systems to the detriment of the overall health system and other less well funded programs. Indeed, the issue of whether vertical health initiatives have a detrimental effect to horizontal, or system-wide, health system strengthening approaches is a much debated argument within the field of global health.

Indeed, difficulties with health system performance are perceived to be major causes for the delays in achieving key targets of the health-related MDGs(25). Related to this, Ooms and colleagues state that lacking support for the health work force could lead to a "Medicines without Doctors" situation, where medicines to fight serious diseases are available, but not the skilled health personnel to administer the medicines properly(20). As pointed out by Ooms and colleagues, the outlook towards establishing sustainable funding of much needed health force development looks grim if the Global Fund to Fight

AIDS, Tuberculosis and Malaria (GFATM) persists to concentrate on three diseases rather than on a wider health systems strengthening approach(20).

Thus, attention should be directed towards efforts to integrate existing vertical initiatives in a horizontal approach, and what benefits this could lead to. In the words of Frenk and Sepúlveda, health is a social value for which all sectors are responsible and accountable, and one should go beyond the traditional stand-off between the vertical and horizontal approaches by extending the geometry metaphor to search for diagonal approaches:

"*–strategies in which we use explicit intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance*."(26)

Several studies show that the quality of interaction between vertical initiatives and non-targeted health services is crucial(27;28). The current multiplicity of disease-specific initiatives, combined with activities by traditional international organizations (which are a mix of disease-specific and system-wide interventions), carry high transaction costs for developing countries(29). Thus, striving to coordinate the efforts of all stakeholders could instantly benefit the overall health systems strengthening needed to cover basic survival needs. Also, as Hunt and Backman argue, by drawing off resources, vertical interventions can jeopardize progress towards the long-term goal of an effective health system. This

problem is particularly manifest by the fact that disease–specific initiatives carry the risk of duplication and fragmentation(30).

Compatibility of existing global health initiatives could thus contribute to assure that aid remains coordinated and purposeful –which in turn would free up resources for further health strengthening. A problem is that most vertical initiatives do not have any immediate interest in coordinating their operations with other stakeholders. Harmonization of bureaucracies and infrastructure would not only eliminate costly duplication; it would also cut down the number of available positions and careers in the health development business. The United Nations Team in Senegal succinctly frames this paradox:

"*Everybody wants to coordinate but nobody wants to be coordinated*."(31)

On the issue of direct funding, it has been proposed that several of the leading vertical initiatives move towards becoming one Global Fund (see above). Cometto and colleagues suggest that the GFATM and GAVI, in their next board meeting, should expend the review of their architecture to provide increased funding to national health plans, including co-financing non-disease-specific human resources for health(32). The challenges to such a merger are substantial, and balance is difficult to define precisely when the knowledge base is thin and conflicting about how vertical programs may affect horizontal efforts(25). However, a global health convention could provide a tool for

stakeholders to reach such a goal. Thus, this issue would be one of the most important, and perhaps difficult, to address under a convention protocol approach.

Cooperation

A fairly common strategy amongst the world's developed nations is to include an element of self-interest when rolling out programs for humanitarian aid and/or health assistance. For governments such interest based approaches represents a systematic way to advance that society's security, political values, and welfare arrangements. Thus, knowledge and consciousness about its own public interests is underpinning any predictable and purposeful foreign policy over time, and also represents a necessary point of reference for other countries when engaging in international negotiation or cooperation. A focus on interests is also crucial to strengthening the ability to prioritize between different needs, strategies and actions in foreign policy.

Advancing a global health convention does not in principle represent an obstacle to such interest-based foreign policy. On the contrary, purposeful and predictable regulations will most likely contribute to strengthening the relationship between countries, and work to alleviate suffering, which in its turn preserves international security, cooperation, and trade. However, when suggesting a legal instrument with the potential to settle international relations, and especially donor-recipient connections, in the global health arena for decades to come, one would be wise to pay particular interest to balancing the interests of the donor and recipient countries.

In the literature, donor countries are often criticized for funding politically popular projects, rather than what is most likely to make an impact on the recipient countries' health status(33). This leads experts to conclude that funding is skewed towards what people in the rich countries want to deliver(34), and in particular towards specific diseases or treatments that give quick and measurable results, rather than on broad bottom-up health systems strengthening(33). And in a desperate attempt to keep the aid flow lines open, at all times and at any cost, host governments in poor countries often simply adopt these policies without paying proper attention to strengthening their existing dysfunctional health systems.

Some authors even go so far as to characterize the impact of aid in Africa as essentially counter-productive:

"*What is […] becoming increasingly clear, is that dependency on aid from foreign donors has undermined the development of the basic institutions needed to govern and the vital link between state and citizen.*"(35)

Consequentially, poor countries that want to improve population health must take ultimate responsibility for the quality of their health systems. This implies that recipient countries should manufacture their own health plans, and thus not accept aid initiatives not fitting into their strategy. By doing so, they could ensure that available resources were used in a coordinated and purposeful manner, while at the same time ensuring that

domestic bottom-up initiatives are not displaced or suppressed by ambitious narrow-sector donor programs.

Indeed, Gostin's proposal seems to include the idea of establishing such rules of engagement between donor and recipient countries. One of the key modalities is described as to:

"*…establish fair terms of international cooperation, with agreed-upon mutually binding obligations to create enduring health system capacities*."(6)

There is no detail on how such fair terms should be established. However, the convention-protocol approach suggests that a bottom-up initiative can help create the political, scientific, and normative space for agreement to be reached(6). Such an approach does not depend on more funds to be injected into deteriorating health systems. It rather grants support to an incremental regime development mobilizing the diverse drivers of health.

Accountability

Establishing globally binding regulations on contentious health issues requires a coherent approach which, in addition to agreeing on basic policy questions and creating innovative finance mechanisms, also includes the establishment of firm accountability structures suitable to guarantee adequate aid effectiveness. As stated in the Paris Declaration on Aid Effectiveness, one of the main issues of scaling up for more effective aid is assured by:

"*Enhancing donors' and partner countries' respective accountability to their citizens and parliaments for their development policies, strategies and performance.*"(2)

Indeed, the notion of accountability covers a variety of concepts:

- donor accountability (towards recipient states, bi- and multilateral institutions in the global health arena)
- recipient accountability (towards donors, and their own citizens)
- country accountability (towards other countries –whether they are donors, recipients or none– as well as NGOs/IGOs, and towards the international society as a whole).

In addition, in civil society there are multiple layers of accountability that run parallel to those purely international responsibilities: society representatives' accountability towards their constituencies at community level(36), national states' accountability towards their individual citizens (and non-citizens), and individuals' responsibilities towards their governments. Not all these aspects of accountability can be touched upon in this article. However, they are important to bear in mind as a successful global health convention initiative would most likely need to establish or confirm comprehensive accountability structures on all levels. We will instead highlight some of the main principles that are crucial when establishing accountability mechanisms.

In the 2005 High-Level Forum on the Health MDGs best practice principles for global health partnership (GHP) activities at country level were discussed. With relation to accountability the main findings were that:

"*As a matter of principle, in order to ensure public accountability, all GHPs should publish key documents on the Internet: annual plans, budgets and performance reports. […] Funding GHPs should provide timely, clear and comprehensive information on GHP assistance, processes, and decisions […] to partner countries…*"(29)

Thus, two main principles seem to be important: transparency and clarity. This is understandable as they are the prerequisites of any kind of revision by external parties.

Also, a global health convention should gather support for institutions that can enforce accountability mechanisms. One could envision accountability measures to be carried into effect by judicial processes, quasi judicial processes, administrative/policy decisions, and social/ethical obligations, even through the media. A prerequisite for any judicial processes is that there must be a clear legal commitment as well as an instrument that can effectuate decisions. If not, the lack of binding rules will lead to an accountability vacuum. Without legal obligations there are only political processes left, and given this, the provision of aid will in principle be a matter of charity. Also, following the recommendations of Transparency International, the global coalition against corruption, a global convention could serve as a tool for donor and recipient countries to:

"*...institutionalise joint and credible enforcement mechanisms that are able to address corruption-related complaints by beneficiaries, civil society and other concerned stakeholders*."(37)

Indeed, a transparent and proactive public redress system can inspire citizens to support centralized anti-corruption measures. Thus, by implementing such recommended measures, a global health convention can contribute to reducing the potential for fraud.

Allocation

Yearly, there are vast sums of money channelled into global health; sums intended to redress the basic needs of the world's least healthy population. However, often substantial amounts are spent on administrative efforts in governments, NGOs, and other agencies. Also, large sums of money disappear in outright corruption(37). It is difficult to determine what is the "right" level of administrative spending, and it is also difficult to decide what necessary expenditures are. Indeed, the problems with cost of delivery are specifically to ensure that the procurement of aid is efficient enough, and to warrant that a larger part of the money is used as intended. In the words of Piva and Dodd, allocation of aid sees:

"*...significant imbalances [...] which run counter to internationally recognized principles of "effective aid". Countries with comparable levels of poverty and health need receive remarkably different levels of aid. [...] Aid is highly fragmented at country level, which entails high transaction costs, divergence from national policies and lack of coherence between development partners.*"(38)

One could argue that raising taxes, or even introducing new taxation systems where none is available, in developing world countries would contribute with tools to improve transparency in national economic affairs. However, a question is whether people in poor countries would at all find taxation acceptable. Often no social contract readily exists between the governments and the people in many developing world countries, which again make it impossible for a regulator to assert the necessary authority to collect tax money, or even to design the information systems needed to control this kind of activity. Whether a global health convention would be a suitable instrument to facilitate the introduction of reformed national tax regimes, or even grant legitimacy to governments in their efforts to collect tax revenues, is an open question. However, the suggested protocol approach under the suggested FCGH regime allows great flexibility, and also longevity with respect to reaching goals. It is therefore something that could be advantageously explored in the continued work towards a binding instrument.

Similarly, it may seem obvious that flows of aid should be recorded, so recipients can ensure citizen representation and oversight in planning, budget processes, and monitoring public health care delivery(39). But there is no evidence that this happens today.
The most substantial allocation problem, however, seems to be too many aid agencies(40). In practice, the best way of coping with the galloping cost of delivery for recipient countries is thus to lay down a set of national development priorities and ask donors to fit in with their plans. In consequence, recipient countries could decline offers

of aid that do not fit into their domestic processes. As stated by *The Economist*, this hardly ever happens. Neither does the preparation of domestic plans for use of aid:

"The Paris target is for three-quarters of recipient governments to publish development programmes that aid agencies can use. Last year, according to a survey on monitoring the Paris declaration, only a fifth did. Unless that improves, aid is likely to remain badly fragmented."(40)

A global health convention could alleviate such allocation problems by creating an agreed upon aid management regime pertaining to both recipients and donors. Such a regime could contain unambiguous rules on conditions and terms for the contribution and reception of aid funds.

Output

Basic Survival Needs

One important feature of a global health convention would be to clearly define what constitutes basic survival needs within the global health sphere. A mechanism under the framework convention approach could indeed be that all nations, by ratifying the instrument, were obliged to guarantee access to such basic health services to all individuals. In reality, such provision of basic survival needs implicitly would imply a global implementation of a horizontal health systems strengthening initiative.

Basic survival needs have been defined several times in the literature as well as in international legal instruments. The CESCR in General Comment No. 14 highlights

certain core rights that represent a “minimum package” or an “existential minimum”. These core obligations include access to health facilities, goods and services, access to the minimum essential foods, freedom from hunger, provision of essential drugs, access to basic shelter, housing and sanitation, and an adequate supply of potable water. Other obligations are reproductive, maternal and child health care, immunization against communicable disease, information access, and appropriate training for medical personnel.

The CESCR definition is supported by the United Nations Committee on Economic, Social and Cultural Rights (ECOSOC) which includes immunization, essential medicines, food, potable water, sanitation, disease prevention and treatment, primary health care, and health education as basic survival needs(16). The health related MDGs highlight provisions that reduces child mortality, increases maternal health, and diminishes the burden of infectious diseases(41).

A global health convention initiative would be best served by a focus on survival needs within the most basic areas of health care. As such, it would have to span areas like access to functioning health systems run by skilled medical personnel, vaccination, essential foods and medicines, maternal health care, provisions that reduce child mortality and provisions that diminish the burden of infectious disease. According to WHO, such a “minimum package” could be provided for a cost of $35-50 per person(15).

Outcome

Access to Health Services

In most high-income societies there exists an unwritten, however functioning, societal contract between the government and the people. The people expect the governments to grant a number of basic goods like security, public infrastructure, courts of justice, democratic electoral processes, education, health care, and so on. In response, the people accept the government's authority and power to raise taxes, or to police daily interactions. Thus, for most people living in rich countries access to health care is part of the societal contract. However, as stated by one commentator, no such relationship exists on a global scale(42). Thus, problems with access to health services appear where no formally responsible government exists, or the moment a government chooses to neglect their duty to the people, or indeed assumes that no such duty exists.

A tenet of a global health convention would be to provide access to basic health care services to all citizens and non-nationals, irrespective of their legal status, within a country's borders. Logically, a commitment would also be to guarantee international health care services in countries that cannot or will not provide for their own.
This challenges the sovereignty principle, which leaves every state responsible only towards its own citizens, and consequently does not grant states authority to provide services to other states' citizens. It also represents a foreign policy problem for activist states because a number of non-committing nation states likely will respond belligerently towards any foreign initiative within their borders. Questions could also be raised as to what should be national states' obligations towards their own citizens compared to other

countries' peoples? And under what circumstances should such international obligations be activated? Also, provision of universal access will lead to a problem in relation to domestic immigration policies. There are already several dilemmas with respect to those who have been denied asylum or citizenship, and provision of health care is a major one. Finally, from a national viewpoint, one could ask what kind of funding would be available for strengthening health care systems abroad. Although most developed nation states are resourceful, it would be a question of domestic policy whether such money could be made available.

Enforcement

In order to be effective, a global health convention needs backing from a robust enforcement instrument. Such an instrument could be an International Court of Health. Such a court could be specially designed to implement the global health convention and its protocols, thus contributing towards incremental regime creation. Interestingly, the European Convention on Human Rights(43) dictates the rules for an international Human Rights Court, which could serve as a model for an International Court of Health. However, an enforcement instrument within the framework of a global health convention would instantly create an array of problems of political, economic, and practical nature. What should be the mandate of the International Health Court? Where should the money come from? Would the Court's decisions be binding? How should one guarantee the execution of the judgments? Such issues need further discussion.

Convening Authority

We have now discussed the global health convention approach according to our model, and have identified strengths, weaknesses, and some issues that need to be resolved before real progress can be made.

Any regulatory initiative with features as comprehensive as a global health convention would need some kind of shepherding authority for it to come into existence. Both before and after the adoption of a binding regulatory instrument, it would also need a secretariat that harbors advisory capabilities on legal issues, negotiation challenges, and technical questions. In the international arena, sovereign entities like nation states, or federations of states, are obvious candidates to take on such a role. Indeed, the United States and the EU indisputably form the two most dominant players in the global health arena, and might well initiate a global health convention. However, such action would disregard established international procedures on the adoption of international regulatory instruments. It would also run the risk of disempowering countries in other regions of the world by disregarding their particular positions, needs and interests, as well as ignoring any constructive contributions.

Furthermore, there are several intergovernmental conglomerates that could act as conveners for the deliberations on a potential global health convention. Commentators especially emphasize the role of the G8, and conceivably the G20(25). They also argue that into this increasingly crowded area of global health has emerged a new informal and self-appointed entity known as the Health 8 or H8—comprised of WHO, the World

Bank, GAVI, the GFATM, UNICEF, UNFPA, UNAIDS, and the Bill & Melinda Gates Foundation(25). Within the trade sector the WTO continues to be the most important agency dealing with international trade and as such. Indeed, trade liberalization will continue to overlap with and compound the protection of human rights and other vital interests, including those affecting labor and health and safety rights worldwide. Such organizations are loosely jointed, and often have united to fend for interests considerably divergent from health. However, their role as supporting agencies in sector-relevant issues should not be overlooked,.

The World Bank is a considerable force within the health, nutrition and population sector in developing world countries. During the FCTC-process the Bank collaborated with WHO in establishing the evidence base on which the FCTC-regulations could be based(44). However, the Bank suffers criticism for its self-interest and undemocratic processes(45). This, and the organization's role and mandate, make it questionable whether the World Bank could act as a gathering force in facilitating discussions on a global health convention.

The most prominent vertical initiatives are GAVI, GFATM, and UNAIDS. Although operating within different developing countries, and with different objectives, these initiatives are often criticized for their narrow attention towards one specific disease or conglomerate of problems. They are also criticized for being bureaucratic, thus blocking local initiatives by channeling away scarce resources. One would have to expect that several vertical initiatives will have reason to contest the proposal of a global health

convention on grounds that a systemic approach comes in the way of their interests. It is thus unlikely that any of them would act as convening authorities for a global health convention.

WHO is the directing and coordinating authority for health within the UN system. Hence, it is an agency within the world's most prominent international network of states. In addition, the World Health Assembly (WHA), where all 193 WHO member states meet to discuss upcoming issues, is the world's foremost health policy setting body, and a mechanism that allows for representation by every country's highest health authorities. This means that any WHO proposal that musters support in the WHA would represent a democratic and deeply founded global endeavour. It would thus be the natural starting point of a global health convention initiative. Indeed, WHO itself has emphasized three main areas of action(46): 1) produce global norms, 2) assist development of systems that impact on health, and 3) support health systems strengthening. Also, some commentators assess that WHO will play a critical role especially in treaty content, consensus building and member state ratification and implementation(47). Given the history of WHO, and including the hopes for the future or the organization, it is possibly the most likely candidate to initiate and coordinate a global health convention initiative. In reality, such a feat would be very difficult without WHO. At the moment it is unclear whether WHO has at all envisioned an instrument like a global health convention for the years to come. An important task for supporters of a convention would thus be to examine more closely the organization's positions and interests in this relation. In addition the proposal for a convention needs to be further elaborated before it is mature, but such an elaboration may

also be linked up with WHO. In this respect, considerable support could be gained from academia, think tanks, etc.

Need for further Discussions

We have supposed that nation states are the likely signatories to a global health convention. However, because of the immensity of the task, we have not analyzed the context specific circumstances that would make a global health convention desirable or not for candidate countries. Also, we have not discussed whether there are other subjects in the global health arena that could potentially commit to a convention text, e.g. private enterprises or non-governmental organizations. In addition, we have assumed that the health sector is closest to promote the adoption of a convention. It could, however, be argued that other state/public sectors should play central roles, e.g. the foreign policy(48), educational, judicial, or trade sectors.

We have found WHO the most likely candidate to act as a convening body for further discussions, and eventually the initiation and execution of a convention adoption process. A discussion paper analyzing what WHO has done so far regarding a global health convention should thus be developed. Such analysis could concentrate on any resolutions and decisions pertaining to the idea of universal access to health made by WHO in the last decades. Also, a discussion paper analyzing the potential for constructive and efficient division of labor between other existing stakeholders should be included in this. Such a text should contain analytic tools to define who the relevant parties to a convention are, and which sectors of society should be included in future discussions. The discussion papers should be circulated between all interested parties so that a

structuring of the process could be as high-quality and as agreed upon as possible. Input from future potential parties to a convention would be the most important, and is best secured by an open and inclusive environment.

For a subsequent negotiation phase, the main challenge will most likely be to create the right balance between the positions, interests and needs of the parties involved. The interests of the developing world will be clearly set against those of the developed countries, the rich against the poor. Another easily identifiable conflict could be the turf wars between existing stakeholders, e.g. vertical global health initiatives. Thus, including parties in integrative and constructive discussions on principles and crucial issues during an integrative bottom-up process grants both time and place to the all important empowerment and mobilization that this process demands. A framework for such a negotiation process should thus set in place powerful mechanisms to explore parties' positions and interests, as well as timely inclusion of legal advice whenever there is need to explore whether any emergent issues could create legitimacy problems. It should also include a set of agreed upon impasse breakers, as well as incentives to reengage in negotiation if breakdowns occur. A negotiation phase could moreover be exploited to explore the issue of purpose and goal of a convention initiative. Consensus about purpose could soon prove to be the driving force that carries the process forward. In fact, initial informal negotiation on such issues could seamlessly be developed into more committing cooperation on the concrete contents of a framework convention text.

The financing of further steps towards the adoption of a binding instrument is a crucial point, and must be discussed by supporters of a global health convention. Investigations should be done into how an initial brainstorming process and the first gathering of potential convention parties to elect a formal secretariat could be financed. It cannot be assumed that any institution or state alone will be able to raise all the funds needed. Also, supporters should study experimental sources of funding for global health that have been developed during the recent years, and continue to develop credible models whilst considering how to finance a comprehensive system of binding international regulations. One example of an innovative financing model is the UNITAID initiative on taxing of plane tickets. Through its implementing partners, UNITAID now channels its funds to purchasing tests and medicines of assured quality and ensuring fast delivery to the patients who most need them, especially those in low– and middle–income countries. Another example often referred to is the Tobin tax. The suggested tax on all trade of currency across borders is intended to put a penalty on short-term speculation in currencies. A third proposal for sustainable funding is to make WTO membership conditional of contributions towards global health investments(49).

Conclusions

Our analyses have shown that a global health convention could be an appropriate instrument to deal with some of the intractable problems of global health, namely to (co-)create a sustainable funding mechanism, coordinate stakeholders, control the allocation of aid, define basic survival needs, and provide access to health services. We have also shown that some of the most important problems preceding a convention approach might be to muster international support for supra-national health regulations

and negotiate compromises between existing stakeholders in the global health arena. There are several remaining challenges and issues that need to be addresses and discussed before setting up a more formal process. We believe that WHO could take a coordinating role in these further discussions, and that this can be done without making any commitments to whether or not a convention approach should be realized. However, if the proposal for a global health convention should manage to obtain substantial international support, and particularly through the WHA, we think that WHO would be the natural convening authority for the formal initiation and coordination of the adoption processes.