



2013

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

Lawrence O. Gostin

Georgetown University Law Center, gostin@law.georgetown.edu

Eric A. Friedman

Georgetown University Law Center, eaf74@law.georgetown.edu

Georgetown Public Law and Legal Theory Research Paper No. 13-054

This paper can be downloaded free of charge from:

<https://scholarship.law.georgetown.edu/facpub/1224>

<http://ssrn.com/abstract=2273749>

13 Yale J. Health Pol'y L. & Ethics 1-75 (2013)

This open-access article is brought to you by the Georgetown Law Library. Posted with permission of the author. Follow this and additional works at: <https://scholarship.law.georgetown.edu/facpub>

 Part of the [Health Law and Policy Commons](#), [Health Policy Commons](#), [Human Rights Law Commons](#), [Public Health Commons](#), and the [Public Policy Commons](#)

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

Lawrence O. Gostin^{*} & Eric A. Friedman^{}**

ABSTRACT:

Global health inequities cause nearly 20 million deaths annually, mostly among the world's poor. Yet international law currently does little to reduce the massive inequalities that underlie these deaths. This Article offers the first systematic account of the goals and justifications, normative foundations, and potential construction of a proposed new global health treaty, a Framework Convention on Global Health (FCGH), grounded in the human right to health. Already endorsed by the United Nations Secretary-General, the FCGH would reimagine global governance for health, offering a new, post-Millennium Development Goals vision. A global coalition of civil society and academics has formed the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) to advance the FCGH.

[†] Professor Lawrence O. Gostin and Mr. Eric A. Friedman are members of the Steering Committee of the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI). JALI is an international campaign, comprised of civil society and academic leaders, from the global South and North, dedicated to establishing a Framework Convention on Global Health. This framework convention would serve as a historic, innovative treaty on global health equity. See JOINT ACTION AND LEARNING INITIATIVE ON NATIONAL AND GLOBAL RESPONSIBILITIES FOR HEALTH, <http://www.jalihealth.org> (last visited Nov. 29, 2012). This Article offers the first detailed account of the treaty's mission, norms, and processes, together with a systematic justification for a radically new form of global governance for health. The authors thank current and former members of the JALI Steering Committee: Adila Hassim (SECTION27, South Africa), Anand Grover (Lawyers Collective), Armando De Negri (World Social Forum on Health and Social Security, Brazil), Attiya Waris (University of Nairobi/Tax Justice Network), Devi Sridhar (Oxford University, United Kingdom), Gorik Ooms (Hélène De Beir Foundation, Belgium), Harald Siem (Norwegian Directorate of Health), Mark Heywood (SECTION27, South Africa), Mayowa Joel (Communication for Development Centre, Nigeria), Moses Mulumba (Center for Health, Human Rights and Development, Uganda), Shiba Phurailatpam (Asia Pacific Network of People Living with HIV/AIDS), Thomas Gebauer (Medico International, Germany), and Tim Evans (BRAC University, Bangladesh).

^{*} University Professor and Faculty Director, O'Neill Institute for National and Global Health Law, Georgetown University Law Center; and Director, World Health Organization Collaborating Center on Public Health Law and Human Rights.

^{**} Project Leader, JALI, O'Neill Institute for National and Global Health Law, Georgetown University Law Center.

TABLE OF CONTENTS

INTRODUCTION	4
I. THE IMPOVERISHED STATE OF WORLD HEALTH	9
A. CHILD AND MATERNAL HEALTH	9
B. INFECTIOUS DISEASES.....	11
C. NON-COMMUNICABLE DISEASES.....	13
D. MENTAL DISABILITIES	14
E. INJURIES	15
F. CLIMATE CHANGE.....	15
G. NATIONAL HEALTH DISPARITIES.....	16
II. PROSPECTS FOR A PERMANENT UNDERCLASS IN HEALTH: THE IMPERATIVES OF SUSTAINABLE FUNDING, GOOD GOVERNANCE, AND INTERNATIONAL LEGAL OBLIGATIONS	18
A. THE RISK OF A PERSISTING GLOBAL HEALTH UNDERCLASS	18
B. WHY EXTANT GLOBAL HEALTH LAW AND GOVERNANCE FOR HEALTH ARE INSUFFICIENT FOR GLOBAL HEALTH JUSTICE.....	20
1. INSUFFICIENT AND UNPREDICTABLE FUNDING	23
2. THE LACK OF COLLABORATION AND COORDINATION AMONG MULTIPLE PLAYERS	26
3. THE NEED FOR ACCOUNTABILITY, TRANSPARENCY, MONITORING, AND ENFORCEMENT.....	27
4. THE NEGLECT OF ESSENTIAL HEALTH NEEDS AND HEALTH SYSTEM STRENGTHENING	27
5. THE NEGLECT OF VITAL HEALTH RESEARCH AND DEVELOPMENT	28
6. THE LACK OF GLOBAL HEALTH LEADERSHIP	29
7. THE NEED FOR HEALTH AND HUMAN RIGHTS LEADERS TO INFLUENCE MULTIPLE GLOBAL SECTORS TO PROMOTE HEALTH	30
III. RECONCEPTUALIZING “HEALTH AID”: FROM CHARITY TO HUMAN RIGHTS.....	34
A. A SHARED OBLIGATION: THE RIGHT TO HEALTH AND REINFORCING FRAMEWORKS.....	35
IV. FOUR DEFINING QUESTIONS FOR THE FUTURE OF THE WORLD’S HEALTH	39

TOWARDS A FRAMEWORK CONVENTION ON GLOBAL HEALTH

A. THE FOUR QUESTIONS	39
1. WHAT ARE THE HEALTH SERVICES AND GOODS GUARANTEED TO EVERY HUMAN BEING UNDER THE RIGHT TO HEALTH?	39
2. WHAT DO STATES OWE FOR THE HEALTH OF THEIR OWN POPULATIONS?	43
3. WHAT RESPONSIBILITY DO STATES HAVE FOR IMPROVING THE HEALTH OF PEOPLE BEYOND THEIR BORDERS?.....	47
4. WHAT KIND OF GLOBAL GOVERNANCE MECHANISMS ARE REQUIRED TO ENSURE THAT ALL STATES LIVE UP TO THEIR MUTUAL RESPONSIBILITIES TO PROVIDE HEALTH GOODS AND SERVICES TO ALL PEOPLE?	53
V. A FRAMEWORK CONVENTION / PROTOCOL APPROACH TO GLOBAL HEALTH	54
A. NORMATIVE STANDARDS AND PRIORITIES.....	55
B. TARGETS AND BENCHMARKS.....	58
C. A FLEXIBLE AND INCLUSIVE PROCESS	59
D. SUSTAINABLE FUNDING SCALABLE TO NEEDS.....	60
E. GLOBAL GOVERNANCE FOR HEALTH.....	63
F. ACCOUNTABILITY AND TREATY MONITORING AND COMPLIANCE.....	66
VI. THE PATH TOWARDS AN FCGH.....	68
A. OVERCOMING RESISTANCE AND OTHER CHALLENGES.....	68
B. LEGAL PATHWAYS	72
VII. CONCLUSION	74

INTRODUCTION

Consider two children—one born in sub-Saharan Africa and the other in a developed region, such as Europe or North America. The African child is fifteen times more likely to die in her first five years of life. If she lives to childbearing age, she is nearly one-hundred times more likely to die in labor. Overall, she can expect to die twenty-six years earlier than a child born into a wealthy part of the world.¹ Collectively, the vast inequalities between richer and poorer countries as well as the inequalities among people within poorer countries translate into nearly 20 million deaths every year—and have for at least the past two decades. These disparities in health represent approximately one-third of global deaths, not including deaths related to inequalities within high-income countries.²

The persistence of such an unconscionable level of avoidable deaths reveals the single greatest gap in international law. In general, there is a dearth of international law addressing the most fundamental issue of life and death. Some international legal regimes, such as trade and investment treaties, negligibly influence or even harm health.³ Others, such as environmental, refugee, and labor

1 *Human Development Report 2011*, U.N. DEV. PROGRAMME 130 (2011), http://hdr.undp.org/en/media/HDR_2011_EN_Complete.pdf; *Levels & Trends in Child Mortality: Report 2012*, UNICEF 9 (2012), http://www.unicef.org/media/files/UNICEF_2012_IGME_child_mortality_report.pdf (last visited Nov. 29, 2012); *Trends in Maternal Mortality: 1990 to 2010*, WORLD HEALTH ORG. 19 (2012), http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf.

The life expectancy at birth in the 47 countries that score highest on the UNDP's Human Development Index is 80.0 years, compared to 54.4 years in sub-Saharan Africa. *Human Development Report, supra*.

2 Juan Garay, *Global Health (GH) = GH Equity = GH Justice = Global Social Justice: The Opportunities of Joining EU and US Forces Together*, NEWSL. EUR. UNION EXCELLENCE U.C. BERKELEY (Winter 2012), <http://eucenter.berkeley.edu/newsletter/winter12/garay.html>. The figure derives from the difference in death rates between high-income countries and other regions of the world.

3 See, e.g., Panel Report, *United States—Measures Affecting the Production and Sale of Clove Cigarettes*, WT/DS406/R (Sept. 2, 2011) (holding that the United States' ban on clove cigarettes violated the non-discrimination principle of article 2.1 of the Agreement on Technical Barriers to Trade, even though it was a valid public health measure). Tobacco industry giant Philip Morris, meanwhile, has brought separate suits against Uruguay and Australia under bilateral investment treaties. The company is claiming that Uruguay breached its obligations to protect Philip Morris' trademark rights under a bilateral investment treaty with Switzerland. Uruguayan regulations, implemented in 2009, require graphic warning labels that cover 80% of cigarette packages and limit the number of cigarette varieties a brand can sell. Meanwhile, Philip Morris asserts that Australia's new packaging legislation, requiring cigarettes to have graphic health warnings and standardized designs, breaches Australia's bilateral investment treaty with Hong Kong by expropriating company investments and intellectual property without compensation. Philip Morris Brand Sàrl (Switz.), Philip Morris Prods. S.A. (Switz.) and Abal Hermanos S.A. (Uru.) v. Oriental Republic of Uru., ICSID Case No. ARB/10/7 (ongoing arbitration); *Bilateral Treatment Treaty Claim, Uruguay*, PHILIP MORRIS INT'L (Oct. 5, 2010), http://www.pmi.com/eng/media_center/company_statements/Pages/uruguay_bit_claim.aspx; *Philip Morris Sues Australia Over Cigarette Packaging*, BBC NEWS (Nov. 21, 2011), <http://www.bbc.co.uk/news/world-asia-15815311>;

law, improve health and save lives in less-developed countries, but their impact is marginal relative to the large magnitude of these deaths.

Several international law regimes, however, could play a greater role in combating health inequities. Humanitarian law espouses the chief goal of protecting the lives of non-combatants. Because most of today's wars occur in poorer countries, this body of law could reduce global health inequities. Recently enacted arms control treaties, such as the Mine Ban Treaty,⁴ as well as treaties currently being negotiated, like the Arms Trade Treaty,⁵ will prove most beneficial to developing countries. Nonetheless, humanitarian law does not impact global health inequities in most nations, which do not fall into the narrow set of countries facing large-scale armed conflict. And even within this limited set of countries, notoriously poor compliance with these international agreements limits the impact of humanitarian protection of non-combatants, such as can be witnessed in the genocide in Sudan, the massive shelling of civilians in Sri Lanka, or the violence of the Burmese military against ethnic minorities.⁶

The closest legal regime to addressing these health inequities is human rights law. Yet even this regime, which asserts the rights to health and an adequate standard of living, has yet to be adequately developed and enforced. As a result, it cannot easily translate its norms into wide-scale practices sufficient to avert the large numbers of deaths resulting from health inequities. Along with poor adherence, the fact that international action is only weakly addressed in human rights law poses a critical challenge for tackling these inequities.⁷ Although this Article will later discuss the potential for human rights law to form the basis of a global health agreement to reduce health inequities, at present, it suffices to note that even the explicit commitment of human rights law to health

Windsor Genova, *Philip Morris Files Arbitration Case Vs. Australia Over Plain-Packaging Law*, INT'L BUS. TIMES (Nov. 22, 2011).

⁴ Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction, Sept. 18, 1997, 36 I.L.M. 1507 [hereinafter Mine Ban Treaty] (entered into force Mar. 1, 1999).

⁵ *Towards an Arms Trade Treaty*, U.N. OFFICE FOR DISARMAMENT AFFAIRS, <http://www.un.org/disarmament/convarms/ArmsTradeTreaty/> (last visited Dec. 1, 2011).

⁶ See, e.g., Lydia Polgreen, *U.N. Panel Says Sri Lanka Attacked Civilians Near End of War on Rebels*, N.Y. TIMES (Apr. 19, 2011), available at <http://www.nytimes.com/2011/04/19/world/asia/19lanka.html>; Marlise Simons et al., *Arrest Is Sought of Sudan Leader in Genocide Case*, N.Y. TIMES (July 15, 2008), <http://www.nytimes.com/2008/07/15/world/africa/15sudan.html>; Edward Wong, *An Ethnic War is Rekindled in Myanmar*, N.Y. TIMES (Jan. 20, 2012), <http://www.nytimes.com/2012/01/20/world/asia/ethnic-war-with-kachin-intensifies-in-myanmar-jeopardizing-united-states-ties.html>.

⁷ A group of human rights experts have sought to clarify extraterritorial obligations. *Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights* (2011), http://www.humanrights.ch/upload/pdf/120111_Maastricht_ETO_Principles_-_FINAL.pdf [hereinafter *Maastricht Principles*]. While an important advance, even these principles, interpreting existing law, provide little guidance on such critical questions of the level of international assistance states are obliged to provide.

is insufficient to prevent the majority of these avoidable deaths.

Very few international law regimes are directed primarily toward the main causes of avoidable sickness, injury, and premature death. The two major World Health Organization (WHO) treaties—the International Health Regulations (IHR)⁸ and the Framework Convention on Tobacco Control (FCTC)⁹—have the potential to save millions of lives. The IHR is devoted to public health emergencies of international concern, such as a novel strand of influenza. This treaty, however, does not reach the major causes of illness and premature death, such as enduring infectious diseases (e.g., AIDS, malaria, and tuberculosis) or chronic non-communicable diseases (e.g., cancer, cardiovascular disease, diabetes, and respiratory disease). The FCTC's focus on tobacco use is certainly directed towards a major cause of preventable illnesses and death. Yet, it uniquely benefits from the nearly universal aversion to unethical tobacco company practices. Moreover, both treaties lack strong accountability regimes and robust mechanisms that would be necessary for effectively enhancing the capacities of developing countries to respond to public health emergencies and enforce tobacco control measures.

Aside from international health law, including the WHO's constitution, international regimes are remarkable primarily for their silence on matters of population health and safety. It is not that international law is powerless to improve human health and well-being. Wealthier countries with strong public health regulation have made considerable progress over the past several decades in reducing child and maternal mortality and combating AIDS and malaria.¹⁰ Concerted national and international efforts have led to significant declines in maternal and child deaths and have brought life-saving medicine to millions of people living with HIV/AIDS.¹¹ These experiences confirm that societal action—either influenced or directed through law—can dramatically reduce illness, suffering, and premature death. International law has significant, yet largely untapped, potential to extend the benefits of good health to people in all countries, with dramatic improvements in health for those who live in the poorest countries and communities.

This Article offers an innovative framework for clarifying national and

8 WHO, *Revision of the International Health Regulations*, WHA Doc. WHA58.3 (May 23, 2005).

9 WHO Framework Convention on Tobacco Control, Feb. 27, 2005, 2302 U.N.T.S. 166 [hereinafter F.C.T.C.], available at http://www.who.int/fctc/signatories_parties/en/index.html.

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

11 Maternal deaths fell from 543,000 in 1990 to 287,000 in 2010 and child deaths from 12 million in 1990 to 6.9 million in 2010. *Levels and Trends in Child Mortality*, *supra* note 1, at 9; *Trends in Maternal Mortality*, *supra* note 1, at 25. More than 8 million people in low- and middle-income countries were receiving AIDS treatment by the end of 2011. *Together We Will End AIDS*, UNAIDS 18 (2012), http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/20120718_togetherwewillendaids_en.pdf.

global responsibilities to ensure the right to health by reducing global and national health inequities. It explains a proposal to codify these obligations and create accountability for their effective implementation by describing the potential for a new legal instrument—a Framework Convention on Global Health (FCGH).¹² Our goal is to show the potential of international law to markedly transform prospects for good health, particularly for the world’s most disadvantaged people.

Part I begins by describing the major causes of injury, disease, and premature death and demonstrating their disproportionately high levels among the poor—both globally and nationally. Part II then discusses extant global health law and governance: the rules, norms, institutions, and processes that shape the health of the world’s population. It explains why current global health governance is deeply inadequate to the task of resolving these inequities.¹³ Section I.A lays out seven challenges of global governance for health that underlie this inadequacy. The main purpose of the FCGH would be to reshape global governance for health to redress the unequal burdens of suffering, disease, and early death among the world’s poor.

Next, Part III argues that human rights law is the best conceptual and practical framework to underpin the international community’s solution to these health inequities by reconceptualizing health aid as a protection of the essential human right, rather than the provision of charity. To be sure, human rights law has significant structural flaws. It lacks hard standards or effective compliance mechanisms and relies on the vague “progressive realization” principle behind socioeconomic rights.¹⁴ Nevertheless, human rights law is uniquely positioned to

12 In this Article, we develop the idea of a Framework Convention on Global Health (FCGH) originally proposed in 2008, discussing in detail the elements of such a treaty as well as its value to national and global health. See Lawrence O. Gostin, *Meeting Basic Survival Needs of The World’s Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO L.J. 331 (2008) [hereinafter *Meeting Basic Survival Needs*]. Since 2010, the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) has advanced the Convention as a realistic global health strategy. See Lawrence O. Gostin et al., *The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health*, 8 PLOS MED. E1001031 (May 2011) [hereinafter *Joint Action and Learning Initiative*]; Lawrence O. Gostin et al., *The Joint Action and Learning Initiative on National and Global Responsibilities for Health*, World Health Report, WORLD HEALTH ORG. (2010), http://www.who.int/entity/healthsystems/topics/financing/healthreport/JALI_No53.pdf [hereinafter *JALI World Health Report Background Paper*]; Lawrence O. Gostin et al., *National and Global Responsibilities for Health*, 88 BULL. WORLD HEALTH ORG. 719 (2010) [hereinafter *National and Global Responsibilities for Health*], available at <http://www.who.int/bulletin/volumes/88/10/10-082636/en/>; see also Lawrence O. Gostin, *Redressing the Unconscionable Health Gap: A Global Plan for Justice*, 4 HARV. L. & POL’Y REV. 271 (2010) (proposing a voluntary compact among states and partners in civil society, philanthropy, and business to reduce global health inequities).

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

14 *JALI/Framework Convention on Global Health: Preliminary Answers to 5 Priority Questions*, JOINT ACTION & LEARNING INITIATIVE ON NAT’L & GLOBAL RESPS. FOR HEALTH (2012),

advance global health justice, given its universal acceptance, along with its emphasis on equality and accountability.

Part IV explores four fundamental questions to clarify national and international responsibilities under the human right to health and offers preliminary answers to these questions.¹⁵ These questions define the future of global health:

(1) *What are the health services and goods guaranteed to every human being under the right to health?* We will argue that everyone is entitled to the conditions required to be healthy. This entails well-functioning health systems, underlying determinants of health such as nutritious food, clean water, and adequate sanitation, and broader socioeconomic determinants of health, such as employment and gender equity.

(2) *What do states owe for the health of their own populations?* States must allocate adequate funding to health. The critical question is how much. They must simultaneously maintain good governance and a focus on equity to ensure that these funds are used properly.

(3) *What responsibility do states have for improving the health of people beyond their borders?* We argue that general principles related to international cooperation and assistance must be more robust. More precise funding requirements should be based on a shared responsibility to achieving human rights and directly assuring everyone healthy conditions, with an emphasis on the least well-off. Beyond funding, states must articulate coherent policies regarding the right to health, such that actions outside the health sector do not undermine the right to health.

(4) *What kind of global governance mechanisms are required to guarantee that all states live up to their mutual responsibilities to provide health goods and services to all people?* Governance mechanisms will need to embody principles of the right to health, such as equity and accountability, while addressing problems such as poor coordination, unpredictable funding, lack of enforcement, and inadequate global health leadership in other legal regimes. We will propose some possibilities to overcome these challenges.

The answers to these four questions promise markedly improved health outcomes and reduced health inequalities, which will occur if all people enjoy the conditions required to be healthy. Such a world can be ours if states meet their responsibilities both to their own populations and to people beyond national borders, with governance structures designed to hold states accountable to meeting their responsibilities and facilitating their ability to do so. Finally, we explain the idea of the FCGH, showing how it could drive national and global

<http://www.jalihealth.org/>.

¹⁵ These questions were developed at a meeting in Oslo, Norway, in March 2010, hosted by the Norwegian Directorate of Health. At this meeting, JALI was formed and attendees were called to explore the idea of an FCGH.

policies with respect to these four questions. The Convention would establish the norms, monitoring, and accountability necessary to improve health for all and significantly narrow health inequities.

I. THE IMPOVERISHED STATE OF WORLD HEALTH

Basic human needs continue to go unmet for the world's poorest people. In 2010, 780 million people lacked access to clean water and 2.5 billion people were without access to proper sanitation facilities, while approximately 870 million people faced chronic hunger.¹⁶ Despite United Nations' Millennium Development Goal (MDG) pledges to enable more people to meet these basic needs, these statistics represent more hungry people than in the 1990 benchmark year of the MDGs. (Although, the proportion of people suffering from hunger has decreased very modestly.)¹⁷

Even with notable health improvements in a number of areas in the past several decades, deep inequities—unfair inequalities¹⁸—and millions of preventable deaths persist. The depth of inequity is two-fold, with overwhelming numbers of preventable deaths in poorer countries and the poor and marginalized within these countries suffering most. With the happenstance of one's birth still the greatest determinant of health, the current state of the world is one of deep global health injustice.

A. Child and Maternal Health

Progress in reducing child and maternal deaths over the past decades has been significant. But with millions of preventable deaths that continue to occur annually—overwhelmingly in poorer countries—such progress is still deeply inadequate. Since 1970, the mortality rate for children under five has declined by

¹⁶ *Progress on Drinking Water and Sanitation: 2012 Update*, WORLD HEALTH ORG. (2012), http://www.who.int/water_sanitation_health/publications/2012/jmp_report/en/index.html; *The State of Food Insecurity in the World 2012*, FOOD & AGRIC. ORG. (2012), <http://www.fao.org/docrep/016/i3027e/i3027e.pdf> (providing projects for 2010-2012).

¹⁷ In 1990-1992, the Millennium Development Goal on halving the proportion of people suffering from hunger by 2015 used the official baseline measurement of 828 million people suffering from hunger. U.N., THE MILLENNIUM DEVELOPMENT GOALS REPORT 2011, at 11 (2011), available at http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf.

¹⁸ Health inequities are unfair differences in health. For example, some people have better health than others because of different socioeconomic positions. We use the term “inequity,” rather than “inequality,” because lack of full health equality might not be unfair. Consider, for instance, the case when hospitals are not as close to people in far-flung rural areas compared to those individuals who live in in urban areas. Moreover, ending health disparities might not always be medically feasible. For example, there are differences in life expectancy for people born healthy compared to those born with certain severe genetic illnesses. For more on the meaning of health equity, see Paula Braveman & Sofia Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & COMMUNITY HEALTH 254 (2003).

60%;¹⁹ yet too many parents still grieve over undersized coffins. Nearly 7 million children under the age of five died in 2011, including almost 3 million in their first month of life.²⁰ There are gaping inequities: 33.9% of child mortality occurs in Southern Asia and 48.7% occurs in sub-Saharan Africa, while only 1.4% of deaths occur in high-income countries.²¹ Relatively simple and inexpensive interventions such as child nutrition, clean water, basic medications and treatments, and vector control²² would avert most of these deaths.

Like their children, mothers too face intolerable risks, including the risk of dying in childbirth. Maternal mortality has dropped, from 543,000 in 1990 to 287,000 in 2010. However, the improvements mask extreme variations across and within countries and regions. The overwhelming majority of these deaths—around 99%—occur in developing countries,²³ where there are vast inequalities of access to obstetric care within countries. In Southern Asia, for example, women in the top wealth quintile are almost five times more likely to be attended by a skilled health worker than women in the poorest quintile.²⁴

The aggregate improvements are largely attributable to skilled childbirth attendants and emergency obstetric services; coverage has increased in many countries, thanks to growing funds and greater understanding of what it takes to save mothers' lives.²⁵ Skilled birth attendants with back-up care, as well as

19 Julie Knoll Rajaratnam et al., *Neonatal, Postneonatal, Childhood, and Under-5 Mortality for 187 Countries, 1970-2010: A Systematic Analysis of Progress Towards Millennium Development Goal 4*, 375 LANCET 1988 (2010).

20 See *Levels and Trends in Child Mortality*, *supra* note 1, at 9 (reporting 6.9 million deaths of children under 5 in 2011); *id.* at 12 (reporting nearly 3.0 million neonatal deaths). Infections, complications from premature birth, and asphyxia are the main causes of death for children who die in their first month. Overall, infectious diseases, including pneumonia, diarrheal diseases, and malaria, are responsible for approximately two-thirds of deaths of children. Robert E. Black et al., *Global, Regional, and National Causes of Child Mortality in 2008: A Systematic Analysis*, 375 LANCET 1969 (2010).

21 See *Levels and Trends in Child Mortality*, *supra* note 1, at 10. Our use of country income groupings—high-, middle-, and low-income—is based on World Bank classifications. See *Country and Lending Groups*, WORLD BANK, <http://data.worldbank.org/about/country-classifications/country-and-lending-groups> (last visited Nov. 29, 2012).

22 Vector control refers to methods to reduce disease-carrying animals (“vectors”), such as mosquitoes.

23 *Trends in Maternal Mortality*, *supra* note 1, at 19. For every maternal death, approximately twenty to thirty women suffer severe complications from pregnancy and childbirth, including acute and long-term disabilities. *Safe Motherhood*, U.N.F.P.A., <http://www.unfpa.org/public/mothers/> (last visited Nov. 29, 2010) (reporting that “for every woman who dies, 20 or more experience serious complications”); *Constraints to Scaling Up and Costs*, WORLD HEALTH ORG. & WORLD BANK WORKING GROUP 1, at 11 (2009), http://www.who.int/pmnch/media/membernews/2009/htltf_wg1_report_EN.pdf [hereinafter WORKING GROUP 1] (“For every woman who dies in childbirth, around 30 suffer short- or long-term consequences including a broad range of acute and long-term disabilities.”).

24 *Progress for Children: Achieving the MDGs with Equity*, UNICEF 27 (2010), http://www.unicef.org/publications/files/Progress_for_Children-No.9_EN_081710.pdf.

25 *Trends in Maternal Mortality*, *supra* note 1, at 27-28; *World Health Report 2005—Make*

inexpensive interventions such as the drug misoprostol, could prevent most of this death, disability, and suffering.

B. Infectious Diseases

Infectious diseases continue to cause millions of deaths in developing countries, while also posing threats to every region of the world. More than 3 million people die annually from AIDS, tuberculosis, and malaria.²⁶ The global incidence of HIV is falling, and there have been real improvements in access to anti-retroviral therapy. More than 8 million people in developing countries were on anti-retroviral medication by the end of 2011.²⁷ Yet, nearly 7 million people in need of treatment were still not receiving it.²⁸ Moreover, for every person who enters treatment each year, nearly two become newly infected.²⁹

Some of the greatest global health successes in recent years have been against malaria. According to the WHO, malaria deaths fell from 810,000 in 2004 to 655,000 in 2010,³⁰ with forty-three countries reducing disease incidence by more than half over the past decade.³¹ Still, malaria persists as a leading cause of death for children in Africa.³² Climate change, coupled with growing resistance to anti-malaria medications, pose major threats to sustaining progress over the long term, although a vaccine may be launched for children in Africa by 2015.³³

Every Mother and Child Count, WORLD HEALTH ORG. (2005), <http://www.who.int/whr/2005/en/index.html>.

26 *The Global AIDS Epidemic – Key Facts*, UNAIDS 1 (2012), http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf (reporting 1.7 million AIDS deaths in 2011); *Global Tuberculosis Report 2012*, WORLD HEALTH ORG. 17 (2012), http://www.who.int/tb/publications/global_report/en/ (reporting 990,000 tuberculosis deaths in 2011, excluding 430,000 deaths from tuberculosis among HIV-positive people, as these are classified among HIV/AIDS deaths); *World Malaria Report 2011*, WORLD HEALTH ORG. 74 (2011), http://www.who.int/malaria/world_malaria_report_2011/en/index.html (reporting 655,000 malaria deaths in 2010).

27 *Together We Will End AIDS*, *supra* note 11, at 18. The number of people in sub-Saharan Africa receiving anti-retroviral therapy to treat AIDS increased approximately 100-fold from 2000 through 2010. In 2000, about 50,000 people in sub-Saharan Africa were receiving anti-retroviral therapy. This number grew to 6.2 million by the end of 2011, including an increase of more than 1 million during 2011 alone. *Id.* at 20.

28 *The Global AIDS Epidemic – Key Facts*, *supra* note 26, at 1.

29 In 2011, 1.4 million additional people received AIDS treatment, compared to 2.5 million new HIV infections. *Id.*

30 *World Malaria Report 2011*, *supra* note 26, at 74. A new study questions these figures, finding higher rates of malaria, particularly among older children and adults, with total malaria deaths peaking at 1.82 million in 2004 and then falling to 1.24 million in 2010. Christopher J.L. Murray et al., *Global Malaria Mortality Between 1980 and 2010: A Systematic Analysis*, 379 LANCET 413, 421 (2012).

31 *World Malaria Report 2011*, *supra* note 26, at ix.

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

33 Nicholas J. White, Editorial, *A Vaccine for Malaria*, 365 NEW ENG. J. MED 1926 (2011).

There also has been progress against tuberculosis (TB), with a 41% reduction in mortality since 1990. Still, 1.4 million people died from tuberculosis in 2011, including people infected with HIV.³⁴ Multi-drug-resistant (MDR) TB, especially in the former Soviet Union, and the particularly pernicious, extensively drug-resistant (XDR) TB threaten tuberculosis control.

Neglected tropical diseases (NTDs), meanwhile, are infectious diseases that thrive in impoverished settings. There are seventeen in all, including Chagas disease, trachoma, leprosy, schistosomiasis, lymphatic filariasis, and dengue. NTDs are often transmitted by insects or the eggs of worms and infect more than 1 billion people annually, killing more than half a million people each year.³⁵ Beyond early death, these diseases of poverty cause great pain and physical anguish, for example, when filarial worms cause disfiguring enlargement of the arms, legs, breasts, and genitals (elephantiasis), or river blindness leading to unbearable itching and loss of eyesight. Sufferers are often tormented by social stigmatization for the rest of their lives. Diseases of poverty exacerbate the cycle of poverty, decreasing earning capacity and economic productivity.³⁶

In addition, emerging infectious diseases, such as SARS and novel influenza strains (e.g., H1N1 and H5N1), which are universally threatening, pose a disproportionate risk to people in developing countries. The health systems in poorer countries are least prepared to detect and contain these emerging health dangers. And absent a global agreement on sharing the vaccines and medications needed to prevent and treat them, people in developing countries are last in line for these essential medical technologies.³⁷

34 *Global Tuberculosis Report* 2012, *supra* note 26, at 17. This represents little change in the absolute number of deaths from tuberculosis since 1990. *See id.* at 12 fig. 2.4. There are 8.7 million new cases of tuberculosis in 2011, 85% of which were in Asia (56%) and Africa (29%). Global incident rates were steady during the 1990s, but began to fall in 2001. In absolute terms, while the number of new HIV infections had begun to fall since peaking in the early 2000s, today's annual incidence is still higher than in 1990. *Id.* at 9, 11, 12 fig. 2.4. HIV, which makes individuals susceptible to tuberculosis, factors heavily in the tuberculosis epidemic, particularly in sub-Saharan Africa, where in 2011, 39% of people with tuberculosis were co-infected with HIV. *Id.* at 11.

35 *Neglected Tropical Diseases, Hidden Successes, Emerging Opportunities*, WORLD HEALTH ORG. ii-iii (2009), http://whqlibdoc.who.int/publications/2009/9789241598705_eng.pdf.

36 *Neglected Diseases: The Diseases of Poverty*, PAN AM. HEALTH ORG., <http://www.paho.org/english/ad/dpc/cd/psit-nd-poster.pdf> (last visited Nov. 29, 2012); Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Mission to Uganda*, Comm'n on Human Rights, U.N. Doc. E/CN.4/2006/48/Add.2 (Jan. 19, 2006) (by Paul Hunt) (reporting that neglected tropical diseases "cause immense suffering and lifelong disabilities among the poorest populations ... [contributing] to the entrenched cycle of poverty, ill health, stigmatization and discrimination experienced by neglected populations").

37 The WHO's *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits* offers some limited access to novel influenza vaccines. *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits*, WHA Doc. WHA64.5 (May 24, 2011) [hereinafter *Pandemic Influenza Preparedness Framework*], available at http://apps.who.int/gb/ebwha/pdf_files/

C. Non-Communicable Diseases

The terrible toll of infectious diseases has overshadowed a fast growing rate of non-communicable diseases (NCDs), which are an even more substantial cause of morbidity and premature mortality in low-income and middle-income countries. NCDs include cardiovascular disease, stroke, cancer, diabetes, chronic respiratory diseases, and mental disabilities. Though often thought to primarily affect people in wealthy countries, recent statistics tell a different story. In 2005, 80% of deaths from NCDs occurred in developing countries.³⁸ The epidemiologic transition, from infections to non-communicable diseases as the greatest killers, is unmistakable. NCDs are on track to cause 70% of all deaths in developing countries by 2020.³⁹ The poor already die at higher rates than the wealthy—from cancer especially—due to vastly inferior early detection and treatment.⁴⁰

These rising numbers have become too daunting and disconcerting to ignore. In September 2011, the United Nations General Assembly held a high-level summit,⁴¹ adopting a Political Declaration on the Prevention and Control of NCDs.⁴² This was only the second health issue that a high-level United Nations summit has addressed. The other was HIV/AIDS, where a 2001 summit transformed the global response to the AIDS pandemic. The NCD Summit, while vital in raising the political profile of NCDs, thus far has not mobilized a global response comparable to AIDS.

WHA64/A64_R5-en.pdf. However, it is a highly limited vehicle for sharing vaccines and essential medicines in a global health emergency. David P. Fidler & Lawrence O. Gostin, *The WHO Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health*, 306 JAMA 200 (2011).

38 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, WORLD HEALTH ORG. (2008), http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf.

39 Abdesslam Boutayeb & Saber Boutayeb, *The Burden of Non Communicable Diseases in Developing Countries*, 4 INT'L J. FOR EQUITY IN HEALTH (2005), <http://www.equityhealthj.com/content/pdf/1475-9276-4-2.pdf>.

40 Tan Ee Lyn, *Developing Nations to Bear Cancer Brunt*, REUTERS (Aug. 19, 2010), <http://www.reuters.com/article/2010/08/19/us-cancer-preparedness-developing-idUSTRE6711GT20100819>. For example, more than 80% of the 274,000 annual cervical cancer deaths worldwide occur in developing countries. Dylan Neel, *An Exercise in Economics: Cervical Cancer Prevention in the Developing World*, HARV. COLLEGE GLOBAL HEALTH REV. (Nov. 15, 2011), <http://www.hcs.harvard.edu/hghr/online/cervical-cancer-prevention/>.

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

42 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, G.A. Res. 66/2, U.N. Doc. A/RES/66/2 [hereinafter Political Declaration on Non-communicable Diseases], available at http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf.

D. Mental Disabilities

One category of NCDs has been particularly marginalized: mental illness. This category of diseases was not even part of the agenda of the NCD Summit.⁴³ Yet unipolar depression alone was the third largest contributor to the global burden of disease in 2004,⁴⁴ and is expected to become the largest contributor to the global burden of disease by 2030.⁴⁵ Most of the burden of depression, bipolar disorder, schizophrenia, and other mental illnesses falls on people in low-income and lower-middle income countries, where nearly three-quarters of the global burden of psychiatric disorders is felt. More than 75% of people in developing countries have no access to mental health treatment, in part due to an extreme paucity of mental health workers.⁴⁶

The human rights violations against persons with mental disabilities are historic and enduring. Under official state policy, mentally ill persons may be committed to isolated and abusive institutions, or they may lose civil and political rights such as voting, driving, and managing personal and financial affairs. Popular culture marginalizes the mentally ill through society's deep stigma, fear of dangerousness, and discrimination.⁴⁷

43 Priya Shetty, *Mental health a forgotten problem*, SciDEV.NET (Oct. 19, 2010), <http://www.scidev.net/en/opinions/biomed-analysis-mental-health-a-forgotten-problem-1.html>; Angelina Wilson & Emily Fisher, *The "Missing Story" on Mental Health during the UN-High Level Summit on Non-Communicable Diseases*, IUHPE STUDENT AND EARLY CAREER NETWORK (Nov. 2, 2012), <http://iisecr.org/2011/11/02/the-missing-story-on-mental-health-during-the-un-high-level-summit-on-non-communicable-diseases/>.

44 *The Global Burden of Disease: 2004 Update*, WORLD HEALTH ORG. 43 tbl. 12 (2008), http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html.

45 *Depression: A Global Crisis*, WORLD FEDERATION FOR MENTAL HEALTH 14 (Oct. 10, 2012) available at <http://www.wfmh.org/2012DOCS/WMHDAY%202012%20SMALL%20FILE%20FINAL.pdf>. Depression leads to approximately 1 million suicides annually. *Depression: Fact sheet No. 269*, WORLD HEALTH ORG. (Oct. 2012), <http://www.who.int/mediacentre/factsheets/fs369/en/index.html>.

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

47 Civil society and human rights courts have documented inhuman and degrading treatment in psychiatric institutions, prisons, homeless shelters, and even group homes. DISABILITY RIGHTS INTERNATIONAL, TORTURE NOT TREATMENT: ELECTRIC SHOCK AND LONG-TERM RESTRAINT IN THE UNITED STATES ON CHILDREN AND ADULTS WITH DISABILITIES AT THE JUDGE ROTENBERG CENTER (2010); Lance Gable & Lawrence O. Gostin, *Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights*, in PRINCIPLES OF MENTAL HEALTH LAW AND POLICY 103 (Lawrence O. Gostin et al. eds., 2010); Lawrence O. Gostin, 'Old' and 'New' Institutions for Persons with Mental Illness: Treatment, Punishment, or Preventive Confinement?, 122 PUB. HEALTH 906 (2008).

E. Injuries

The health impact of injuries in developing countries is also frequently overlooked. More than 90% of deaths from unintentional injuries occur in low-income and middle-income countries.⁴⁸ Poverty heightens the risk of injury in myriad ways: for example, through unsafe working conditions, uncovered wells leading to drowning, the use of open fires for cooking, and the use of kerosene or paraffin lamps, which can easily be knocked over and ignited.⁴⁹ It also correlates with increased injuries resulting from poorly designed roads, defective motor vehicles, lack of safety equipment, inadequately enforced traffic safety laws, and chaotic traffic. Although low-income and middle-income countries have only 48% of the world's registered vehicles, they experience over 90% of traffic fatalities.⁵⁰ Injuries are a major public health problem, which are amenable to cost-effective prevention strategies given the resources and political will.

F. Climate Change

Even as greenhouse gas emission levels are increasing to the point where 2010 emissions exceeded the worst-case scenario according to estimates made in 2007 by the Intergovernmental Panel on Climate Change,⁵¹ climate change already exacts a grim toll. It causes 300,000 deaths annually⁵² and is projected to substantially exacerbate health hazards in the coming decades. Although climate change will affect the entire world, it will impose vastly disproportionate burdens on low-income and middle-income countries.⁵³ Poorer countries are

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

49 See, e.g., *Drowning: Fact sheet No. 347*, WORLD HEALTH ORG., (Oct. 2012) <http://www.who.int/mediacentre/factsheets/fs347/en/index.html> (stating that 96% of the 388,000 deaths in 2004 from drowning occur in low- and middle-income countries); *Stamping Out Tin Kerosene Lamps in Kenya*, TIEDMANN GLOBE. (Jan. 31, 2011), <http://tiedemanglobe.com/blog/2011/1/31> (citing example of children dying in a fire in Kenya caused by a kerosene lamp).

50 WORLD HEALTH ORG., *GLOBAL STATUS REPORT ON ROAD SAFETY: TIME FOR ACTION* (2009). The cited statistics are based primarily on data from 2007.

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

52 John Vidal, *Global Warming Causes 300,000 Deaths a Year, Says Kofi Annan Thinktank*, GUARDIAN (May 29, 2009), <http://www.guardian.co.uk/environment/2009/may/29/1>. The WHO's estimate is more conservative. *Climate change and health: Fact sheet No. 266*, WORLD HEALTH ORG. (Oct. 2012), <http://www.who.int/mediacentre/factsheets/fs266/en/index.html> ("Global warming that has occurred since the 1970s caused over 140,000 excess deaths annually by the year 2004.").

53 *Climate Change: Impacts, Vulnerabilities and Adaptation in Developing Countries*, U.N. FRAMEWORK CONVENTION ON CLIMATE CHANGE (2007), <http://unfccc.int/resource/docs/publications/impacts.pdf>.

predominately located in warmer climates that will only become more extreme. Furthermore, lower-income countries have fewer resources with which to adapt to changing climatic conditions, such as by erecting flood barriers, sanitizing drinking water, and delivering emergency services.

As the climate changes and air temperatures rise, the intensity and range of climate-sensitive diseases, such as malaria and dengue, will increase. Changes to rain patterns, along with rising sea levels, will affect the supply of food and clean water, leading to increased hunger and waterborne diseases such as diarrhea and cholera. Extreme weather events will kill both directly and indirectly, by causing droughts and floods that destroy crops, reduce biodiversity, contaminate water sources, displace people, and expand habitats for mosquitoes. Models indicate that some of the world's poorest regions, in southern Africa and south Asia, will experience reductions of staple food crops of 10% to 30% by 2030.⁵⁴ Climate change will also degrade air quality and cause severe heat waves, contributing to cardiovascular and respiratory illnesses.⁵⁵ Further, the stress, trauma, and displacement wrought by climate change can lead to mental illness, particularly post-traumatic stress disorder, and may contribute to other mental illness and psychological suffering.⁵⁶

G. National Health Disparities

Aggregate figures of the disabilities, diseases, and early deaths that continue to burden the world's poorer regions should not mask the disparities within these regions, and the extra burdens faced by poor and other disadvantaged populations, such as indigenous peoples and persons with disabilities. In Nairobi, Kenya, for example, the death rate for children under five in the worst-off slums is many times the rate in the wealthiest neighborhoods.⁵⁷ In thirty-eight countries containing the highest levels of maternal mortality, more than 80% of women are attended by skilled health personnel, compared to a mere 30% for women in the poorest quintile.⁵⁸ The disparities are far worse in some countries.⁵⁹

⁵⁴ *Climate Could Devastate Crops*, BBC NEWS (Jan. 31, 2008), <http://news.bbc.co.uk/2/hi/science/nature/7220807.stm>.

⁵⁵ See *Redressing the Unconscionable Health Gap*, *supra* note 12, at 271–94.

⁵⁶ Helen Louise Barry et al., *Climate Change and Mental Health: A Causal Pathways Framework*, 55 INT'L J. OF PUB. HEALTH 123 (2010).

⁵⁷ Neil MacFarquhar, *Wider Disparity in Life Expectancy is Found Between Rich and Poor*, N.Y. TIMES (Oct. 17, 2008), http://www.nytimes.com/2008/10/17/world/17briefs-WIDERDISPARI_BRF.html; *World Health Report 2008 – Primary Health Care (Now More Than Ever)*, WORLD HEALTH ORG. (2008), <http://www.who.int/whr/2008/en/index.html> [hereinafter *WORLD HEALTH REPORT 2008*]. *Population and Health Dynamics in Nairobi's Informal Settlements*, AFR. POPULATION & HEALTH RES. CENTER (2002), <http://www.aphrc.org/insidepage/page.php?app=downloads&articleid=285>.

⁵⁸ Zulfiqar A. Bhutta et al., *Countdown to 2015 Decade Report (2000-10): Taking Stock of Maternal, Newborn, and Child Survival*, 375 LANCET 2032, 2040 fig. 8 (2010) [hereinafter *Countdown to 2015 Decade Report*].

The yawning health gap, moreover, cannot be understood fully by using the over-simplified division of the world into the global rich and poor. In fact, more than one-third of the largest fortunes in the world are in low- and middle-income countries, with one-quarter of the world's billionaires in Brazil, Russia, India, and China.⁶⁰ In addition, even within wealthy states, dramatic health differences exist that are closely linked with degrees of social disadvantage. The poorest people in Europe and North America often have life expectancies similar to citizens of the least developed countries. A black unemployed youth in Baltimore, Maryland has a lifespan thirty-two years shorter than a white corporate lawyer.⁶¹ Infants born to black women in Pittsburgh, Pennsylvania are five times more likely to die than infants born to white women.⁶² Native Americans on the Pine Ridge Reservation in South Dakota have a life expectancy in the upper forties.⁶³

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. Furthermore, the gap in Brazil between the prevalence of stunting among children in the richest and poorest quintiles shrank from 35-37% in 1989 to 5-7% in 2007.⁶⁴ Brazil's accomplishments, along with many other successes throughout the developing world, demonstrate that the extreme level of avoidable death and disease in developing countries is just that—avoidable. Effective interventions exist, but many of the world's poor cannot access them.

59 In West and Central Africa, a woman in the top income quintile is three-and-a-half times more likely to have her birth attended by a skilled health worker than a woman in the lowest income quintile. In Nigeria, skilled health workers cover 84% of births for women in the highest quintile, compared to 12% for women in the lowest quintile. *Progress for Children: A Report Card for Maternal Mortality*, No. 7, UNICEF 16 (2008), http://www.unicef.org/publications/files/Progress_for_Children-No._7_Lo-Res_082008.pdf.

60 WalletPop Staff, *Forbes: The Richest People in the World 2011*, DAILYFINANCE (Mar. 9, 2011), <http://www.dailyfinance.com/2011/03/09/forbes-the-richest-people-in-the-world-2011/>. Among the top 100 wealthiest people on the 2011 *Forbes* list of the world's billionaires, 37 were from low- and middle-income countries, primarily from countries that the World Bank classifies as upper middle-income, namely Brazil (4), Chile (3), China (1), Colombia (2), Malaysia (2), Mexico (4), and Russia (13). Others were from India (4), Nigeria (1), and Ukraine (1). *The World's Billionaires*, FORBES (Mar. 9, 2011), <http://www.forbes.com/wealth/billionaires/list>; *World Bank List of Economies (Jul. 2011)*, WORLD BANK, <http://siteresources.worldbank.org/DATASTATISTICS/Resources/CLASS.XLS> (last visited Dec. 5, 2012).

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

62 In Pittsburgh, infant mortality among African-Americans was 20.7 in 2009, compared to 4.0 for white infants. Timothy Williams, *Tackling High Infant Mortality Rates Among Blacks*, N.Y. TIMES, Oct. 14, 2011, at A10.

63 Nicholas D. Kristof, *Poverty's Poster Child*, N.Y. TIMES (May 9, 2012), <http://www.nytimes.com/2012/05/10/opinion/kristof-povertys-poster-child.html>.

64 *Countdown to 2015 Decade Report*, *supra* note 58, at 2040–41.

II. PROSPECTS FOR A PERMANENT UNDERCLASS IN HEALTH: THE IMPERATIVES OF SUSTAINABLE FUNDING, GOOD GOVERNANCE, AND INTERNATIONAL LEGAL OBLIGATIONS

A. *The Risk of a Persisting Global Health Underclass*

Progress over the past several decades demonstrates that the world has the collective knowledge to dramatically improve health, even in the poorest settings. What, then, is our fear? Why do we advance a new treaty and major innovations in how health is governed even as the world has mobilized to treat millions of people living with AIDS and some of the most egregious markers of health inequities are falling rapidly?

We do so because, despite real progress, we cannot be confident that current arrangements are attuned to global health justice. We have several abiding concerns that lead to the conclusion that the world must pave a new path towards global health justice.

First, even today's progress is unnecessarily slow, meaning millions of lives needlessly cut short and vast human potential lost. We will examine several reasons for this below. Important evidence of lost opportunities to save lives comes from the widely differing levels of progress across countries. Although progress in some countries has been impressive, populations in other countries suffer and die young, much as before. For example, while some countries are on track to achieve the MDGs on maternal⁶⁵ and child health,⁶⁶ others have made scant progress. National efforts towards universal access to AIDS treatment similarly vary.⁶⁷

65 Among countries on or nearly on track for achieving the maternal mortality target in the Millennium Development Goals are China (70% reduction in maternal mortality ratio from 1990 to 2010), Equatorial Guinea (81% reduction), Eritrea (73% reduction), and Vietnam (76% reduction). Among those that have experienced little or no progress from 1990 to 2008 are the Central African Republic (4% reduction), Kenya (9% decrease), Lesotho (19% increase), Somalia (15% increase), South Africa (21% increase), Sudan (27% decrease), Zambia (7% decrease), and Zimbabwe (28% increase). See TRENDS IN MATERNAL MORTALITY, *supra* note 1, at 37-45.

66 Countries in Asia making significant progress in reducing child mortality include China (where child mortality decreased from 39.6 out of 1,000 to 15.4 out of 1,000 from 1990 to 2010) and Vietnam (decrease of 46.3 out of 1,000 to 12.9 out of 1,000), with lesser improvements in Afghanistan (163.5 out of 1,000 to 121.3 out of 1,000) and Pakistan (113.3 out of 1,000 to 80.3 out of 1,000). Among countries in Southern and Central Africa with little or no progress in reducing child mortality during this timeframe were Equatorial Guinea (178.7 out of 1,000 to 180.1 out of 1,000), Congo (109.4 out of 1,000 to 107.5 out of 1,000), Swaziland (73.7 out of 1,000 to 101.2 out of 1,000), and Zimbabwe (73.3 out of 1,000 to 70.4 out of 1,000), with levels in many countries elsewhere in Africa remaining astronomical in 2010 (such as 168.7 out of 1,000 in Chad, 161.1 in Niger, and 157.0 out of 1,000 in Nigeria), even with reductions of the past decades. See Rajaratnam, *supra* note 19, at 1992-96.

67 Some countries, such as the Democratic Republic of Congo and Ukraine, provide antiretroviral therapy to less than 20% of their HIV-infected population in the most immediate need

This points to a second concern. Are we seeing the creation of a permanent global health underclass of poor and marginalized people? This could include both disadvantaged populations within better-off countries along with the vast majority of people in worse-off countries, those where factors such as poor governance, lack of political will, and inadequate funding threatens generations still to come with profound ill health. This health underclass might reside in any country, from the Native Americans of the Pine Ridge Reservation in the United States to slum dwellers, the rural poor, people with disabilities, and other disregarded people in the poorest—and wealthiest—countries of Africa. If even the richest countries have such pronounced health inequalities, will there persist into the indefinite future untold hundreds of millions of people whose broken lives are hidden behind significant aggregate improvements?

Several factors heighten the risk of long-persisting ill health for poor and marginalized populations. First, health improvements are often greater for wealthier than poor populations, as for child health. Second, inequality within countries is growing, exacerbating the levels and effects of health inequities.⁶⁸ Third, progress in some areas stands in sharp contrast to others. Maternal and child health are improving, but NCDs in developing countries are fast rising. Disproportionate burdens among the poor for this set of diseases risk replicating present inequities and becoming entrenched. Future threats present similar risks. Will another virus with the force of HIV emerge and again cause millions of deaths in the poorest parts of the world before an adequate global response? Will the pattern of death from a novel influenza virus replicate global and national inequities?

Meanwhile, present gains are not secure, with three global crises already beginning to bear down on us: climate change, food, and finance. Will climate change combined with growing global demand for food contribute to the type of jumps in food price we saw in 2007-2008,⁶⁹ only more frequently and persistently, with dire consequences? Will countries meet these new, complex health threats, or will the threats become a reality and further compound global health inequities?

The questions on present gains and further progress continue. Will there be

of treatment, while coverage in Botswana and Rwanda, among others, exceeds 80%. *World AIDS Day Report*, UNAIDS 20 (2011), http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf.

⁶⁸ See, *Born Equal: How Reducing Inequality Could Give Our Children a Better Future*, SAVE THE CHILDREN 15 (2012), http://www.savethechildren.org.uk/sites/default/files/images/Born_Equal.pdf (reporting that across 32 countries surveyed, the gap between the richest and poorest children has grown by 35% since the 1990s).

⁶⁹ FOOD & AGRIC. ORG., *supra* note 16, at 30 (arguing that increased food prices along with the economic downturn contributed to stalled progress in the fight against hunger); see Michael McCarthy, *Global Recession Halts Decades of Steady Progress in Reducing World Hunger*, INDEPENDENT (UK) (Oct. 9, 2012), <http://www.independent.co.uk/news/world/politics/global-recession-halts-decades-of-steady-progress-in-reducing-world-hunger-8204331.html>.

long-term economic retrenchment in wealthy countries struggling with debts and their own growing health care costs, reducing international funding to the poorest countries? Will inadequate funding for research and development mean that the world is ill-prepared to address drug resistance for diseases that are most prevalent among poorer populations?

Finally, we believe that global health has the opportunity to lead the way towards a more just world beyond health. Just as national health systems can either reflect and exacerbate or rebel against and begin to ameliorate inequities,⁷⁰ so too can the global health system. Achieving respect in the realm of health could help empower marginalized populations to effectively assert their rights in other spheres. Better health has very real benefits in other realms, such as education and economic well-being.⁷¹ Moreover, enforceable guarantees of healthy conditions for all could be a step towards broad social protection that encompasses education, social security, and employment. Global health justice can be a foundation for greater global justice.

Present global governance for health, and the law that is its backbone, are inadequate, unable to expeditiously and permanently root out domestic and global health inequities. Global health justice remains in search of its own foundation.

B. Why Extant Global Health Law and Governance for Health Are Insufficient for Global Health Justice

The scope of global health law remains far too narrow to effectively respond to global health inequities. Binding global health law is scarce. Along with the first global health treaty—the WHO Constitution—global health is populated by three major multilateral treaties: (1) two sets of international regulations binding on all WHO members:⁷² the WHO Regulations No. 1 Regarding Nomenclature with Respect to Diseases and Causes of Death (the Nomenclature Rule) and the

⁷⁰ See Lynn P. Freedman et al., *Who's Got the Power? Transforming Health Systems for Women and Children*, U.N. MILLENNIUM PROJECT (2005), http://www.unmillenniumproject.org/reports/tf_health.htm.

⁷¹ See, *Strategic Implications of Global Health*, U.S. NAT'L INTELLIGENCE COUNCIL 10, 23–24 (2008), http://kms1.isn.ethz.ch/serviceengine/Files/ISN/95395/ipublicationdocument_singledocument/a028363c-5843-4c3f-b34a-c4f245faaefb/en/ICA_Global_Health_2008.pdf (connections between health and education, such as the effects of malnutrition on intelligence and poor reproductive health care for girls and the ability to attend school). Another link is that poor health can keep children out of school. Meanwhile, health expenditures thrust 100 million people into poverty every year. *The World Health Report - Health Systems Financing: The Path to Universal Coverage*, WORLD HEALTH ORG. 5 (2010), <http://www.who.int/whr/2010/en/index.html> [hereinafter *World Health Report 2010*].

⁷² Under the WHO Constitution, regulations within the scope of Article 21 are binding on all WHO members unless they inform the WHO Director-General within a limited period of time that they reject them. WHO CONST. arts. 21–22, Apr. 7, 1948, available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

International Health Regulations (IHR); and (2) the first public health convention under article 19 of the WHO Constitution: the Framework Convention on Tobacco Control.⁷³ Binding global health law also encompasses certain stipulations found in other areas of law, such as the right to health and its accompanying obligations, which we discuss below.⁷⁴

The IHR and FCTC demonstrate the potential impact of binding global health law. An independent review found that the “IHR helped make the world better prepared to cope with public-health emergencies.”⁷⁵ Meanwhile, the FCTC has demonstrated great potential for addressing this major preventable cause of premature death. More than 60% of the seventy-two states party to the FCTC for more than five years have increased tobacco taxes and expanded smoke-free public places since ratifying the Convention. Measures that at least one-third of these seventy-two countries have taken include strengthening tobacco product health warnings, protecting public health policies against tobacco industry interference, and prohibiting tobacco industry advertising, promotion, and sponsorship.⁷⁶

International health law demonstrates the potential of hard law to improve global health outcomes. Yet, existing treaties are deeply inadequate for the potent task of reducing global health disparities. The WHO’s review of the IHR also found that there were significant shortcomings in its first test. The 2009 H1N1 influenza pandemic demonstrated that the IHR alone were insufficient to enable the world to effectively respond to a severe pandemic. The IHR and FCTC are flawed because many of their norms lack enforceable standards, they have no concrete accountability provisions, and their norms fail to ensure that developing countries gain the scientific, legal, and technical capacity to safeguard their own population’s health, as well as contribute meaningfully to global health.⁷⁷

⁷³ *Id.* at arts. 19, 21; WHO, *Revision of the International Health Regulations*, WHA58.3 (May 23, 2005); F.C.T.C., *supra* note 9; see Final Act of the International Health Conference (Arrangement concluded by the Governments represented at the Conference and Protocol concerning the Office international d’hygiène publique) (New York, 22 July 1946) 9 U.N.S.T. 3, *entered into force* 20 Oct. 1947 (dissolving the Office International d’Hygiène Publique, whose functions were integrated into the newly established WHO); see also Agreement on the Establishment of the International Vaccine Institute (New York, 28 October 1996) 1979 U.N.T.S. 199, *entered into force* 29 May 1997.

⁷⁴ International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (1966), [hereinafter ICESCR] *available at* <http://www1.umn.edu/humanrts/instatee/b2esc.htm>.

⁷⁵ WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009* W.H.A. DOC. A64/10 (May 5, 2011).

⁷⁶ *Global Implementation of the WHO Framework Convention on Tobacco Control – Progress Note*, WORLD HEALTH ORG. (Sept. 2011), http://www.who.int/fctc/reporting/Progress_note_September2011.pdf.

⁷⁷ WORLD HEALTH ORGANIZATION, *supra* note 75, at 13 (observing that many countries lack the core capacities to detect and respond to potential threats, are not on track to develop these

Perhaps more importantly, these treaties address singular areas of global health—health security from diseases of international health importance (the IHR) and tobacco prevention and control (the FCTC). Neither treaty purports to deal with key determinants of health such as socioeconomic status, sanitation and hygiene, vector abatement, climate change, food security, and as behavioral lifestyles (e.g., nutrition and physical activity) leading to chronic diseases. Nor do they build stronger sustainable health systems or ensure access to essential vaccines and medicines.

Non-binding global health instruments, or “soft law,” are more abundant, including codes (e.g., the Global Code of Practice on the International Recruitment of Health Personnel),⁷⁸ declarations (e.g., the UN Millennium Declaration,⁷⁹ the Declaration of Commitment on HIV/AIDS,⁸⁰ the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases),⁸¹ frameworks (e.g., the Pandemic Influenza Preparedness Framework)⁸² and strategies (e.g., WHO’s Global Strategy on Diet, Physical Activity and Health).⁸³

These instruments are more comprehensive. Yet by their non-binding nature, the possibilities of enforcement and accountability measures are more limited. Moreover, the precision of their norms and responsibilities varies considerably, they rarely include the specific accountability mechanisms, and even the corpus of these instruments includes significant gaps, such as an effective system to share vaccines with poorer countries in the event of a pandemic disease outbreak.⁸⁴ In short, while an important part of global health

capacities by the 2012 deadline, and that the lack of enforceable sanctions is “the most important structural shortcoming of the IHR”); Heather Wipfli et al., *Achieving the Framework Convention on Tobacco Control’s Potential by Investing in National Capacity*, 13 *TOBACCO CONTROL* 433 (2004) (observing that lack of national capacity is a major barrier to implementing the Framework Convention on Tobacco Control and that funding is required to build capacity); *Campaign for Tobacco-Free Kids Promotes WHO International Treaty on Tobacco Control: Grant Report*, CAMPAIGN FOR KIDS FREE TOBACCO (2007), available at <http://www.rwjf.org/reports/grt/042060.htm> (observing that only four of the key measures contained in the Framework Convention on Tobacco Control are obligatory).

78 WHO GLOBAL CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL, WHA Doc. WHA63-16 (May 21, 2010), [hereinafter CODE OF PRACTICE] available at http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf.

79 U.N. Millennium Declaration, G.A. Res. 55/2, U.N. Doc. A/RES/55/2 (Sept. 8, 2000) [hereinafter U.N. MILLENNIUM DECLARATION], available at <http://www.un.org/millennium/declaration/ares552e.htm> (including health and other areas of development, as well as other areas including human rights, peace, and the environment).

80 Declaration of Commitment on HIV/AIDS, G.A. Res. S-26/2, U.N. Doc. A/RES/S-26/2 (June 27, 2001), available at <http://www.un.org/ga/aids/docs/aress262.pdf>.

81 *Political Declaration on Non-communicable Diseases*, *supra* note 42.

82 Pandemic Influenza Preparedness Framework, *supra* note 37.

83 See WHA 51.17, available at http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf (last visited Jan. 16, 2013).

84 The Pandemic Influenza Preparedness Framework takes initial, though insufficient, steps in

law, particularly for establishing norms, these instruments have not been and will not be sufficient for global health justice. A firmer foundation in health law is needed.

Today's shortcomings in global governance for health and persisting inequities demonstrate the insufficiency of current global health law. The world has witnessed a dramatic rise in interest and funding in global health on the part of governments, non-governmental organizations, philanthropists, volunteers, and businesses, often through public-private partnerships.⁸⁵ Yet this unprecedented engagement, despite admirable achievements, has not fundamentally changed the reality for the world's least healthy people. Nor has it significantly closed the health gap between the rich and poor.

A global governance structure—and the laws the underpin it—that can at last make “health for all” a reality will have to respond to at least seven “grand challenges” in global health:

1. Insufficient and Unpredictable Funding

Despite significant growth in domestic and international health investments over the past decade, funding remains insufficient, with risks to future health financing. From 2000 to 2009, per capita government health spending in sub-Saharan Africa more than doubled, from an average of \$15 to \$41 per capita.⁸⁶ International health assistance increased from less than \$6 billion annually in the early 1990s to \$10.5 billion in 2000, and climbed to nearly \$26.9 billion in 2010. In addition, official development assistance for water and sanitation reached \$5.6 billion in 2009.⁸⁷

this direction. See Pandemic Influenza Preparedness Framework, *supra* note 37.

⁸⁵ See Gill Walt et al., *Mapping the Global Health Architecture*, in MAKING SENSE OF GLOBAL HEALTH GOVERNANCE: A POLICY PERSPECTIVE 47-71 (in Kent Buse et al. eds., 2009); Mark Dybul et al., *Reshaping Global Health*, 173 POL'Y REV. (2012), <http://www.hoover.org/publications/policy-review/article/118116>.

⁸⁶ These figures are in nominal dollars and include on-budget external assistance. *World Health Statistics 2012*, WORLD HEALTH ORG.133 (2012), http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf.

⁸⁷ Christopher J.L. Murray et al., *Development Assistance for Health: Trends and Prospects*, 378 LANCET 8, 8-10 (2011) [hereinafter *Development Assistance for Health*]; *Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty*, INST. FOR HEALTH METRICS & EVALUATION (2010), http://www.healthmetricsandevaluation.org/publications/policy-report/financing_global_health_2010_IHME; Jen Kates et al., *Donor Funding for Health in Low- and Middle-Income Countries, 2001-2009*, KAISER FAMILY FOUND. (2011), <http://www.kff.org/globalhealth/upload/7679-05.pdf>. The international health assistance figures of less than \$6 billion, \$10.5 billion, and \$26.9 billion in 2008 include funding from governments, multilateral agencies, foundations, and NGOs incorporated in the United States and cover HIV/AIDS, tuberculosis, malaria, non-communicable diseases, maternal, newborn, child health, and health sector support. The \$5.6 billion in health assistance for water and sanitation in 2009 includes only government and multilateral agency funding.

Even these funding increases are inadequate, however. The \$41 per capita of government spending in sub-Saharan Africa—and only half that level in South East Asia⁸⁸—is well below the minimum \$60 per capita that WHO estimates that low-income countries require by 2015 to ensure their populations key health interventions. On average, forty-nine low-income countries would have required \$44 per capita spending in 2009 to be on track for near universal access to these interventions by 2015, but thirty-one of them were spending less than \$35 per capita.⁸⁹

Moreover, the upward trajectory of health investments, particularly international assistance, is under severe threat due to the global financial crisis. Austerity has become the order of the day, with high debts in European countries and the United States leading to budget constraints, which promise to continue for many years,⁹⁰ that are already affecting international assistance. In 2011, official development assistance fell for the first time since 1997, with pressures to limit international assistance budgets likely to continue.⁹¹ This follows slowed growth from 2008 through 2010.⁹² Consequences in the health arena have included the Global Fund canceling a funding round and many billions of dollars lower U.S. investments in global health than the Obama Administration had planned.⁹³

88 Government spending on health in South East Asia is the lowest in the world. It increased as a percent of total government expenditure from 4.4% in 2000 to 4.9% in 2009, and from \$6 per capita to \$19 per capita during the same time period. See *World Health Statistics 2012*, *supra* note 86, at 142–43.

89 *World Health Report 2010*, *supra* note 71, at 22–23; see WORKING GROUP 1, *supra* note 23. In practice, more than \$60 on average would be required. The minimum requirement estimates assume, counterfactually, highly efficient spending. It also covers only identified priority interventions, even as actual government health spending extends beyond these interventions.

90 An agreement of all European Members, except the United Kingdom, regarding strict European enforcement debt limits will further pressure budgets and motivate cuts, including in international assistance. Stephen Erlanger & Stephen Castle, *German Vision Prevails as Leaders Agree on Fiscal Pact*, N.Y. TIMES, Dec. 10, 2011, <http://www.nytimes.com/2011/12/10/business/global/european-leaders-agree-on-fiscal-treaty.html?> Meanwhile, a painfully slow economic recovery underway in the United States, combined with a political consensus on the need to cut the deficit, threatens U.S. global health funding for years to come.

91 *Development: Aid To Developing Countries Falls Because Of Global Recession*, ORG. OF ECON. CO-OPERATION & DEV., DEV. CO-OPERATION DIRECTORATE (Apr. 4, 2012), <http://www.oecd.org/dac/aidstatistics/developmentaidtodevelopingcountriesfallsbecauseofglobalrecession.htm>. To take one health example, international funding for HIV “had been largely stable between 2008 and 2011.” *Together We Will End AIDS*, *supra*, note 11, at 104.

92 Katherine Leach-Kemon et al., *The Global Financial Crisis Has Led to a Slowdown in Growth of Funding to Improve Health in Many Developing Countries*, 31 HEALTH AFF. 1, 3 (2012) (noting that international health assistance jumped by 17% from 2007 to 2008, but that over the next several years assistance increased by only 4% annually).

93 Shortfalls in contributions to the Global Fund led it to cancel a funding round in 2011 after having initially launched the round, an unprecedented step *Modification of Grant Renewals and Transition to New Funding*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA (Nov. 21–22, 2011), http://www.theglobalfund.org/documents/board/25/BM25_DecisionPoints_Report_en/.

Although the financial crisis emerged largely from the dishonest and irresponsible practices of the financial industry in the North, economies of the global South are directly affected. The financial crisis has reduced demand for products in the global South and reduced foreign investment. Even as African countries recover from the initial downturn, continued slow or no growth in wealthier countries threatens economic growth—and hence domestic health spending—in Africa.⁹⁴ Foreign direct investment declined sharply in Africa from 2008 to 2010.⁹⁵

The threats to economic growth have special importance, because the past decade has demonstrated that under existing governance arrangements, the primary source of increased health funding and international assistance is economic growth, not greater allocation to health. Despite a pledge by all African countries to spend at least 15% of their budgets in the health sector, on average they increased their investments in the sector from 8.2% to only 9.4% of their budgets from 2000 to 2009.⁹⁶ Turning to international assistance, the proportion of gross national income (GNI) that members of the Organization for Economic Co-operation and Development (OECD) allocated to ODA in 2010 (0.32% GNI)⁹⁷ is essentially the same as it was in 1970 (0.33% GNP)—the year that wealthy countries pledged to spend 0.7% GNP on ODA.⁹⁸

International health assistance can be volatile, as levels depend on annual appropriation cycles and the political party in power. Funders may switch from

The Global Fund established a Transitional Funding Mechanism to continue to fund essential prevention, care, and treatment activities to current grantees. *Id.* The United States is well behind the pace set in the spending targets of the President's Global Health Initiative, originally planned at \$63 billion from 2009 through 2014. SUSAN B. EPSTEIN ET AL., CONG. RES. SERV., R41905, STATE, FOREIGN OPERATIONS, AND RELATED PROGRAMS: FY2012 BUDGET AND APPROPRIATIONS 8 (July 7, 2011), available at <http://fpc.state.gov/documents/organization/169056.pdf>; Laurie Garrett, *The U.S. Global Health Initiative is Dead: Long Live the U.S. Global Health Initiative!*, LAURIE GARRET BLOG, (July 2012), <http://www.lauriegarrett.com/index.php/en/blog/The%20U.S.%20Global%20Health%20Initiative%20is%20Dead:%20Long%20Live%20the%20U.S.%20Global%20Health%20Initiative!/>.

⁹⁴ *Macroeconomic Prospects*, AFR. ECON. OUTLOOK, <http://www.africaneconomicoutlook.org/en/outlook/forecast/> (last visited Nov. 29, 2012).

⁹⁵ AFR. DEV. BANK, *Africa's Performance & Mid-Term Prospects*, 1 AFRICA EMERGING ISSUES 13 (Nov. 2011), <http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Africa%20Emerging%20Issues%20Series.pdf>. A 1% decrease in GDP across countries of the Organization for Economic Cooperation and Development (OECD) could lead Africa's export earnings to fall by 9%. *Id.*

⁹⁶ *World Health Statistics 2012*, *supra* note 86, at 142.

⁹⁷ *Development Aid Reaches an Historic High in 2010*, ORG. OF ECON. CO-OPERATION DEV. http://www.oecd.org/document/35/0,3746,en_2649_34447_47515235_1_1_1_1,00.html (last visited Nov. 29, 2012).

⁹⁸ HELMUT FÜHRER, *THE STORY OF OFFICIAL DEVELOPMENT ASSISTANCE* (1994). For a historical perspective on foreign assistance, see Anup Shah, *Foreign Aid for Development Assistance*, GLOBAL ISSUES (April 8, 2012), <http://www.globalissues.org/article/35/foreign-aid-development-assistance>.

one health issue to another, or one sector to another (e.g., health to education), and funding grants may come to an end with no strategy for transition. This makes it difficult for countries to fully benefit from assistance. They may have to choose between developing programs for which long-term funding is insecure—with the risk that life-saving programs will be terminated—or passing up on funds that might be available. Countries may be particularly wary of investing in recurrent spending, such as health worker salaries, despite the need.⁹⁹

Too frequently geopolitical interests drive development assistance, leading to a misalignment of spending compared to need (e.g., U.S. investments in Iraq and Afghanistan). Certain countries become donor favorites (e.g., Uganda, Rwanda, Zambia),¹⁰⁰ while others are orphaned (e.g., Central African Republic).¹⁰¹ In addition, shifting priorities of wealthy countries can undermine country ownership, neglect basic needs, and enable diseases to resurge.

Funding also needs to be well-spent. There are growing efficiencies in some areas, notably AIDS, with funds able to stretch further. However, 20-40% of health spending is wasted, with even higher levels being wasted in poorer countries.¹⁰² Among the factors that conspire against available funds yielding health benefits include the next two challenges: poor coordination among health actors and lack of accountability.

2. *The Lack of Collaboration and Coordination Among Multiple Players*

Today's global health discourse is dominated by terms such as "fragmentation" and "duplication," with a proliferation of actors, pictorially represented as an incomprehensible, tangled web of agencies and programs. Such complexity reduces the efficiency of health spending, at times even pitting international actors and local service providers against each other. Multiple systems are duplicative (e.g., an HIV drug supply chain alongside a national drug distribution system) and the high transaction costs of fragmentation consume health ministry resources, as ministries compile an endless series of reports for an array of partners. Partners often poorly coordinate among themselves, and often do not align their funding and programs with national strategies. They may fail to collaborate with health ministries, and even to inform health ministries of all of their activities. Furthermore, more generous compensation in partner

99 JALI World Health Report Background Paper, *supra* note 12.

100 Nirmala Ravishankar et al., *Financing of Global Health: Tracking Development Assistance for Health from 1990 to 2007*, 373 LANCET 2113, 2122 (2009); *Development Assistance for Health*, *supra* note 87.

101 *Central African Republic – The Forgotten Country*, MERLIN (May 15, 2012), <http://www.merlin.org.uk/central-african-republic-forgotten-country> (last visited Nov. 29, 2012).

102 *World Health Report 2010*, *supra* note 71, at 71-72; *Investing in Health for Africa: The Case for Strengthening Systems for Better Health Outcomes*, HARMONIZATION FOR HEALTH IN AFRICA 4 (2011), http://www.who.int/pmnch/media/membernews/2011/investing_health_africa_eng.pdf.

organizations can draw the most qualified people away from health ministries.

The proliferation of uncoordinated actors poses significant challenges to the stewardship role of ministries of health and misses opportunities for collaboration and synergy. A new global governance structure will need a simplified architecture that translates into a more coherent and manageable picture at the country level, with relationships rooted in collaboration that harmonizes global health actions and aligns with national strategies.¹⁰³

3. The Need for Accountability, Transparency, Monitoring, and Enforcement

Basic principles of good governance are required at all levels: subnational, national, and international. Yet the global health field is marked by a paucity of detailed targets with concrete plans to achieve them, along with a lack of accountability. There is insufficient transparency among states and international organizations, and inadequate monitoring and evaluation of health initiatives. Meanwhile, global health funding and activities are, in practice, voluntary, with few mechanisms to ensure compliance.

Global health mechanisms have also proven inadequate to support effective health spending nationally and locally. From continued inefficient spending (e.g., vehicles for health ministries, ineffective short-term trainings) and over-spending (e.g., non-competitive tenders) to outright corruption—much less inappropriate medical care, such as unnecessary prescriptions and the overuse of injections—global mechanisms also fail to sufficiently support transparency and other accountability strategies at local and national levels, such as civil society advocacy. An effective global health architecture would include the following: (1) clear targets to improve the public's health and reduce health inequities; (2) benchmarks and indicators of success that are rigorously monitored; (3) incentives and enforcement mechanisms to ensure compliance; and (4) civil society engagement, virtual and in-person interactive forums, and publicly provided reasons for decisions to improve transparency.

It is not merely that there is too little money, too much of which is spent inefficiently, and too often in the dark. The funds that countries do invest in health largely neglect particularly important health needs. This is the subject of the next two challenges.

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, adequate nutrition, sanitation, sewage, and tobacco

103 *The Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability*, ORG. OF ECON. CO-OPERATION & DEV. (2005), <http://www.oecd.org/dataoecd/30/63/43911948.pdf> [hereinafter *Paris Declaration*].

control, and abating disease vectors such as mosquitoes and rodents, and from developing health systems that equitably and efficiently deliver known, effective health interventions. A heightened global priority toward meeting these human needs would more effectively reduce the diseases and injuries that are responsible for most of the world's suffering, morbidity, and premature mortality.

Yet despite their demonstrable value in improving public health, basic needs have been largely overlooked—although this is beginning to change with a new focus on health system strengthening, including by mechanisms such as the Global Fund, with its primary mission still focused on AIDS, tuberculosis, and malaria.¹⁰⁴ Currently, though, there is no major funder that prioritizes resources for prevention, primary care, and access to essential medicines. Reforming the global health architecture would end this neglect.

5. The Neglect of Vital Health Research and Development

Also inadequately reflected in global governance for health is the need for research and development, both for diseases that are most prevalent among poorer countries and populations and diseases common globally, but with specific research and development needs for developing countries. With beneficiaries who have little money, companies lack the financial incentives to produce medicines and vaccines for these populations.¹⁰⁵ Pressing needs include new diagnostic tools and therapies for tuberculosis and treatments for neglected tropical diseases.¹⁰⁶ A prominent working group convened by WHO, the Consultative Expert Working Group, estimated that public funding on this research and development should double, with countries spending at least 0.01% of their GNP.¹⁰⁷

There are nascent efforts to address this research gap, such as GAVI's Advanced Market Commitment, which spurred development and increased production of the pneumococcal vaccine (protecting against pneumonia).¹⁰⁸ The International Finance Facility for Immunization frontloads funds for GAVI

104 The Global Fund now encourages interventions to improve maternal and child health and to strengthen health systems, but only if sufficiently connected to improving AIDS, tuberculosis, or malaria outcomes. Eric A. Friedman, *Guide to Using Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria to Support Health Systems Strengthening*, PHYSICIANS HUMAN RIGHTS (2010), https://s3.amazonaws.com/PHR_other/round10-gf-hss-guide.pdf.

105 *Financing and Coordination, Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination*, CONSULTATIVE EXPERT WORKING GROUP ON RESEARCH & DEV. (2012), http://www.who.int/phi/CEWG_Report_5_April_2012.pdf [hereinafter CONSULTATIVE EXPERT WORKING GROUP].

106 *Id.* at 25–26.

107 *Id.* at 83–84.

108 *How the Pneumococcal AMC Works*, GAVI ALLIANCE, <http://www.gavialliance.org/funding/pneumococcal-amc/how-the-pneumococcal-amc-works/> (last visited Nov. 29, 2012).

through bond sales to allow GAVI to commit to vaccine purchases at scale, helping to assure vaccine manufacturers that they will have a market.¹⁰⁹ Other possibilities, such as a Health Impact Fund to stimulate investment in diseases that cause the highest levels of morbidity and mortality,¹¹⁰ are on the table. Recognizing the extent of the continued deficit, the Consultative Expert Working Group has proposed a new treaty on research and development.¹¹¹

6. *The Lack of Global Health Leadership*

Underlying many of these challenges is a lack of global health leadership. Such leadership is required to mobilize, coordinate, and focus a large and diverse set of actors around a clear mission, common objectives, effective approaches, sustained action, and mutual accountability. It is needed to ensure that all health actors have—and have the power to act on—the best available scientific information to ensure that they can have the greatest impact on health. Moreover, global health leadership must ensure a focus on equity in national and international health policies and regimes by enhancing the understanding of national leaders on which policies can have the greatest impact on public health and by focusing on the importance of addressing health inequities.¹¹²

The WHO has the unique authority and legitimacy to assume this role, but it is experiencing a crisis of leadership.¹¹³ Also, the Organization has proved reluctant to exercise its broad normative powers.¹¹⁴ More importantly, however, the WHO controls little more than 30% of its own budget, with most resources going to what donors want rather than what the WHO requires,¹¹⁵ restricting its

109 *About IFFIm: Overview*, INT'L FIN. FACILITY FOR IMMUNISATION, <http://www.iffim.org/about/overview/> (last visited Nov. 29, 2012); *Why Immunization?*, INT'L FIN. FACILITY FOR IMMUNISATION, <http://www.iffim.org/about/why-immunisation/> (last visited Nov. 29, 2012).

110 HEALTH IMPACT FUND, <http://healthimpactfund.org/> (last visited Nov. 29, 2012).

111 CONSULTATIVE EXPERT WORKING GROUP, *supra* note 105, at 120–24.

112 For instance, laws that criminalize homosexual behavior keep men who have sex with men away from the public health system. When their health problems go unaddressed, along with harming their own health, the impact can be more broadly felt, such as leading HIV to spread into the population more generally. To take another example, failure to address the affordability of medicines can contribute to individuals' inability to complete medicine regimens, leading to drug resistance.

113 Devi Sridhar & Lawrence O. Gostin, *Reforming the World Health Organization*, 305 JAMA 1585 (2011).

114 See RICHARD DODGSON ET AL., *GLOBAL HEALTH GOVERNANCE: A CONCEPTUAL REVIEW* (2002); David P. Fidler, *The Future of the World Health Organization: What Role for International Law?* 31 VAND. J. OF TRANSNAT'L L. 1079 (1998); Allyn Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301 (1992).

115 Assessed contributions edged up from 21% of WHO's 2010-2011 budget to 24% of its 2012-2013 budget. The remaining contributions are voluntary. Most voluntary contributions are earmarked, though a small portion is highly flexible. In the 2012-2013 budget, assessed contributions and highly flexible voluntary contributions together comprised 34% of WHO's

ability to direct and coordinate the global health agenda. Meanwhile, WHO's member states have failed to act as though they have a stake in the Organization's success, leading to a major deficit and staff-cutting in 2011.¹¹⁶ Without leadership, the response to global health challenges has been *ad hoc* and fragmented. Furthermore, without a global health advocate, other regimes, such as intellectual property and world trade, have dominated when they have been at odds with global health concerns.

7. The Need for Health and Human Rights Leaders To Influence Multiple Global Sectors To Promote Health

However effective the direct instruments of global health may be, such as global health treaties and funding mechanisms, they are alone insufficient to fully address the demands of global governance for health. International legal regimes outside of health can powerfully affect, for better or worse, human health. Health leadership in these regimes is often either absent or insufficient, or simply overwhelmed by more powerful interests.¹¹⁷ Health and human rights leaders must be empowered to influence these sectors, including intellectual property rules that reduce access to essential medicines and vaccines; trade and restrictive macroeconomic policies that limit government revenue and hence ability to invest in health; agricultural policies such as subsidies that promote unhealthy foods and biofuel production targets that impact global food markets; and energy policies, including subsidies, targets, and investments, that will exacerbate climate change, with its numerous adverse effects on health. Trade and investment treaties may undermine state power to enact rigorous tobacco control

budget. *Medium-Term Strategic Plan 2008–2013 and Proposed Programme Budget 2012–2013*, WORLD HEALTH ORG. 14–15 (Apr. 4, 2011), http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf.

¹¹⁶ Facing a \$300 million deficit, WHO cut headquarters staff by over 10% in 2011. Stephanie Nebehay & Barbara Lewis, *WHO Slashes Budget, Jobs in New Era of Austerity*, REUTERS (May 19, 2011), <http://www.reuters.com/article/2011/05/19/us-who-idUSTRE74I5I320110519>; see also *WHO in Overhaul as Body Faces Losses*, NEW AGE (S. Afr.) (May 16, 2011), http://www.thenewage.co.za/18030-1020-53-WHO_in_overhaul_as_body_faces_losses.

¹¹⁷ For example, despite the risk that overly protective intellectual property regimes will increase the price of medicines, putting even essential medicines out of reach of people in poorer countries, many bilateral and regional free trade agreements include higher levels of protection—so-called “TRIPs-plus” provisions—than required by the World Trade Organization's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs). See, e.g., James Harrison, *Trade Agreements, Intellectual Property and Access to Essential Medicines: What Future Role for the Right to Health?*, in GLOBAL GOVERNANCE OF HIV/AIDS (Obijiofor Aginam et al., eds., 2011); *All Costs, No Benefits: How TRIPs-Plus Intellectual Property Rules in the US-Jordan FTA Affect Access to Medicines*, OXFAM 2 (2007), <http://www.scribd.com/doc/52829094/All-Costs-No-Benefits-How-TRIPs-plus-intellectual-property-rules-in-the-US-Jordan-FTA-affect-access-to-medicines> (noting that TRIP-plus provisions of the United States-Jordan Free Trade Agreement have contributed to the 20% rise in the price of medicines in Jordan since 2001).

laws as required under the FCTC. Domestic workforce policies and international recruitment can accelerate the migration of trained doctors, nurses, and pharmacists out of developing countries already experiencing serious health worker shortages.

Health and human rights leaders will need to collaborate and take an active role in transforming sectors that adversely affect health and human rights, and those that need to be strengthened in their protection for health and human rights. Along with working to affect regimes on an individual basis, they should work to develop a hierarchy of rules that uniformly give priority to health and human rights. Otherwise, a narrow focus on a global health regime, without a positive influence on potentially competing regimes, will not result in global health justice.

* * *

Global governance for health, therefore, is characterized by struggling leadership, inadequate and volatile funding, poor coordination, neglected priorities, little accountability, and insufficient intersectoral influence. This is hardly a recipe for a breakthrough in health equity. Yet, it is entirely possible to dramatically improve the world's health and reduce health inequalities with modest investments and smart, proven policies.

Thus far, the international community has only taken halting steps in the right direction. The Monterrey Consensus,¹¹⁸ Paris Declaration on Aid Effectiveness, the Accra Agenda for Action,¹¹⁹ and the Busan Partnership Agreement¹²⁰ established a new paradigm that became quickly accepted in principle. This paradigm advocates targets and indicators of success to establish benchmarks to enhance accountability,¹²¹ harmonization among partners to improve coordination, alignment with country strategies to enable greater country ownership and reduce burdens on national policymakers, longer-term and more predictable international assistance, engagement with multiple stakeholders in civil society, and mutual accountability among development partners to better clarify mutual responsibilities.

Yet efforts to implement these principles have had setbacks. Consider the International Health Partnership and related initiatives (IHP+)—a partnership launched in 2007 consisting of most developed countries (with the notable

118 International Conference on Financing for Development, Monterrey, Mex., Mar. 18-22, 2002, *Monterrey Consensus on Financing for Development*, U.N. Doc. A/CONF.198/11 (2003), available at <http://www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf>.

119 *Paris Declaration*, *supra* note 103.

120 *Busan Partnership for Effective Development Co-operation*, ORG. OF ECON. CO-OPERATION & DEV. (2011), <http://www.oecd.org/dataoecd/54/15/49650173.pdf> [hereinafter *Busan Partnership Agreement*].

121 For indicators and targets, see *Paris Declaration*, *supra* note 103, at 9–11.

exceptions of the United States and Japan) and by late 2012, thirty-one developing countries, primarily in Africa.¹²² IHP+ has had successes in several areas as it has sought to put these principles into practice, including high-level alignment of partner plans with country plans, increased civil society involvement, and more timely disbursements of partner funding commitments. Yet progress has been decidedly mixed. While “[i]mportant progress has been made toward country ownership of development assistance . . . Development Partners as a whole have to date not realized the ‘step change’ in aid effectiveness that” the IHP+ originally envisioned.¹²³ Only three of twelve IHP+ targets were met. Evidence did not permit meaningful evaluation of the nature of civil society participation, which is particularly critical to ensure that countries are meeting the needs of marginalized populations and to hold governments accountable.¹²⁴

The Global Fund embodies several key principles of good global governance. It is driven by country demand and receives multi-year funding proposals from Country Coordinating Mechanisms (CCMs), whose members include government officials—often from multiple sectors—civil society, development partners, and the private sector.¹²⁵ Civil society from developed and developing countries, governments from the North and South, foundations, the private sector, and most significantly a community delegation sit as equals on the Global Fund Board. Transparent in its programs in each country, the Fund also incorporates robust, independent measures to counter corruption.

Yet the purely voluntary funding scheme has caused the Global Fund to fall well short of its needs,¹²⁶ forcing it to delay grants, limit support to middle-income countries, slow its pace of new funding and, most dramatically, cancel its

122 *IHPA+ Partners*, INT’L HEALTH PARTNERSHIP & RELATED INITIATIVES, <http://www.internationalhealthpartnership.net/en/partners> (last visited Nov. 29, 2012).

123 *Progress in the International Health Partnership & Related Initiatives (IHP+): 2012 Annual Performance Report*, IHP+ RESULTS ii (2012), http://ihpresults.burgercom.co.za/wp-content/uploads/2012/10/IHP_English.pdf.

124 *Id.*

125 *Country Coordinating Mechanisms*, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA, <http://www.theglobalfund.org/en/ccm/> (last visited Dec. 5, 2012). During its first decade, grant periods were five years, though under a revised funding model, standard grants will last three years, though with some flexibility. *See also* GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA, TWENTY-EIGHTH BOARD MEETING (Nov. 14-15, 2012), *available at* http://www.theglobalfund.org/documents/board/28/BM28_DecisionPoints_Report_en/.

126 At the United Nations Millennium Development Goals Summit in September 2010, countries committed to provide “adequate funding” for the Global Fund. Yet at the Global Fund’s three-year replenishment conference the following month, the Fund received only \$11.7 billion in pledges, even as it had established a minimum need of \$13 billion, with a goal of \$20 billion. *Keeping the Promise: United to Achieve the Millennium Development Goals*, G.A. Res. 65/1, U.N. Doc. A/RES/65/1 (Sept. 22, 2010), *available at* <http://www.un.org/en/mdg/summit2010/pdf/mdg%20outcome%20document.pdf>. Donald G. McNeil Jr., *Global Fight Against AIDS Falts as Pledges Fail to Reach Goal of \$13 Billion*, N.Y. TIMES (Oct. 6, 2010), *available at* <http://www.nytimes.com/2010/10/06/world/africa/06aids.html>.

2011 round of funding. Beyond funding, whether non-governmental members are recognized and empowered to act as equal partners on CCMs—critical to ensuring that the proposals build civil society capabilities, address the needs of marginalized populations, and are sufficiently ambitious—varies significantly among countries.¹²⁷ Meanwhile, the Global Fund captures only a slice of health need, though with its support for health systems strengthening and, indirectly, improving maternal and child health, it is seeking to more fully align with the MDGs and country needs.¹²⁸

In what could have been path-breaking progress on global health accountability, new global funding for maternal and child health has come with commitments to improved accountability. In 2011, the Commission on Information and Accountability for Women’s and Children’s Health laid out a strategy to enhance accountability in women’s and children’s health.¹²⁹ Its recommendations on strengthening health information systems and common indicators, regular reporting on spending and connections to results, improved oversight and transparency, and inclusive national accountability mechanisms are all important, deserve support, and provide standards that should extend throughout global health. The Commission also recognized the vast potential of information and communications technology to enhance information sharing and accountability. Yet the Commission had little new to offer.

Deep reductions in health inequities will require stronger global governance for health than this. Governance must be capable of ensuring that principles captured in the Paris Declaration and its successors are fully implemented. Moreover, it must go beyond these principles to better address the overall volume of health financing, equity, and underlying and deeper socioeconomic determinants of health. Far stronger forms of accountability are still required, as is true global health leadership. Global health law could play a role in all of these areas, yet its scope—particularly in legally binding form—remains narrow. Global health law has demonstrated its potential, yet remains highly

127 *CCM Advocacy Report: Making Global Fund Country Coordinating Mechanisms Work Through Full Engagement of Civil Society*, INT’L TREATMENT PREPAREDNESS COAL. (2008), <http://www.rapnap.org/resources/docs/CCM%20Advo%20Rpt/pdf>.

128 GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA, TWENTY-SECOND BOARD MEETING (Dec. 13-15, 2010), *available at* http://www.theglobalfund.org/documents/board/22/BM22_DecisionPoints_Report_en/; GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS & MALARIA, SIXTEENTH BOARD MEETING (Nov. 12-13, 2007), *available at* http://www.theglobalfund.org/documents/board/16/BM16_BoardMeeting_Decisions_en/.

129 COMMISSION ON INFORMATION & ACCOUNTABILITY FOR WOMEN’S AND CHILDREN’S HEALTH, *KEEPING PROMISES, MEASURING RESULTS* (2011), *available at* http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf. Missing were recommendations for incentives or sanctions that might encourage compliance. The Commission also failed to articulate a recommendation for local accountability mechanisms, building skills among, and ensuring the resources for, civil society and communities to hold their own governments to account—codifying commitments to open the potential for judicial enforcement or other strategies that could help fundamentally improve accountability.

underdeveloped.

A broad, cross-cutting treaty specifically targeted to the major determinants of health—the FCGH—could be at the heart of further developing global health law and reorganizing global governance for health to dramatically reduce global health inequities.

Before proceeding to the four questions whose answers we believe should provide the foundation for the evolution of global health law in general, and an FCGH in particular, we set out the moral and legal underpinning of our approach: that the concept of health aid as charity should be jettisoned in favor of a justice-based commitment to mutual responsibility beyond state borders. Shared national and global responsibilities, social justice, and the right to health form the normative perspective that would properly guide global governance for health.

III. RECONCEPTUALIZING “HEALTH AID”: FROM CHARITY TO HUMAN RIGHTS¹³⁰

Often tied to the concept of global health is that of health assistance provided by the affluent to the poor in a donor-recipient relationship as a form of charity—a concept we will refer to as “Health Aid.” Framing the global health endeavor as Health Aid is fundamentally flawed,¹³¹ as it implies that the world is divided between donors and countries in need. This is too simplistic. Collaboration among countries, both as neighbors and across continents, is also about responding to health risks together and collaboratively building the knowledge, skills, and systems to respond to them—whether through South-South partnerships, gaining access to essential vaccines and medicines, or demanding fair distribution of scarce life-saving technologies. New social, economic, and political alignments are evident, for example, in the emerging health leadership of countries such as Brazil, India, Mexico, and Thailand.¹³²

Likewise, the concept of “aid” both presupposes and imposes an inherently unequal relationship, where one side is a benefactor and the other a dependent. This leads affluent states and other donors to believe that they are giving “charity,” which means that financial contributions and programs are largely at their discretion. It also means that donors decide the amount and objectives of global health initiatives. The level of financial assistance, as a result, is not predictable, scalable to needs, or sustainable in the long term. These features of

¹³⁰ This discussion draws heavily from *JALI World Health Report Background Paper*, *supra* note 12.

¹³¹ See, e.g., Gorik Ooms & Wim Van Damme, *Impossible to ‘Wean’ When More Aid is Needed*, 86 BULL. WORLD HEALTH ORG. 893 (Nov 2008); Gorik Ooms et al., *Financing the Millennium Development Goals for Health and Beyond: Sustaining the ‘Big Push’*, GLOBALIZATION & HEALTH (2010), <http://www.globalizationandhealth.com/content/6/1/17>.

¹³² Jennifer P. Ruger & Nora Y. Ng, *Emerging and Transitioning Countries’ Role in Global Health*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 253 (2010) (describing the role of the “BRIC” nations—Brazil, Russia, India, and China—in global health, as the givers and recipients of aid).

Health Aid could, in turn, mean that host countries do not accept full responsibility for their inhabitants' health, as they can blame donors for shortcomings.

Conceptualizing international assistance as “aid” masks the deeper truth that human health is a globally shared responsibility, reflecting common risks and vulnerabilities.¹³³ An obligation of health justice is that it demands a fair contribution from everyone, North and South. Global governance for health must be seen as a partnership—a direction that is now gaining broad international agreement¹³⁴—with financial and technical assistance understood as an integral component of the common goal of improving global health and reducing health inequalities.

A. A Shared Obligation: The Right to Health and Reinforcing Frameworks

The right to the highest attainable standard of health (“right to health”)¹³⁵ is the most important health-related international legal obligation for all countries. What makes the right to health a compelling framework for holding states accountable is that it has wide international acceptance as binding law. States have recognized the centrality of human rights to their mission, declaring through the United Nations, “[h]uman rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments.”¹³⁶

What does the right to health entail? The most authoritative interpretation, which has since been built upon by a series of reports by the United Nations Special Rapporteurs on the right to health and supplemented by decisions of national courts, comes from General Comment 14 of the United Nations

133 From infectious diseases that do not respect national borders, to cultural influences and trade that bear much responsibility for the growth of NCDs in developing countries, diseases and their determinants are increasingly globalized. Moreover, the contribution of health to other realms of life, such as education and economic productivity, affect countries' economic growth and the skills of its people in ways that benefit all. Health technologies and strategies developed as solutions in lower-income countries can provide lessons and approaches to better health care in wealthier countries. On this last point, see NIGEL CRISP, *TURNING THE WORLD UPSIDE DOWN – THE SEARCH FOR GLOBAL HEALTH IN THE 21ST CENTURY* (2010).

134 For example, the fourth of the first series of high-level global forums on aid effectiveness, in Busan, South Korea, in 2011, issued a declaration not about “aid effectiveness,” like the landmark Paris Declaration that emerged from a 2005 meeting, but was about “development cooperation.” The language changed from that of aid and assistance to partnership and cooperation. See *Paris Declaration*, *supra* note 103; *Busan Partnership Agreement*, *supra* note 120.

135 The full formulation of this right in one of the foundational human rights treaties, the International Covenant on Economic, Social and Cultural Rights is “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” ICESCR, *supra*, note 74, at art. 12.

136 World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration*, ¶ 1, U.N. Doc. A/CONF.157/24 (June 19, 1993) [hereinafter *Vienna Declaration*], available at <http://www2.ohchr.org/english/law/vienna.htm>.

Committee on Economic, Social and Cultural Rights (CESCR).¹³⁷ As the General Comment explains, the right to health in international law covers both health care and the underlying determinants of health. It contains four “interrelated and essential elements,” requiring that health goods, services, and facilities be available and accessible to everyone (including being affordable and geographically accessible), acceptable (including culturally), and of good quality. States must respect, protect, and fulfill the right to health.¹³⁸ That is, states must refrain from interfering with individuals’ abilities to realize this right—for example, discrimination in access to health services is forbidden—and they must protect people from violations of this right by third parties and actively ensure the full realization of this right.¹³⁹

Although the right to health offers a critical framework for national and global responsibilities for health, it also suffers from four limitations: First, the right to health contains broad aspirations, failing to structure obligations with sufficient detail to render them susceptible to rigorous monitoring and enforcement. Second, the oversight body—the CESCR— has possessed few enforcement powers beyond reviewing state reports on treaty implementation and making recommendations. Third, the ICESCR requires states to deliver on the convention’s promises “progressively,” rather than immediately, leading to a

137 Among the special rapporteur reports are: Special Rapporteur of the Commission on Human Rights on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report*, U.N. Economic and Social Council, U.N. Doc. E/CN.4/2005/51 (Feb. 11, 2005) (by Paul Hunt), available at http://www.ifhro.org/images/stories/ifhro/documents_UN_special_rapporteur/3_4_4.pdf; Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Promotion and Protection of all Human Rights, Civil, Political, Economic and Cultural Rights*, U.N. Economic and Social Council, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) (by Paul Hunt), available at http://www.ifhro.org/images/stories/ifhro/documents_UN_special_rapporteur/3_4_2.pdf; Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *The Right to Health, transmitted by Note of the Secretary-General*, U.N. Doc. A/64/263 (Aug. 11, 2008) (by Paul Hunt), available at http://www.ifhro.org/images/stories/ifhro/documents_UN_special_rapporteur/3_4_8.pdf.

The CESCR will soon have additional opportunities to interpret the right to health and other economic, social, and cultural rights. In December 2008, the UN General Assembly adopted the Optional Protocol to the ICESCR, which will allow individuals and groups to file complaints (“communications”) regarding violation of their rights under the ICESCR. Upon ratification of a tenth state in early 2013, the Optional Protocol will enter force in May 2013. Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, G.A. Res. 63/117, U.N. Doc. A/RES/63/117 (2008), available at <http://www1.umn.edu/humanrts/instree/opt-prot08.html>; Press Release, UN Office of the High Commissioner for Human Rights, Pillay Welcomes Major Breakthrough Enabling Individual Complaints on Economic, Social and Cultural Rights (Feb. 6, 2013), available at <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12968&LangID=E>.

138 *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, U.N. Comm. on Econ., Soc. & Cultural Rights, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), available at <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm> [hereinafter *General Comment 14*].

139 *Id.*

staggered and uncertain path toward full realization. Fourth, the legal duty falls primarily on the state (not the international community) to provide health services to its own people, even if the state has few resources and limited capacity.

Yet these four structural limitations in the right to health framework can be overcome. The CESCR can develop clear and enforceable standards and press states harder toward implementation. In May 2013, the Optional Protocol to the ICESCR will enter force with respect to parties that have ratified the Protocol, enabling the CESCR to receive individual and group communications on violations and to issue its views and recommendations on these complaints, and to urge interim measures. The duty to “progressively” realize the right to health could be interpreted to require states to meet precise indicators or benchmarks of tangible progress. The ICESCR’s text itself requires states “to take steps” immediately to achieve “the full realization” of the right to health. The CESCR affirms that states must “move as expeditiously and effectively as possible towards that goal.”¹⁴⁰ As we will discuss more below, an FCGH could further clarify ambiguities and respond to limitations.

The all-important capacity problem can be overcome through the treaty’s insistence that states use “the maximum of [their own] available resources,” and that the international community provide “assistance and co-operation, especially economic and technical.”¹⁴¹ 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].”¹⁴² Taken together, the United Nations Charter, established principles of international law, and the Covenant itself hold that “international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others.”¹⁴³ General Comment 14 states that international assistance is necessary to “enable developing countries to fulfill their core [obligations],” including immediate assurance of essential primary health care for all.¹⁴⁴ Still, like other aspects of the

140 *General Comment No. 3, The Nature of States Parties’ Obligations*, U.N. Comm. on Econ., Soc. & Cultural Rights, U.N. Doc. E/1991/23 (Dec. 14, 1990), available at <http://www1.umn.edu/humanrts/gencomm/epcomm3.htm> [hereinafter *General Comment 3*].

141 ICESCR, *supra* note 74, at art. 2(1). Scholars have made efforts to come to terms with the overly vague and difficult to measure obligations. See, e.g., RADHIKA BALAKRISHNAN ET AL., MAXIMUM AVAILABLE RESOURCES AND HUMAN RIGHTS: ANALYTICAL REPORT (2011), <http://www.cwgl.rutgers.edu/economic-a-social-rights/380-maximum-available-resources-a-human-rights-analytical-report-> [hereinafter MAXIMUM AVAILABLE RESOURCES]. These are among the ICESCR limitations to which an FCGH would respond.

142 *General Comment 14, supra* note 138.

143 *General Comment 3, supra* note 140.

144 *General Comment 14, supra* note 138.

right, the ICESCR and General Comment provide little guidance on what maximum available resources entail and the extent and nature of assistance and cooperation required.

The right to health—and related entitlements such as the right to food, clean water, and adequate sanitation—continues to evolve and gain international acceptance.¹⁴⁵ Meanwhile, several other emerging paradigms join the human rights framework in recognizing global health as a shared responsibility, a partnership, and a priority that requires the cooperation of all countries. These complementary and mutually reinforcing approaches include health as a fundamental aspect of human security¹⁴⁶ as well as health as a global public good.¹⁴⁷ Unlike the right to health, these two frameworks do not have the force of law, but they have gained international acceptance. With human rights benefiting from both widespread acceptance and firm legal grounding, even with their limitations, they are a powerful platform upon which to base a new framework on shared global responsibility for health.

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

146 The concept of human security extends the notion of security far beyond traditional national security interests. The high-level Commission on Human Security, commissioned by the government of Japan, defined human security to mean “to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment,” including by protecting fundamental freedoms and “creating political, social, environmental, economic, military and cultural systems that together give people the building blocks of survival, livelihood and dignity.” *Human Security Now*, COMM’N ON HUMAN SEC. iv (2003), http://www.policyinnovations.org/ideas/policy_library/data/01077/_res/id=sa_File1/. “Good health is both essential and instrumental to achieving human security.” *Id.* at 96.

147 Public goods traditionally share the features of being non-rivalrous (once supplied to one person, the good can be supplied to all other people at no extra cost) and non-excludable (once the good is supplied to one person, it is impossible to exclude other people from the benefits of the good). Technically health does not share these features. For example, it is possible to supply one person with medicine, but not another, while supplying medicine to another person will have an additional cost. However, the collective action required to achieve global health, as well as its considerable positive externalities, such as preventing the spread of communicable disease and improving economic growth, has led scholars to apply this term to global health, or at least aspects of it. See *Global Public Goods*, WORLD HEALTH ORG., <http://www.who.int/trade/glossary/story041/en/index.html> (last visited Dec. 6, 2012); Richard D. Smith & Landis MacKellar, *Global Public Goods and the Global Health Agenda: Problems, Priorities and Potential*, 3 GLOBALIZATION & HEALTH (2007), <http://www.globalizationandhealth.com/content/3/1/9>.

IV. FOUR DEFINING QUESTIONS FOR THE FUTURE OF THE WORLD'S HEALTH

A. *The Four Questions*

Having explained the moral and legal underpinnings of our approach, we now sketch preliminary answers to four questions that, taken together, are critically important for the future of global health.¹⁴⁸ The questions are designed to point the way towards global governance structures that will significantly advance global health equity while directly confronting issues of responsibility to underlie those structures.

These questions, which seek to clarify national and international responsibilities towards vital goals rooted in human rights and the governance required to effectuate these responsibilities, may also be instructive for other legal regimes. For example, how should institutions and processes that bear on food production be structured to ensure food security for all, and what responsibilities do countries hold for achieving this goal, both with respect to their own populations and with respect to the global population? One may ask similar questions about meeting everyone's right to education and to social security.¹⁴⁹

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

Our first foundational challenge is to specify the essential health services and goods that make up the core obligations under the right to health. Answers on this front could guide national efforts to provide universal health coverage. Universal health coverage has become a clearly enunciated aim of an increasing number of countries, with some, such as Thailand and Brazil, making significant progress.¹⁵⁰ The international community, led by the WHO, has revived the goal of universal health coverage established in the 1978 Alma-Ata Declaration on

¹⁴⁸ See *Joint Action and Learning Initiative*, *supra* note 12; *National and Global Responsibilities for Health*, *supra* note 12.

¹⁴⁹ For more on an emerging approach to meet the right to social security by developing a social protection floor, see INT'L LABOUR OFFICE & WORLD HEALTH ORG., SOCIAL PROTECTION FLOOR INITIATIVE (2010), available at <http://www.issa.int/content/download/136762/2785842/file/2social%20protection%20floor%20initiative.pdf>; Nicola Liebert, *No Justice Without Social Protection: What Can International Development Cooperation Do To Make the Social Protection Floor Initiative Work?*, DIALOGUE ON GLOBALIZATION (Sept. 2011), library.fes.de/pdf-files/iez/08519.pdf.

¹⁵⁰ Kannika Damrongplisit & Glenn A. Melnick, *Early Results from Thailand's 30 Baht Health Reform: Something to Smile About*, 28 HEALTH AFF. w457 (2009); Claudia Jurberg & Gary Humphreys, *Brazil's March Towards Universal Coverage*, 88 BULL. WORLD HEALTH ORG. 641, 646-47 (2010).

primary health care.¹⁵¹

A World Health Assembly resolution defined universal coverage “as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost.”¹⁵² Clarifying the health services and goods to which everyone is entitled will help define those “key” health interventions and give greater substance to a state’s core duty to meet the health needs of its inhabitants. Answers will also help assess the minimum extent to which affluent states should enhance the capacities of low-income and middle-income countries.

The WHO describes universal health coverage as a multi-dimensional, progressive process that entails increasing the proportion of the population served, the level of services, and the proportion of health costs covered by prepaid pooled funds.¹⁵³ The core human rights principle of equal access requires states to prioritize covering 100% of their populations. Although 100% coverage of all health services will not be possible immediately, full coverage of “key” health interventions should be an initial benchmark towards universal coverage.

The right to health framework militates against a narrow definition of “key” services. Rather, key services should encompass adequate health systems and services, including essential medicines, vaccines, and the fundamental human needs that are core to the mission of public health and incorporate the “underlying determinants of health” to which all people have a right under the

151 The 1978 Alma-Ata Declaration set the goal of “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life,” with primary health care “key to obtaining this target.” Declaration of Alma-Ata, Int’l Convention on Primary Health Care, Alma-Ata, USSR, art. 5 (Sept. 6-12, 1978), *available at* http://www.who.int/publications/almaata_declaration_en.pdf. Thirty years later, WHO’s World Health Report refocused global attention on primary health care, while WHO’s 2010 World Health Report focused directly on universal health coverage. *See World Health Report 2008*, *supra* note 57; *World Health Report 2010*, *supra* note 71. A 2005 World Health Assembly resolution urged member states “to plan the transition to universal coverage of their citizens.” WHO, Revision of the International Health Regulations, WHA Doc. WHA58.3 ¶ 1(4) (May 23, 2005), http://apps.who.int/gb/ebwha/pdf_files/WHA58-REC1/english/Resolutions.pdf. The G8 has acknowledged “the goal of universal access to health services, especially primary health care.” Group of Eight, Responsibility Leadership for a Sustainable Future, L’Aquila Summit (Italy), July 8, 2009, at ¶ 121, <http://www.g8.utoronto.ca/summit/2009laquila/2009-declaration.html>. The African Union’s health strategy for 2007-2015 frames universal access as “the rallying point of the response to all health challenges.” African Union, *Africa Health Strategy 2007-2015*, CAMH/MIN/5(III), 3rd Session of the African Union Conference of Ministers of Health, Johannesburg, South Africa, Apr. 9-13, 2007, at 20, *available at* http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf. In December 2012, the United Nations General Assembly passed a resolution endorsing universal health coverage. Global Health and Foreign Policy, U.N. General Assembly Res. 67/81, U.N. Doc. A/RES/67/81 (Dec. 12, 2012), *available at* http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36.

152 *Social Health Insurance: Sustainable Health Financing, Universal Coverage & Social Health Insurance - Report by the Secretariat, Fifty-Eighth World Health Assembly*, WORLD HEALTH ORG. (2005) [hereinafter *Sustainable Health Financing, Universal Coverage & Social Health Insurance*].

153 *See World Health Report 2010*, *supra* note 71.

right to health.¹⁵⁴ “Assuring” for everyone these “conditions in which people can be healthy”¹⁵⁵ will go far towards achieving health equity.

The WHO sets out essential building blocks of a well-functioning health system: health services, health workforce, health information, medical products and technologies, a financing system that raises sufficient funds for health and assures access, and leadership and governance.¹⁵⁶ Health systems should ensure basic health care (e.g., primary, emergency, specialized care for acute and chronic diseases and injuries), including essential medicines,¹⁵⁷ and public health services (e.g., surveillance, laboratories, and response) for all inhabitants.

As critical as effective health systems are, people who cannot access nutritious food, whose water contains harmful bacteria, and whose lungs are smothered by pollution and tobacco smoke do not live in conditions that are conducive to good health. People must be ensured the underlying determinants of health and the closely linked ends of a traditional public health strategy, which are vital to maintaining and restoring human capability and functioning. These include adequate sanitation and potable water, clean air, nutritious food, decent housing, vector control, and tobacco and alcohol reduction.¹⁵⁸

These health goods and services will vary by country in their details and should be determined with input from the public to ensure that they are appropriately adapted to country circumstances and to what people themselves see as their health needs and priorities. Whatever the precise health goods and services to which everyone is most immediately entitled under the right to health, states have an obligation to progressively and continually build upon that level, to more fully realize the right to health. States, even wealthy ones, will need to continue to progress towards universal health coverage, as even wealthy countries do not cover the entire range of services that could improve people’s health. They, too, have scope for more fully realizing the right to health. Yet even a core set of essential goods and services—well within the capacity of countries to provide under a framework of mutual responsibility—could greatly improve

154 *General Comment 14*, *supra* note 138, at ¶ 11.

155 The Institute of Medicine of the United States National Academies “defines the mission of public health as fulfilling society’s interest in assuring conditions in which people can be healthy.” *The Future of Public Health*, INST. OF MED. 140 (1988), <http://www.iom.edu/Reports/1988/The-Future-of-Public-Health.aspx>.

156 *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework for Action*, WORLD HEALTH ORG. (2007), http://www.who.int/healthsystems/strategy/everybodys_business.pdf.

157 WHO has developed a Model List of Essential Medicines, which include “the most efficacious, safe and cost-effective medicines for priority conditions.” WORLD HEALTH ORG., *THE SELECTION AND USE OF ESSENTIAL MEDICINES - WHO TECHNICAL REPORT SERIES NO. 920* (2010); *see also WHO Model List of Essential Medicines*, WORLD HEALTH ORG. <http://www.who.int/medicines/publications/essentialmedicines/en/> (last visited Dec. 5, 2012).

158 Lawrence O. Gostin, *Meeting the Survival Needs of the World’s Least Healthy People: A Proposed Model for Global Health Governance*, 298 JAMA 225 (2007).

the lives of a vast number of people.

Healthy conditions require even more, though. If all people are to be assured conditions in which they can be healthy, conditions requisite for a functioning, and indeed flourishing, life,¹⁵⁹ even what we have proposed thus far is insufficient. For example, a woman who is abused by her husband and lacks the educational and economic wherewithal to leave him and support herself and her children, or confidence in a justice system to protect her and prosecute him, still lives in unhealthy conditions even if she lives in a community with an effective health system, clean air, and clean water. The male clerk in the civil service in the United Kingdom in the 1960s would seem to have lived in the conditions required for good health—good health care through National Health Services, the water and food and other necessities readily available in one of the world's wealthiest countries. Yet, this clerk was four times more likely to die over a twenty-five year period than a colleague at the top of the civil service hierarchy.¹⁶⁰ Something needed for health was missing.

What people further require for good health are the broader social and economic determinants of health: gender equity, employment, education, effective justice systems that would have prevented the violence or enabled the woman to escape it, and the reduced stress and greater control over their lives that differentiated the lives of men at the top and bottom of the British civil service hierarchy. Achieving these ends requires healthy living conditions, from early childhood development to social security later in life, and overcoming the inequities in income, power, and other resources.¹⁶¹

The relative nature of many of these, such as greater equality and less stress, prevents them from being conceived of in a set of goods and services guaranteed to all people, like medicine, a health professional at the ready, or even clean air and nutritious food. In addition, goals like access to education and to fair employment belong to a mission that is much broader than improving health alone.

Yet health equity cannot be achieved without addressing these factors. Not only do the least affluent among us suffer the worst health, but wherever people live, the lower a person's socioeconomic status, the worse their health. As the WHO Commission on Social Determinants of Health stated, "Social injustice is killing people on a grand scale."¹⁶² A single treaty focused on global health cannot be expected to solve these problems—to achieve not only greater health

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

160 MICHAEL MARMOT, *THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY* 38-39 (2004).

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

162 *Id.* at 26.

justice, but also a state of global social justice. At the same time, to succeed, an effort to secure global health justice must influence these other spheres of life.

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

As the member states of the United Nations have themselves recognized, “[h]uman rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of Governments.”¹⁶³ Individual states hold primary responsibility to ensure the right to health of their inhabitants. Under the right to health, states are obliged to use the maximum of their available resources to fund and ensure the delivery of all the essential goods and services guaranteed to every human being, and to progressively achieve the highest attainable standard of health. These resources are not limited to financial resources; they also include human resources and information.¹⁶⁴ Some of these resources entail their own obligations, such as not blocking people’s access to health information.¹⁶⁵ Yet sufficient funding is a basic precondition for ensuring people the health services to which they have a right. States must provide adequate funding within their capacity.

Yet many states fail to do so. Despite the undoubted need for expanded health services, developing country health expenditures as a proportion of total government spending are significantly lower than the global average (<10% compared with >14%).¹⁶⁶ 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 sector¹⁶⁷—a pledge reaffirmed at their 2010 summit.¹⁶⁸ At the present rate of increase (from 2000 to 2009), it will not be until 2044—more than four decades after the Abuja Declaration—that average health sector spending among African countries will reach the 15% target.¹⁶⁹ Health spending in South East Asia, both in absolute terms and relative to government

163 *Vienna Declaration*, *supra* note 136, at ¶ 1.

164 Robert E. Robertson, *Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social, and Cultural Rights*, 16 HUMAN RIGHTS QUARTERLY 693 (1994).

165 *See General Comment 14*, *supra* note 138, at ¶ 34.

166 *See World Health Statistics 2012*, *supra* note 86, at 142.

167 Organisation of African Unity, *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, OAU/SPS/ABUJA/3, 36th Ordinary Session, Abuja, Nigeria, Apr. 26-27, 2001, at 26, available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

168 African Union, *Actions on Maternal, Newborn and Child Health and Development in Africa by 2015*, Assembly/AU/Dec.1 (XV), 15th Ordinary Session, Kampala, Uganda, July 25-27, 2010, at 1, available at http://www.unfpa.org/webdav/site/global/shared/documents/news/2010/kampala_au_assembly_dec.pdf.

169 African countries will need to spend, on average, an additional 5.4% of their budgets on the health sector to reach 15%, building on the increase from 8.2% in 2000 to 9.6% in 2009. *See World Health Statistics 2012*, *supra* note 86, at 142. At the current pace of a 1.4% increase every nine years, it will be 35 years after 2009 before the average reaches 15%.

budgets, is even lower.¹⁷⁰

States' own health spending is influenced by foreign assistance, which accounts for 15% of total health expenditures in low-income countries on average, and can be as high as two-thirds in some low-income countries. Developing countries often reduce their domestic health spending in response to increasing international assistance—the so-called “substitution effect.”¹⁷¹ It matters a great deal, of course, the purpose for which domestic health spending is being diverted. Non-health sector expenditures such as agriculture, education, or social security can improve health. Expenditures on infrastructure such as roads or electricity may similarly improve well-being.¹⁷² Yet some governments will use these funds for purposes much less likely to improve health, such as the police or military, or might waste precious resources through corruption or inefficiency.

It is unrealistic to expect that affluent states will carry out their responsibilities efficiently if lower-income states do not provide necessary resources for health within their own economic constraints. Wealthier states may well ask themselves why they should assist countries in meeting their needs if these countries are unwilling to take the measures necessary to help themselves. A firm and realized commitment on the part of lower-income countries to make a clearly defined effort, consistent with their human rights obligations, could convince wealthier countries to accept their mutual responsibilities.

Regardless of whether 15% of government spending on that sector is the most appropriate funding target for health, the multi-sector dimensions of health will require additional government spending. African states again have been in the lead of establishing their own targets, even if they often fall well short of meeting them. They have committed to allocate at least 10% of their national budgets for agricultural development,¹⁷³ and thirty-two African countries set a target, framed as an aspiration, for public sector budget allocations for sanitation and hygiene programs to reach at least 0.5% of gross domestic product.¹⁷⁴

170 Government spending on health in South East Asia is the lowest of any region in the world. It increased as a percent of total government expenditure from 4.4% in 2000 to 4.9% in 2009 and from \$6 per capita to \$19 per capita during the same timespan. See WORLD HEALTH STATISTICS 2012, *supra* note 86, at 142.

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

172 Due to the increased access they provide to health services, greater road density in Africa is significantly associated with lower child and maternal mortality and greater access to improved sanitary facilities. Melina R. Platas, *Africa's Health Tragedy? Ethnic Diversity and Health Outcomes* (Working Group on African Political Economy, Working Paper, Dec. 5, 2010), available at http://www.sscnet.ucla.edu/polisci/wgape/papers/19_Platas.pdf.

173 African Union, *Maputo Declaration on Agriculture and Food Security in Africa*, 2nd Ordinary Session, Maputo, Mozambique, July 10–12, 2003, at 2, available at <http://www.nepad.org/system/files/Maputo%20Declaration.pdf>.

174 Second African Conference on Sanitation and Hygiene, *The eThekweni Declaration and*

A government's fidelity to the maximum available resources requirement raises the question of what resources are available. What revenue is available to the treasury? A certain level of effort, especially through progressive taxation policies and efficient tax collection, is necessary to increase the resources available. It will be difficult for national tax policies in the poorest states to generate government revenue above 20% of the gross national income (GNI).¹⁷⁵ States that rely heavily on royalties, taxes, and fees from natural resources must ensure that they are receiving a fair deal, while also being careful stewards of these funds.

The tax system is particularly critical. Evidence shows a strong positive correlation between the human development index and the proportion of GNI available for government investments through tax revenue.¹⁷⁶ That is, governments that are effective at collecting taxes are also more effective at meeting their people's needs. Yet only a handful of African countries have achieved the 20% level of tax revenue.¹⁷⁷ Countries should also use other levers to increase their resources, including actively seeking international support and through monetary policy.¹⁷⁸

As we have emphasized, money alone will not ensure good health. Achieving the "highest attainable standard of . . . health" requires that the money is well spent, and policies are properly conceived and effectively implemented. Too often, this is not the case. Health sector corruption is a significant problem in some developing countries. According to a World Bank survey of twenty-two developing countries, health was one of the most corrupt sectors.¹⁷⁹ Health sector corruption includes bribes and kickbacks, drug diversion from the public sector to the private market, informal payments to providers, accreditation and licensing bribes, and professional absenteeism.¹⁸⁰ Foreign aid, in particular, is considered "ripe territory for corruption" because it theoretically permits "rent-seeking"

AfricaSan Action Plan, (2008), available at <http://www.wsp.org/wsp/sites/wsp.org/files/publications/eThekwiniAfricaSan.pdf>.

¹⁷⁵ George J. Schieber et al., *Financing Global Health: Mission Unaccomplished*, 26 HEALTH AFF. 921, 921-34 (2007).

¹⁷⁶ Attiya Waris & Matti Kohonen, Building Taxation to Build Millennium Development Goals in Africa: PowerPoint Presentation at the Go4Health meeting, Entebbe Uganda (September 18-19, 2012).

¹⁷⁷ *Id.*

¹⁷⁸ MAXIMUM AVAILABLE RESOURCES, *supra* note 141.

¹⁷⁹ *Corruption in the Health Sector: Causes and Consequences*, ANTI-CORRUPTION RESOURCE CTR., <http://www.u4.no/themes/health/causesandconsequences.cfm> (last visited Dec. 5, 2012); Maureen Lewis, Corruption and Health in Developing and Transition Economies: PowerPoint Presentation, available at <http://www1.worldbank.org/publicsector/anticorrupt/IACC/HealthCorruption.ppt> (last visited Dec. 9, 2012).

¹⁸⁰ For more on health sector corruption in developing countries, see Maureen Lewis, *Center for Global Development Brief: Tackling Healthcare Corruption and Governance Woes in Developing Countries* (2006), CTR. FOR GLOBAL DEV. http://www.cgdev.org/files/7732_file_GovernanceCorruption.pdf.

behavior.¹⁸¹ In other words, local officials can profit from foreign aid, which is often allocated to governments with substantial discretion and—at least historically—little accountability. A vicious cycle of corruption related to foreign assistance can occur, as corrupt countries tend to perform poorly and therefore increasingly depend on aid.¹⁸²

This is not to say that funds are never well spent. To the contrary, the health improvements over the past decades, including the impact of PEPFAR and other global health programs, demonstrate that health investments can and often do lead to better health outcomes. It also obscures tremendous differences across countries. Yet corruption, mismanagement, and inefficiencies do mean that in many countries, health funding could go much further towards improving health outcomes if countries, and the health sector in particular, were better governed.

Along with funding then, states have a responsibility to govern well. The concept of “good governance” sets consistent standards for national management of economic and social resources for development:

Those who exercise authority to expend resources and make policy have a duty of *stewardship*—a personal responsibility to act 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 decisionmaking 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.¹⁸³

In addition, drawing on the right to health principles of equal and non-

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

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

183 JALI World Health Report Background Paper, *supra* note 12, at 25; *see also, e.g., What Is Good Governance?*, U.N. ECON. & SOC. COMM’N IN ASIA & THE PACIFIC, <http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp> (last visited Dec. 5, 2012); WORLD BANK, MANAGING DEVELOPMENT: THE GOVERNANCE DIMENSION: A DISCUSSION PAPER (1991), *available at* http://www-wds.worldbank.org/external/default/WDSContentServer/WDS/IB/2006/03/07/000090341_20060307104630/Rendered/PDF/34899.pdf.

discriminatory access and of equitable distribution,¹⁸⁴ a state should fairly and efficiently distribute health goods and services for its entire population. This requires paying special attention to the needs of the most disadvantaged in society such as those who are poor, minorities, women, children, and people with a physical or mental disability. It requires that health services are accessible and acceptable irrespective of socioeconomic status, language, culture, religion, or locality (e.g., rural or urban), and that states take special measures to ensure that those who would otherwise experience the least healthy conditions fully enjoy the conditions needed for health.

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

The duty of states is not limited only to their own people, but extends to advancing the right to health in other states as well. In our globalized world, health is a matter of common threats, most notably through the spread of infectious diseases, where insufficiently addressed health concerns abroad may harm the health of a state's own population. Beyond this, however, each state has a deeper responsibility to promote the global achievement of all human rights, even as different states will have vastly different capacities to promote human rights abroad.

We recognize that this expansive understanding of state responsibility will not be without controversy, and a fuller discussion could fill reams of paper drawing on centuries of theories of justice. Such a discussion is outside our scope. Here, let us suffice with several observations about why we take this stance, focusing on this responsibility as it relates to health.

First, this is a necessary position if we are to resolve today's global health inequities. These inequities are unacceptable and must be eliminated—a person's life chances should not depend on the happenstance of birth, and will require international action. The underlying premise that human rights are founded on, the “inherent dignity . . . of all members of the human family,”¹⁸⁵ is held by each individual, and is not subject to national borders. The proposition of a shared responsibility on achieving the right to health and other rights is now widely

184 The core obligations include “[t]o ensure equitable distribution of all health facilities, goods and services.” *General Comment 14*, *supra* note 138, ¶ 43(a). General Comment 14 emphasizes vulnerable and marginalized populations throughout. *See, e.g., id.* ¶ 43(f) (including that, as part of the core obligation to develop a national public health strategy, such strategies “shall give particular attention to all vulnerable or marginalized groups”); *id.* ¶ 12(b) (including that, as part of the requirement to non-discrimination, “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact”).

185 Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc A/RES/217(111) at pmb1. (Dec. 10, 1948), *available at* <http://www1.umn.edu/humanrts/instreet/bludhr.htm>.

accepted and is reflected in the “international cooperation and assistance” obligations of the ICESCR, the pledge to cooperate with the United Nations in achieving “universal observance” of human rights,¹⁸⁶ and the shared responsibility inherent to the MDGs. A paradigm shift towards a notion of shared responsibilities is underway, even as the next, critical step of turning this principle into specific responsibilities remains.

Second, in our globalized world, we are interdependent, where many of our actions affect health in other countries. These include direct effects, such as trade agreements that may limit access to medicines, agricultural subsidies that reduce incomes and the ability of families in poorer countries to afford nutritious food, and greenhouse gas emissions that lead to climate change. They also include less direct effects, such as decisions of individual consumers that can support exploitative or fair agricultural and industrial practices abroad, and how wealthier countries manage their economies, affecting demand for imports, with implications for economic growth and health budgets in other parts of the world. Policies and practices of wealthier nations have contributed to the ill health in poorer countries, creating a responsibility for the wealthier nations to rectify national misdeeds. From colonialism to World Bank and International Monetary Fund structural adjustment programs,¹⁸⁷ and irresponsible loans followed by requiring debt repayments that often exceeded health budgets,¹⁸⁸ policies of wealthier nations have caused considerable damage. Countries that today bear the greatest burden of disease have incurred harms both to health directly and to broader national capacities.

Finally, to protect the health of their own populations, countries will need to protect health and strengthen health systems abroad. This is most directly the case for infectious diseases that, if not contained in one country, can spread to

186 U.N. CHARTER art. 55 (“The United Nations shall promote . . . (c) universal respect for, and observance of, human rights and fundamental freedoms for all.”); *see also* U.N. Millennium Declaration, *supra* note 82, ¶ 2. (world leaders affirming that “we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level.”). In addition, while focused on other human rights violations, namely the types of mass atrocities that underlying crimes against humanity, war, and genocide, the international community has now adopted a “responsibility to protect.” Under this responsibility, states agree to the need for collective action where “national authorities are manifestly failing to protect their populations from genocide, war crimes, ethnic cleansing and crimes against humanity.” 2005 World Summit Outcome, G.A. Res. 60/1, U.N. Doc. A/RES/60/1 (Sept. 16, 2005).

187 For example, African countries implementing structural adjustment programs cut health spending by 50%, as the Economic Commission for Africa reported in 1989. Mohammed Nuruzzaman, *The World Bank, Health Policy Reforms and the Poor*, 37 J. CONTEMP. ASIA 59 (2007); *see also* Jennifer Prah Ruger, *The Changing Role of the World Bank in Global Health*, 95 AM. J. PUBLIC HEALTH 60 (2005).

188 Robin Stott, *The World Bank: Friend or Foe to the Poor?*, 318 BRIT. MED. J. 822 (1999); Eric A. Friedman, *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*, PHYSICIANS FOR HUMAN RIGHTS 30 (2004), https://s3.amazonaws.com/PHR_Reports/Africa-prevent-brain-drain-report-2004.pdf.

another. The less capable a country is of containing a disease, the more likely it will spread to other countries and affect the right to health of another country's population. This is also the case with respect to drug resistance. If countries with heavy burdens of tuberculosis were able to ensure prompt, effective treatment for everyone affected with tuberculosis, multiple-drug resistant and extremely drug resistant tuberculosis would not be the global health threats that they are today.

Yet even if we can agree on the need—and responsibility—for collective action to address global health challenges including our foremost concern of health inequities, a harder question remains to be answered: Exactly what are these responsibilities? One, is financing. To what extent are states, particularly wealthier ones, responsible for the provision of health-related goods and services to residents of other countries? Even recognizing transnational obligations, the questions remain, which states have duties, to whom, and for what?¹⁸⁹

Despite the conceptual complexity, it is imperative to find innovative ways for holding richer states accountable for a certain level of international assistance. Unfortunately, a tremendous burden of avoidable morbidity and premature mortality rests on those who have the least capacity to adequately respond to it. As described above, earlier WHO estimates suggest that a basic set of health sector services costs a minimum of \$60 per person annually. If states were to generate 20% of GNI as government revenue and allocate 15% of their government revenue to the health sector, then they would be able to spend 3% of their GNI on the health sector.¹⁹⁰ Thus, in general, only states with a GNI of more than \$2,000 per person per year have the domestic capacity to develop health systems able to provide essential health goods and services.¹⁹¹

The \$60 estimate is a figure that will vary by country because of differences in purchasing power and in epidemiologies, geographies, and priorities. We question this figure because it includes only a limited number of services for non-communicable diseases.¹⁹² More significantly, it does not include the underlying determinants of health such as nutritious food, much less broader socioeconomic determinants of health. Even leaving aside these limitations, even if states with a GDP per capita of \$2,000 had the capacity, using only internal resources, to provide everyone the health goods and services to which all people are entitled, billions of people would go without. More than one-third of the world's people

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

190 Gorik Ooms & Rachel Hammonds, *Taking up Daniels' Challenge: The Case for Global Health Justice*, 12 *HEALTH & HUMAN RTS.* 29 (2010), available at <http://www.hhrjournal.org/index.php/hhr/article/view/201/307>. If the government's revenue is 20% of GNI, 15% of this (i.e., the health sector share) is 3% of GNI. For government spending to be \$60 per capita, total GNI must be \$2,000 per capita ($X * 3\% = \60).

191 *Id.*

192 See also Bellagio JALI meeting report, JALI 18 (2012), <http://www.jalihealth.org/documents/Bellagio%20report%205-3-12.pdf> (suggesting higher spending needs).

live in countries with the per capita GDP below \$2,000.¹⁹³ These countries, and we expect others, will require external support to provide their entire populations essential health goods and services.

The Commission on Macroeconomics and Health calculated that affluent states would need to devote approximately 0.1% of GNI to international development assistance for the health sector.¹⁹⁴ Other data suggest that a similar,¹⁹⁵ or somewhat higher, proportion of GNI may be necessary.¹⁹⁶ In 2008,

193 Ooms & Hammonds, *supra* note 192, at 37. For most countries, GNI per capita is very similar to GDP per capita. For example, India GDP per capita in 2011 was \$1,489, while its GNI per capita the same year was \$1,410. *GDP per capita (current US\$)*, WORLD BANK, <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD> (last visited Feb. 20, 2013); *Gross national income per capita 2011, Atlas method and PPP*, WORLD BANK, <http://databank.worldbank.org/databank/download/GNIPC.pdf> (last visited Feb. 20, 2013).

194 WHO COMMISSION ON MACROECONOMICS AND HEALTH, *MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT* (2001). While international assistance for health has fallen short of the Commission's recommendations, domestic health spending in developing countries has, overall, been higher than the Commission believed necessary. The Commission called for national health spending to increase by \$23 billion by 2007. In fact, from 1995 to 2006, developing countries' health spending increased from \$128 billion to \$241 billion (in 2006 dollars). See Pamela Das & Udani Samarasekera, *The Commission on Macroeconomics and Health: 10 years on*, 378 LANCET 1907 (2011); *Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty*, INST. FOR HEALTH METRICS AND EVALUATION 45–47 (2010), http://www.healthmetricsandevaluation.org/publications/policy-report/financing_global_health_2010_IHME. However, as a percentage of GNI, developing countries have a mixed record with respect to the Commission's recommendation of increasing health spending as a percentage of GDP by 1% by 2007 and 2% by 2015. For example, it increased from 5.5% to 6.5% of GDP in Africa from 2000 to 2009, while during those years, it only edged up in South East Asia from 3.7% to 3.8% of GDP. *Id.*; *World Health Statistics 2012*, *supra* note 86, at 142. This suggests that the increased funding was more related to strong economic growth than to increased prioritization of funding for health. Most significantly, despite increased domestic health spending and genuine advances in health outcomes, the immense inequities we have described remain.

195 The MDG Africa Steering Group estimated that by 2010, Africa required an annual \$28 billion in external assistance for health care to meet the MDGs on maternal and child health and major diseases. MDG AFRICA STEERING GROUP, *ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS IN AFRICA: RECOMMENDATIONS OF THE MDG AFRICA STEERING GROUP* (2008). At present, wealthy countries spend approximately 48% of their health assistance in sub-Saharan Africa (based on 2009 data). See KATES ET AL., *supra* note 86, at 6. To the extent that this reflects an appropriate regional distribution of health assistance, and not accounting for inflation or currency fluctuations, this suggests a global health assistance requirement of \$58 billion in 2010 (\$28 billion being 48% of \$58 billion). This is approximately 0.13% of high-income country GNI, based on a total \$43.4 trillion GNI for high-income countries in 2010. *Gross National Income 2010, Atlas Method*, WORLD BANK, <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNI.pdf> (last visited Dec. 5, 2012).

196 Another perspective on the figures from the MDG Africa Steering Group raises the possibility that a higher percentage of GNI might be required for health care. According to their calculations, the \$28 billion represented 39% of Africa's total MDG-related external assistance requirement. This is considerably higher than the 19% of MDG-related development assistance that would be used for health care if wealthy countries dedicated only 0.1% GNI towards health assistance out of a total of 0.54% GNI needed to meet the MDGs, according to calculations of the

Official Development Assistance (ODA) for health care from traditional donor countries—members of the Development Assistance Committee of the OECD—was slightly below 0.05% GNI, or less than half of what is likely required.¹⁹⁷

Consequently, if low-income and middle-income countries are to afford their inhabitants a reasonable standard of health services, wealthier states will have to ensure financing that is predictable, sustainable, and scalable to needs. The High Level Taskforce on Innovative International Financing for Health Systems reported in 2009 that in order to achieve the MDGs and scale up essential health services, health spending (from all sources) in forty-nine low-income countries alone had to increase from \$31 billion to \$67-76 billion annually by 2015, which was \$10 billion more than existing commitments. Even this recommended level of funding largely excludes basic human needs such as clean water and adequate sanitation and hygiene.¹⁹⁸ However, the world is not on track to meet these and other funding requirements. Moreover, in the aftermath of the present global financial downturn, prospects for future growth in international health assistance appear grim.

The volume of international financial responsibility for global health certainly matters, but is not the only financing concern. Another is the long-term reliability of international funding. We have described harm that this lack of sustained, predicable funding entails, from health programs terminated to health workers not hired.¹⁹⁹

Financial assistance not based on an understanding of mutual responsibility, and unreliable in the long run, is therefore an inefficient expenditure of resources,

United Nations Millennium Project. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, U.N. MILLENNIUM PROJECT (2005), <http://www.unmillenniumproject.org/reports/fullreport.htm>.

197 Official development assistance for health was \$17.2 billion in 2009, excluding water and sanitation, which were not part of the estimate from the Commission on Macroeconomics and Health (nor were included in the \$28 billion required from external sources to reach the health MDGs in Africa as estimated by the MDG Africa Steering Group). Total official development assistance (ODA) in 2009 was \$135.1 billion. Kates et al., *supra* note 86, at 6, 4. According to the OECD, which reports lower levels of total ODA (\$119.8 billion in 2009), OECD's Development Assistance Committee members spent 0.31% of their GNI on ODA in 2009. *Development Aid Rose in 2009 and Most Donors Will Meet 2010 Aid Targets*, ORG. FOR ECON. COOPERATION & DEV. (Apr. 4, 2010), http://www.oecd.org/document/0,3746,en_2649_34447_44981579_1_1_1_1,00.html (last visited Dec. 5, 2012). The difference in total ODA is that the OECD figures provide net ODA (deducting loan repayments) while the Kaiser Family Foundation reports gross ODA (without deducting loan repayments). Using the proportion of ODA that went to health based on the Kaiser Family Foundation report (12.7%), the \$17.2 billion for health care was approximately 0.04% of GNI (0.127 * 0.31) for these countries.

198 *More Money for Health, and More Health for the Money*, TASKFORCE ON INNOVATIVE INT'L FIN. FOR HEALTH SYSTEMS (2009), http://www.who.int/tobacco/economics/en_tfi_economics_final_task_force_report.pdf. The essential health services would cover "a broad set of interventions that address the main causes of burden of disease." They would cost \$8,000-10,000 per death averted. *Id.* at 22.

199 See *Paris Declaration*, *supra* note 103 and accompanying text.

as it is limited in its ability to improve the provision of health-related goods and services. This alone should be sufficient reason to consider a global agreement on norms that clarify national and the global responsibilities for health, transforming ineffective short-term financial assistance into effective sustained funding.

International responsibility extends well beyond financing, as a range of policies, statutes, and bilateral or multilateral treaties outside the health sector have a considerable impact on health. As we have explained, states and multilateral organizations adopt policies that often impede, rather than facilitate, health among the world's poor.²⁰⁰ Yet as part of their international human rights obligations, states must respect the right to health in other countries.²⁰¹ As the United Nations Special Rapporteur on the right to health observed, in the context of massive shortages of health workers facing many poorer countries, developed countries have certain obligations:

[D]eveloped countries should respect the right to health in developing countries . . . If a developed country actively recruits health professionals from a developing country that is suffering from a shortage of health professionals in such a manner that . . . reduces the developing country's capacity to fulfill the right to health obligations that it owes its citizens, the developed country is *prima facie* in breach of its human rights responsibility of international assistance and cooperation.²⁰²

These obligations extend to the full range of regimes that affect health, with immense implications, as with climate change. They also encompass how countries engage through the international organizations in which they are members.²⁰³

200 See IHPA, *supra* note 122 and accompanying text.

201 See *Maastricht Principles*, *supra* note 7, at 4 (“States must desist from acts and omissions that create a real risk of nullifying or impairing the enjoyment of economic, social and cultural rights extraterritorially. The responsibility of States is engaged where such nullification or impairment is a foreseeable result of their conduct. Uncertainty about potential impacts does not constitute justification for such conduct.”)

202 Special Rapporteur of the Commission on Human Rights on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, transmitted by Note of the Secretary-General*, at ¶ 61, U.N. Doc. A/60/348 (Sept. 12, 2005) (by Paul Hunt), available at http://www.ifhro.org/images/stories/ifhro/documents_UN_special_rapporteur/3_4_11.pdf.

203 See *General Comment 14*, *supra* note 138, at ¶ 39.

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

A paradigm shift to genuine mutual responsibility for global health grounded in the right to health will require more than an agreed set of responsibilities and principles. It will also require constructing a more forceful, purposeful, efficient, and accountable set of institutions and arrangements. Global governance for health equity would include clearly defined legal obligations on national and domestic health financing for health and its determinants to ensure sustained, sufficient, and predictable funding—including the funds and the research and development needed to better meet today's health needs and prepare for tomorrow's. It would be directed towards national health strategies, while ensuring their quality. It would expand the agenda of global health from today's important, but overly narrow, focus on health care. This expanded agenda would include the full scope of disease and ill health and the conditions required for good health, including strong medical care systems and underlying determinants of health such as nutritious food and clean water, while linking to the broader social and economic determinants of health.

A shared sense of purpose and priorities, and greater coordination, should complement, not supplant, the benefits that come from a proliferation of global health actors. These include civil society, with its ability to reach and represent disadvantaged populations, to advocate, and to hold governments accountable; the private sector, with its ability to develop new medical technologies, market safer foods, and create safer and healthier workplaces; and foundations and philanthropists, with their ability and willingness to fund imaginative approaches to improving global health and meeting unmet needs. Public-private partnerships based on and organized around a shared respect for human rights and health for all will be vital to success in these challenges.

Global governance for health equity will overcome structural issues such as weak leadership and lack of accountability. The WHO would be empowered. Heightened accountability would come from clearer delineations of responsibility, benchmarks and targeting, newly imagined incentives and sanctions, and, above all, effective structures at local and national levels and strengthened civil society and communities. In addition, legal reforms would ensure an elevated place for health in other international regimes, including clear stipulations against undermining the right to health.

At every stage, global governance would be directed towards equity. Funding must take into account obstacles that keep poor and other marginalized populations from health care, from out-of-pocket payments for health to transportation costs. Governance structures and health institutions will need to directly incorporate the voices of these communities. Even as policies emanate

from regimes outside of health, health leaders must exert their influence against oppressive policies that discriminate against women and contribute to marginalization and undermine health. Researchers and innovators will need to ask whether their health technologies will work for the poorest among us. Health strategies will need to incorporate policies to meet the needs of poorer populations, as countries end policies that obstruct their needs. Finally, systems of accountability will need to find ways, beginning, but not ending, with incorporating poorer and marginalized populations into their procedures and at the top of their concerns, to transform the global health system into one that turns traditional power dynamics upside down, with the greatest, not least, accountability to those who have the least political power and suffer the worst health.

An initiative to fill international law's most significant gap, however difficult, is possible. We now propose specific elements of an FCGH. The treaty would be designed along the four dimensions discussed above. It would create standards on the universal conditions required for good health, clarify national and global responsibilities towards securing these conditions and the right to health more broadly, and structure a system of global governance for health that could effectively and efficiently effectuate these responsibilities. A worldwide civil society and academic-led initiative launched in 2010—the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)—is campaigning for an FCGH, conducting research, and launching an inclusive dialogue to further develop the Convention.²⁰⁴

V. A FRAMEWORK CONVENTION / PROTOCOL APPROACH TO GLOBAL HEALTH

In April 2011, the United Nations Secretary-General Ban Ki-moon asked political leaders to make a pledge:

[C]ommit to global solidarity, built on the tenets of shared responsibility, true national ownership and mutual accountability. . . . Let the AIDS response be a beacon of global solidarity for health as a human right and set the stage for a future United Nations Framework Convention on Global Health.²⁰⁵

204 See, e.g., *Submission to Rio+20: Outcome Document*, JOINT ACTION AND LEARNING INITIATIVE ON NATIONAL AND GLOBAL HEALTH RESPONSIBILITIES (Nov. 1, 2011), <http://www.uncsd2012.org/rio20/index.php?page=view&type=510&nr=279&menu=20>. For more information about JALI, please see JALI's website: JALI, <http://www.jalihealth.org> (last visited Dec. 9, 2012).

205 U.N. Secretary-General, *Uniting for Universal Access: Towards Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths: Rep. of the Secretary-General*, ¶ 73, U.N. Doc A/65/797 (Mar. 2011), available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/A-65-797_English.pdf.

First proposed in 2008,²⁰⁶ a framework convention/protocol approach to global health, using a bottom-up inclusive process, would accomplish the following: (1) set globally-applicable norms and priorities for health systems and essential human needs; (2) afford countries flexibility to meet domestic needs and take “ownership” of national policies and programs; (3) establish a sustainable funding mechanism or framework scalable to needs; (4) effectively govern the proliferating number of actors and activities in a crowded global health landscape; (5) create methods for holding state and non-state actors accountable to their obligations under the right to health, including for monitoring progress and achieving compliance with the FCGH itself; and (6) devise a process for the international community to establish further commitments beyond those in the initial Convention.

A. Normative Standards and Priorities

The central objective of the FCGH is to improve health for all, with particular attention to the least advantaged populations, thus seeking major reductions in health inequities within and among states. Any legal intervention with this avowed aim can succeed only if it addresses the full gamut of major determinants of health, including such broader social determinants such as employment, education, a healthy environment, and gender equity.

The entire scope of this task is more than any one treaty can be expected to accomplish, but the FCGH may be a milestone along the way to full health equity. It could firmly establish universal health coverage as a central goal of the post-MDG global health agenda and develop a normative framework for ensuring everyone effective, accessible health systems and a broad array of public health services. Furthermore, it could help ensure that countries have at least basic frameworks in place to address broader health determinants, building on the Rio Political Declaration on Social Determinants of Health of 2011.²⁰⁷

The treaty would ensure universal conditions for good health that extend far beyond universal health coverage as defined by WHO,²⁰⁸ embracing not only health systems, but also underlying determinants of health. The treaty could delineate critical capacities and policies in each of the six health system building blocks that the WHO has identified along with commitments for shared national and global efforts to develop these capacities and support these policies. For example, it could build on the WHO Global Code of Practice on the International

²⁰⁶ See *Meeting Basic Survival Needs*, *supra* note 12.

²⁰⁷ WHO, *Rio Political Declaration on Social Determinants of Health* (Oct. 21, 2011), [hereinafter WHO RIO POLITICAL DECLARATION], available at http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf.

²⁰⁸ See *Sustainable Health Financing, Universal Coverage & Social Health Insurance*, *supra* note 152.

Recruitment of Health Personnel, including by turning guidance against actively recruiting health workers from countries facing critical health personal shortages into binding law.²⁰⁹ It could delineate types of services that health systems must be able to provide, especially to ensure that potentially politically contentious services (e.g., comprehensive reproductive health care), traditionally neglected services (e.g., mental health care), services that are particularly prevalent among poor or other marginalized populations (e.g., neglected tropical diseases), and critically needed, but more expensive, services (e.g., AIDS treatment, including for children) are provided.

Further, the FCGH could specify a minimal proportion of national health costs covered by prepaid pooled funds, ensuring that out-of-pocket expenses do not exclude equal access by the poor. This might entail WHO's estimate of the level of prepaid pooled funds required or higher levels, with commensurate reductions in overall out-of-pocket spending.²¹⁰ The proportion of health spending out-of-pocket and across socioeconomic groups could be a crucial indicator in monitoring progress on universal health coverage.

The FCGH would extend commitments of universal coverage to include underlying determinants of health, establish what these include, and operationalize both long-standing and existing human rights norms, including the rights to food, clean drinking water, sanitation, and established principles and priorities of public health by the United Nations General Assembly.²¹¹

Coverage must be effective. It is not enough that a well-equipped clinic is available if a person cannot afford transportation to reach it, or if women avoid it because they are mistreated. Nutritious food must come with the knowledge about what food is nutritious. For some of these underlying determinants of health, the FCGH could establish universal minimums based on the best scientific evidence, such as the minimum number of liters of clean drinking water that must be available to each person every day, and the minimum number of calories and vital nutrients. The treaty could set floors for the annual pace towards ensuring clean water, decent sanitation, and nutritious food for all. Tobacco control measures could build on and incorporate obligations from the Framework Convention on Tobacco Control, subjecting them to the rigorous compliance mechanisms envisaged for the FCGH. Policies in other areas, such as vector control, alcohol reduction, or diet and nutrition, could build on WHO global strategies or other authoritative sources.²¹²

209 CODE OF PRACTICE, *supra* note 78, at art. 5.1 ("Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.").

210 The WHO reports that out-of-pocket expenses should not exceed 15-20% of total health spending to avoid forcing people into poverty. WORLD HEALTH REPORT 2010, *supra* note 71, at 98.

211 G.A. Res. 64/292, ¶ 3, U.N. Doc. A/RES/64/292 (Aug. 3, 2010).

212 See, e.g., *Strategy to Reduce the Harmful Use of Alcohol*, WORLD HEALTH ORG. (2008) http://www.who.int/entity/substance_abuse/alcstratenglishfinal.pdf; GLOBAL STRATEGY ON DIET,

Even this vision of universal coverage of effective health systems and the underlying determinants of health would be narrower than the full range of determinants of health, which would require a variety of additional social and economic levers, such as education, housing, employment, the environment, a social safety net, and greater income equality. Many of the deeper causes of ill health are addressed by, or require, entire legal regimes focusing on gender equality, unequal distribution of power and resources, and more. Still, the FCGH could offer pathways for addressing the broader socioeconomic determinants of health.

The treaty could require countries to develop comprehensive public health strategies that encompass social determinants of health identified in the FCGH, along with benchmarked actions plans, with associated budgets and timelines, to implement these strategies. The Convention itself, or a later protocol, could establish processes for monitoring progress on and encouraging international support for these plans. A protocol might also extend commitments on universal health coverage to a broader set of social services, establishing for everyone a social protection floor.²¹³ Similarly, the FCGH could both require countries to develop specific plans of action to ensure full health equity for women and require that these plans remove obstacles women and girls face to health systems and other determinants of health.

By establishing an agreed and obligatory roadmap to universal coverage, the treaty would help clarify, monitor, and incentivize compliance with the right to health, including specifying its core obligations²¹⁴ and elucidating its progressive realization requirement. An FCGH would set out principles, benchmarks, and processes for expanding the level of health services available to all under the human rights framework. The norms that the FCGH affirms or establishes in international law would range beyond universal health coverage. It would elevate the right of people to participate in health-related planning²¹⁵ to a clearly articulated and legally enforceable principle of the right to health.

Perhaps most significantly, the FCGH would firmly embed in binding international law not only non-discrimination, but also the more far-reaching concepts of equal access as an immediate obligation of the right to health. It would affirm that this obligation is both a shield against malfeasance and a sword to cut away at inequities—in access to health services and fundamental human needs and in securing broader determinants of health, such as employment and

PHYSICAL ACTIVITY AND HEALTH, WORLD HEALTH ORG. (2004), http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf.

²¹³ *See id.*

²¹⁴ *General Comment 14*, *supra* note 138, ¶ 43.

²¹⁵ *E.g., id.* ¶ 11 (stating that an important aspect of the right to health is “participation of the population in all health-related decision-making at the community, national and international levels”); *id.* ¶ 43(f) (requiring a national public health strategy and plan of action to be developed “on the basis of a participatory and transparent process”).

healthy environments. It is not enough that states protect all of their inhabitants from policies and practices that would undermine the health status of certain groups. States must also take affirmative measures to improve health outcomes for population groups that are being left behind.

We turn now to the aspects of an FCGH required to realize this expansive vision of universal health coverage and to significantly advance the right to health. We discuss different targets that the FCGH could include, explain a process to balance global norms with country circumstances, and illustrate how an FCGH could mobilize the funding required for universal health coverage. We outline how an FCGH could promote the global governance for health required to organize a multiplicity of international organizations and NGOs towards a common purpose of universal health coverage, and to ensure that other international legal regimes do not detract from—but rather contribute to—the right to health. Finally, we offer ways in which an FCGH could promote accountability, from that of the local health services to state obligations under the FCGH.

B. Targets and Benchmarks

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

Countries typically already establish targets, timelines, and strategies in many of these areas. The difference now is that they must accord to certain standards and goals backed by the necessary resources—as well as the assurance of international support to achieve these goals. Similarly, the pathways to underlying determinants of health for everyone might be tailored to country circumstances, with targets, timelines, and strategies. Consider clean water and decent sanitation. A country where only 75% of the population has access to safe drinking water cannot be expected to achieve universal access to safe drinking water by the same year as a country where 98% of the population already has

such access. Conversely, it should not be acceptable for countries where coverage is already high to delay in achieving universal coverage until far poorer countries can achieve this goal.

Further, what precisely clean water and decent sanitation entail is not straightforward. The MDGs measure the proportion of the world's population with "improved" sources of water and sanitation.²¹⁶ Yet within these improved sources is a wide range of technologies, not all of which are equal in protecting health. Improved water sources range from a borehole or protected well that might be a kilometer away from a person's dwelling to clean water piped into one's home. Improved sanitation includes not only indoor toilets, but also pit latrines.²¹⁷ Different countries may establish varying timelines to provide universal access first to more modest "improved" sources of drinking water and sanitation, then to piped water and indoor toilets.

C. A Flexible and Inclusive Process

A key strength of the Framework Convention/Protocol approach is that the treaty sets globally applicable norms that are needed in every society for good health and reduced inequalities, while launching an inclusive process for grassroots buy-in and specifically tailoring commitments to the specific national and local population health needs. Here is an illustration of how this bottom-up, inclusive process would operate.

The FCGH could include ambitious, yet achievable, global targets. These would be refined locally through participatory, equitable processes that adapt them to local circumstances and ensure national and community ownership.²¹⁸ This local tailoring should enhance accountability, as the targets will truly be the country's own, and not viewed as externally imposed. Country ownership should promote not only government buy-in, but also genuine national priorities for improved health. The nationally developed targets could be included in a treaty protocol, a later codification that could affirm international support for these targets, while also subjecting them to the various monitoring and compliance processes of the FCGH.

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

216 *The Millennium Development Goals Report 2011*, UNITED NATIONS 53–55 (2011), http://www.beta.undp.org/content/dam/undp/library/MDG/english/MDG_Report_2011_EN.pdf.

217 *Water Sanitation Health*, WORLD HEALTH ORG., <http://www.hho.int/water-sanitation-health/monitoring/jmp2012/key-terms/en/index.html> (last visited Dec. 1, 2012).

218 See Jeff Waage et al., *The Millennium Development Goals: A Cross-Sectoral Analysis and Principles for Goal Setting After 2015*, 376 LANCET 991 (2010).

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

This inclusive, national process can also establish the health services guaranteed to everyone, based on general guidelines and minimum standards in the FCGH. This will ensure that these guarantees match local circumstances and priorities, while avoiding endless battles at the global level to come to agreement on a detailed list of requirements.

The FCGH's process also foresees protocols that could be used for agreements on issues that parties cannot resolve when negotiating the initial treaty, to address problems that arise during the course of treaty implementation, and to respond to changes in the global health environment. A protocol might include a more detailed financing framework, effectively encompass a proposed new treaty on health research and development, more fully address complexities of health worker migration, establish innovative financing mechanisms, and strengthen mechanisms to promote treaty compliance and right to health accountability. Protocols could include specific ways in which state parties will engage in other legal regimes to promote health, bring additional social health determinants within the treaty's scope, or link the FCGH to broader initiatives, such as ensuring a universal social protection floor.

They might be supplemented by amendments to the treaty, such as updated funding formulas and standards, to respond to changing costs, economic growth, and evolving scientific knowledge. The expectation of protocols will also help maintain a global focus and stimulate global discussion on health inequities.

D. Sustainable Funding Scalable to Needs

Although increased global health spending has not reduced the global health equity gap, it has contributed to significant progress against AIDS and other diseases and causes of death that have their greatest impact in the global South. Moreover, even while efficiencies can contribute significantly to “more health for the money,” “more money for health” is also required if global health inequities are to be significantly reduced.²¹⁹ The FCGH, therefore, would have to

²¹⁹ *More Money for Health, and More Health for the Money*, TASKFORCE ON INNOVATIVE INT'L FIN. FOR HEALTH SYS. (2009), http://www.ausaid.gov.au/publications/Documents/more_

include a financing framework with clear funding benchmarks for governments' domestic health spending and for international health funding commitments.

The urgency of a framework to secure adequate funding is especially great now, as major economies look for ways to cut budgets, particularly expenditures for foreign assistance. The framework will have to ensure adequate funding backed by mechanisms to hold all partners accountable, while achieving political buy-in and avoiding detrimental competition with other global financing demands, such as climate change mitigation and adaptation. This poses a particularly difficult challenge for any international law regime.

Innovative financing mechanisms, support for countries' efforts to increase tax collection and prevent tax avoidance and evasion, private financing, and other measures could supplement ordinary government funding. With some creativity and the fortitude to resist entrenched interests (e.g., beverage industry opposition to taxes on sugary drinks and financial industry opposition to financial transaction taxes), these mechanisms could raise substantial resources.

New forms of taxes and fees, such as those placed on unhealthy foods and on medical tourism, could be implemented domestically and raise additional funds.²²⁰ Meanwhile, illicit capital flight from low- and middle-income countries has been estimated at more than \$850 billion in 2010, representing enormous losses in tax revenue; tax havens for wealthy individuals alone may cost low- and middle-income countries \$50 billion annually in lost tax revenue.²²¹ The FCGH could facilitate these taxes, fees, and enhanced tax collection, such as through establishing information sharing, capacity building, and international cooperation responsibilities. Or, going beyond this, the FCGH could include more precise commitments, such as requiring taxes on unhealthy foods, increased tobacco taxes, or other sources of revenue.

FCGH financing commitments and mechanisms would establish and put into effect an understanding that financial sustainability should encompass both domestic and international funds, based on national and global solidarity and the right to health.²²² International funding would be provided directly to countries or channeled through a common funding mechanism, such as a Global Fund for Health,²²³ to best ensure country ownership and to simplify the landscape of health actors at the country level. It could be that only wealthier nations provide international financing. Alternatively, not unlike a highly progressive national

money_for_health.pdf.

²²⁰ See *World Health Report 2010*, *supra* note 71, at 29.

²²¹ Dev Kar & Sarah Freitas, *Illicit Financial Flows from Developing Countries: 2001-2010*, GLOBAL FINANCIAL INTEGRITY 9 (Dec. 2012), <http://iff.gfintegrity.org/iff2012/2012report.html>; *Why Do Tax and Capital Flight Matter for Health?*, ECON. GOVERNANCE FOR HEALTH (Apr. 1, 2009), <http://www.eg4health.org/get-informed/tax-capital-flight-and-health/>.

²²² See Ooms & Hammonds, *supra* note 186.

²²³ Giorgio Cometto et al., *A Global Fund for the Health MDGs?*, 373 LANCET 1500 (2009); see Ooms et al., *supra* note 131.

system of social protection extended globally,²²⁴ in line with the concept of global solidarity and to take into account the growing financial capacity of many developing countries, all countries would provide international health assistance, with levels based on economic capacity. Poorer countries would receive far more than they contribute, and wealthier countries would contribute far more than they receive. Particularly if wealthier countries continue to provide much of their assistance bilaterally, supplementary provisions may be necessary, such as to untie aid²²⁵ and to encourage using local contractors and sources of technical expertise to make aid more efficient and effective.²²⁶

Much as the FCGH could encourage and facilitate innovative sources of domestic financing, it could also establish forms of innovative international financing for health, such as financial transaction taxes. One review found eleven operational and three proposed novel international funding mechanisms for global health (and another twelve operational or proposed mechanisms to stimulate innovation and fund global health research).²²⁷ These mechanisms could provide predictable sources of health funding that are less dependent on state compliance to the FCGH. In addition, a trust fund or similar mechanism could guard against funding volatility. For example, if several countries are failing to meet their international financing responsibilities, funding formulas could automatically adjust so that other countries cover the difference, or innovative mechanisms could compensate through slightly higher fees or tax levels. Such an approach would need to be coupled with a treaty enforcement regime that effectively dissuades countries from being free riders, knowing that other sources of revenue will be found.

Any funding formula that the FCGH includes is unlikely to be nuanced enough to fully capture the many factors that go into determining whether a country is spending the maximum of its available resources,²²⁸ particularly given that this requirement spans all economic and social rights and cannot be viewed in isolation from them. Thus, the requirements in the FCGH would not obviate the more general obligations of the ICECSR. They could establish, however, valuable benchmarks that serve as strong indicators of whether a country is meeting its obligation to spend “the maximum of its available resources.” The requirements in the FCGH would also provide far greater clarity on what the

224 Gorik Ooms, *From the Global AIDS Response Towards Global Health?* (Hélène de Beir Foundation and the International Civil Society Support Group, Working Paper, Jan. 2009), available at http://photos.pih.org/inforesources/IHSJ_Stony_Point_Conference_2009/From_the_Global_AIDS_Response_towards_Global_Health_G.Ooms.pdf.

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

226 See Dybul et al., *supra* note 85.

227 Josh Michaud & Jen Kates, *Innovative Financing Mechanisms for Global Health: Overview & Considerations for U.S. Government Participation*, THE HENRY J. KAISER FAMILY FOUND. 11–12 (2011), <http://www.kff.org/globalhealth/upload/8247.pdf>.

228 MAXIMUM AVAILABLE RESOURCES, *supra* note 141.

ICESCR's obligation on international assistance entails, as well as the comparable obligation in the United Nations Charter.²²⁹

E. Global Governance for Health

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

The FCGH would empower host countries to take the lead in managing all funding and technical partners around a single national health strategy. The treaty could extend and strengthen present efforts, such as through the IHP+,²³⁰ to align international funding with national health strategies. Ministries of health would be responsible for monitoring and evaluation frameworks by firmly embedding in international law the global health equivalent of the three ones (one national AIDS action framework used to coordinate the work of all partners, one national AIDS coordinating authority with a multi-sector mandate, and one agreed country monitoring and evaluation system).²³¹

The FCGH could require international partners to report regularly on obstacles to adhering to these principles and to develop action plans to overcome them, to inform health ministries of any funding and programs outside the direct control of the ministries, and to contribute to a national map of health activities to avoid duplication and gaps in coverage. It could require that countries providing bilateral assistance channel a minimum and gradually increasing percentage of it to direct support for the national strategy. Alternatively, as part of a financing framework, the FCGH could specify the proportion of international support that should be directed to a Global Fund for Health, with its direct support for national strategies.

The FCGH could also insist that where national systems (e.g., supply chain, health information, and financial management) achieve a certain level of quality, international partners commit to using these systems rather than creating their

229 Through article 56 of the United Nations Charter, states "pledge themselves to take joint and separate action in co-operation with the" United Nations to achieve "conditions of stability and well-being," including universal observance of human rights and fundamental freedoms. U.N. Charter arts. 55–56.

230 For more information on the International Health Partnership and related initiatives (IHP+), see INTERNATIONAL HEALTH PARTNERSHIP AND RELATED INITIATIVES, <http://www.internationalhealthpartnership.net/> (last visited Dec. 3, 2012).

231 "Three Ones" Key Principles UNAIDS, (2004), http://data.unaids.org/UNA-docs/three-ones_keyprinciples_en.pdf.

own parallel systems. One approach would be to build on the Joint Assessments of National Health Strategies and Plans (JANS) of the IHP+ process. Through JANS, the host government, civil society, and development partners collectively review national health strategies. Where the assessments give a quality stamp of approval on a national health system component, partners could agree to use these systems, while they could also agree to strengthen system components that remain inadequate.

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

Although rationalization of health sector actors is important, so too is harmonizing widely diverse requirements in parallel international law regimes. The FCGH would have to seek greater consistency and priority for human health among non-health sectors, such as trade, environment, finance, and migration. It might provide that all clear conflicts that might arise between these regimes and the FCGH must be resolved in favor of the FCGH and the right to health. For example, a policy that another regime allowed or even encouraged that interferes with a country's capacity to ensure universal health coverage would be impermissible. Such a rule might not only alter the behavior of states under the FCGH, but could also begin to establish new norms applicable to all states. The FCGH could require countries to conduct national policy reviews to identify conflicts with the right to health and to reform policies inconsistent with the right. In addition, to ensure continued policy cohesion around the right to health, countries would conduct right to health assessments of planned policies and projects outside the health sector to ensure their consistency with the right to health.²³²

The FCGH could offer specific actions that countries should take in non-health realms and mechanisms to evaluate the adoption and effective implementation of these measures. For example, an FCGH could inform adaptation measures that will reduce the health impact of climate change, ensure that intellectual property agreements and laws do not interfere with public health,

232 Eric A. Friedman & Lawrence O Gostin, *Pillars for progress on the right to health: Harnessing the potential of human rights through a Framework Convention on Global Health*, 14 HEALTH AND HUMAN RIGHTS 1, 4–5 (June 2012), available at <http://www.hhrjournal.org/index.php/hhr/article/view/483/740> [hereinafter *Pillars for Progress*].

and regulate “land grabs”—the large-scale foreign purchase of land in developing countries, which can threaten food security.²³³ The FCGH may be able to manage potential resource competition among regimes, for example, if a Global Fund for Health and a Green Climate Fund were both mandated to raise some of their resources through financial transaction taxes.

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

Along with placing WHO at the center of global governance for health, the FCGH could include other measures to enhance WHO’s leadership. It could commit states to increased unearmarked funding to WHO. The FCGH might even include steps to enhance civil society participation in WHO governance, from lowering the bar to NGO participation in the World Health Assembly to more far-reaching reforms.²³⁴

The FCGH should find ways to respond not only to regimes where health is not presently a central value, but also to non-state actors that that can powerfully impact—both for better and for worse—the right to health. The private sector, for example, has a substantial effect on the health of populations, ranging from pharmaceuticals, food, beverages, alcohol, and tobacco to energy, mining, transportation, and labor practices. The treaty could define the responsibilities of states to effectively regulate transnational corporations as they relate to health and identify ways to incentivize compliance. By mediating their interactions with states, or international organizations, it could find innovative ways to more

233 *Special Investigation Phase One: Understanding Land Investment Deals in Africa*, OAKLAND INST., <http://www.oaklandinstitute.org/special-investigation-understanding-land-investment-deals-africa> (last visited Dec. 9, 2012).

234 See Sridhar & Gostin, *supra* note 113. The potential for reforming the WHO through an FCGH would depend in part on whether the FCGH were to be adopted by the World Health Assembly or another forum, in particular, the United Nations General Assembly. For more on possibilities for greater civil society inclusion in WHO processes, see WHO, *WHO Reforms for a Healthy future: Report by the Director-General*, Doc. EBSS/2/2 (October 15, 2011), at ¶ 88-91; Gaudenz Silberschmidt, Don Matheson & Ilona Kickbusch, *Creating a Committee C of the World Health Assembly*, 371 LANCET 1483 (2008).

directly bring corporations under requirements of the right to health, even if they are not themselves party to the FCGH. The PIPF has found a way to create contractual corporate obligations, even though PIP only directly applies to states.²³⁵

F. Accountability and Treaty Monitoring and Compliance

Greater accountability must be at the heart of improved global governance for health and hence would be central to the FCGH, from government accountability for health services delivered to communities to accountability for their international obligations. To enhance accountability within countries, the FCGH could require countries to develop plans to combat corruption and poor accountability in the health sector. The FCGH could have several guidelines for what all states must include in these plans, such as local accountability mechanisms; rules on transparent procurement including through competitive bidding; and transparent reporting on funding allocations in health and related sectors, including the flow of these funds to particular programs and even specific projects, communities, and facilities.

As part, or instead, of a national strategy, the FCGH could also separately require these measures, including developing community-based strategies for monitoring and holding government responsible for local health services. These strategies might include community scorecards and functioning community health committees.²³⁶ Countries could tailor their accountability strategies to incorporate solutions to other corruption concerns, such as through improved supervision, incentives to reduce health worker absenteeism, curtailing informal payments, and a computerized database of health workers to remove “ghost” workers from payrolls.²³⁷

An FCGH could establish additional national and local accountability processes, such as maternal and child mortality audits.²³⁸ To ensure

235 See Pandemic Influenza Preparedness Framework, *supra* note 37, at art. 5.4, Annex 2 (providing a Standard Model Transfer Agreement under which, through enforceable private contracts, vaccine or medical manufacturers that benefit from WHO’s virus sharing network would agree to donate a portion of the vaccines or medications to WHO).

236 For more on community scorecards see *Citizen Report Card and Community Score Card*, WORLD BANK, <http://go.worldbank.org/QFAVL64790> (last visited Nov. 29, 2012). Community-based monitoring, such as scorecards, can have a powerful impact on health outcomes. A study in Uganda attributed a one-third drop in child mortality in certain communities to use of scorecards and associated monitoring activities. See Martina Björkman & Jakob Svensson, *Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda*, 124 Q. J. ECON. 735 (2009).

237 See Lewis, *supra* note 180, at 6–7.

238 Maternal, newborn, and child death audits are meant to capture the structural and systematic factors that must be addressed to reduce maternal, newborn, and child deaths. For more on these audits, see UN Special Rapporteur on Health, *Preliminary Note on the Mission to India, Addendum*, U.N. Doc. A/HRC/7/11/Add.4 (Feb. 29, 2008); *No Tally of the Anguish: Accountability*

accountability to poor, marginalized, and vulnerable populations, an FCGH could include targets, strategies, and mechanisms—or processes to develop them—to ensure an emphasis on equity and meeting the needs of these populations. These could encompass disaggregated data, funding, participation, and outreach. The FCGH could require states to assess stigma and discrimination in the health sector, implement strategies to reduce such attitudes and practices, and hold health workers accountable for mistreating patients.

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

The FCGH could establish a new right to health capacity-building mechanism to fund civil society organizations and community networks, expand public and health worker education on the right to health, educate policymakers on this right, and support other measures to strengthen accountability and national understanding of the right to health, what it entails, and what obligations and rights it entails.²³⁹

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

As with any treaty, an FCGH's success will depend on the difficult issue of compliance. States would regularly and transparently report on their compliance with the FCGH, including progress towards benchmarks. Civil

in Maternal Health Care in India, HUMAN RIGHTS WATCH (2009), <http://www.hrw.org/en/reports/2009/10/08/no-tally-anguish-0>; South Africa Every Death Counts Writing Group, *Every Death Counts: Use of Mortality Audit Data for Decision Making To Save the Lives of Mothers, Babies, and Children in South Africa*, 371 LANCET 1293 (2008).

²³⁹ *Pillars for Progress*, *supra* note 232, at 5.

society organizations and other non-state actors would be welcome to formally provide their own reports and data on state compliance, which would also be factored into determining state compliance, with states encouraged to include civil society in drafting their own formal reports. Through a process of peer review, neighboring states might also have a role in assessing compliance. To further ensure the credibility and effectiveness of the compliance regime, the FCGH might also include a proactive mechanism to investigate state compliance if states fail to adhere to reporting requirements.

Effective compliance for the FCGH should also include an innovative regime of incentives and sanctions. This regime could include certain forms of international support provided only to states meeting obligations, suspension of eligibility for WHO Executive Board membership or of other WHO rights, and encouraging or requiring state parties to grant national courts jurisdiction to hear cases brought by their populations involving FCGH violations. Any sanctions would have to be carefully designed to ensure that this treaty on the right to health does not inadvertently undermine that right by limiting international support to the populations that most need it.

VI. THE PATH TOWARDS AN FCGH

Therefore, the architecture of a Framework Convention on Global Health would (1) encompass core normative standards for health systems and underlying determinants of health, while beginning to reach broader socioeconomic determinants as well, (2) facilitate an inclusive participatory process for norm development suited to national needs and priorities, (3) establish funding modalities to build capacity in low-income and middle-income countries to meet the broad health needs of their populations, (4) prioritize and incorporate the right to health in other legal regimes, (5) strengthen health monitoring and accountability at community, national, and global levels, and (6) ensure a priority to equity and the needs and rights of disadvantaged populations throughout.

A. Overcoming Resistance and Other Challenges

The scope and ambition of such a treaty promises that achieving it will not be easy. Even some in civil society have asked whether such a treaty is truly needed, whether it is achievable, and, even if states adopt and ratify it, whether they will then follow through and implement it. Here we touch on these concerns.²⁴⁰

First, why promote a treaty? After all, the right to health that would be at the core of the FCGH is already contained in numerous treaties. Yet this fact has

²⁴⁰ For additional discussion on these and other possible objections, see *Preliminary Answers to 5 Priority Questions on the Framework Convention on Global Health*, JALI (Feb. 2012), <http://jalihealth.org/>.

proven insufficient to resolve tremendous and persistent health inequities. The right to health requires far greater precision to clarify such central obligations as what entails the primary health care that is part of its core minimum obligations, the pace and nature of progressive realization, and what precisely counts as states' maximum available resources. Moreover, to resolve health inequities, the delineation of these responsibilities may have to extend beyond prevailing understandings, as with international cooperation and assistance, and cover areas and actors inadequately addressed, such as state responsibility vis-à-vis transnational corporations. Further, such key principles as equal access, equity (beyond the command of non-discrimination), and participation are poorly reflected in such central treaties as the ICESCR, being instead developed through non-binding mechanisms, including the CESCR and reports of the United Nations Special Rapporteur on the right to health.

Why, though, is binding law required? For even as non-binding agreements may form welcome stepping stones towards the FCGH, ultimately, a new legally binding agreement is needed, for at least three reasons, beyond the truism that creating binding law will create or clarify obligations that are decidedly not optional, as they should not be for a concern as grave as health inequities. First, at least in countries where rule of law prevails, a treaty will likely create a greater sense of internal commitment to the agreement's stipulations, thus encouraging compliance.

Second, a treaty opens up additional channels of accountability, including the courts, with their increasing importance in enforcing economic, social, and cultural rights. Wherever treaties are justiciable directly, or where incorporated into national law as treaty ratifiers would be obliged to do, the courts can be an avenue to force treaty compliance. Legally binding commitments, particularly those with the precision that an FCGH would include, will create a stronger foundation for civil society advocacy. They will also create additional incentives (e.g., assured levels of assistance) and sanctions (e.g., suspension of certain WHO privileges) for compliance.

Third, law is needed to respond to law. Regimes that can negatively impact health are themselves rooted in bilateral, regional, and global treaties. A legally binding treaty has a far greater chance of influencing the position of health within these regimes than a non-binding agreement.

Even accepting the importance of the FCGH, is it achievable? Would states agree to assume its obligations? Or would distrust between the global North and South, or the financial obligations—and indeed, good governance obligations thrust upon states where poor governance can be lucrative—prove too great obstacles?

States may well conclude that such a treaty is in their interest, as they recognize that with mutual responsibilities come benefits for all. Countries in the global South would benefit above all from improved health for their populations,

but also from greater respect from international partners for their strategies; more, and more predictable, international funding; and prioritization of health in other legal regimes where the health harms otherwise fall most on their populations. Strengthened accountability systems would give wealthier countries more confidence that their assistance is being well spent, while strengthened health systems in poorer countries will help protect their own populations from global public health threats. Domestic financing commitments should over time lead to decreased need for international assistance over time. Meanwhile, all countries—and people everywhere—would benefit from the positive effects of better health in other realms—including economic,²⁴¹ educational, environmental, and security—along with lessons on improving health that they may be able to adopt. In addition, all countries can know that, as with endorsing a human rights regime decades ago, they are taking a significant step forward in a historic venture to create a more just world.²⁴²

Still, the key to achieving an FCGH is likely to be political pressure. We view the campaign for an FCGH not as an independent movement directed at a single treaty, but rather as part of a process of building social movements around

241 Economic benefits will be considerable. Health services contribute to increased productivity and other sources of economic growth, including by maintaining a healthy workforce and, over the longer-term, by contributing to children's education and healthy development. Under-nutrition alone can lower a country's GDP by 2%. Ban Ki-moon, U.N. Secretary-General, *Global Strategy for Women and Children's Health* 6 (2010), http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf (citing SUSAN HORTON ET AL., SCALING UP NUTRITION: WHAT WILL IT COST? (2010)). Meanwhile, 30-50% of economic growth in Asia from 1965 to 1990 has been attributed to improved reproductive health, reduced infant and child mortality, and reduced fertility. *Id.* (citing *Investing in Maternal, Newborn and Child Health – The Case for Asia and the Pacific*, WORLD HEALTH ORG. & THE P'SHIP FOR MATERNAL, NEWBORN, & CHILD HEALTH (2009), http://www.who.int/pmnch/topics/economics/20090501_investinginmch/en/index.html).

HIV/AIDS slowed the rate of annual GDP growth across 33 countries in sub-Saharan Africa from 1992 through 2002 by an average of 1.1%. *HIV/AIDS and Work: Global Estimates, Impact and Response*, INT'L LABOUR OFFICE 77 (2004), http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_116379.pdf. The World Bank found that, compared to maintaining 2005 levels of tuberculosis treatment in sub-Saharan Africa, scaling up tuberculosis treatment and control interventions through 2015, in-line with the Stop TB Partnership's Global Plan to Stop TB, would require an additional of \$10 billion, but would bring \$88 billion in economic benefits. Ramanan Laxminarayan et al., *Economic Benefits of Tuberculosis Control* 16–17 (World Bank Human Development Network Health, Nutrition & Population Team, Working Paper, Aug. 2007), available at <http://www.who.int/management/EconomicBenefitofTuberculosisControl.pdf>. More broadly, a year increase in life expectancy raises a country's per capita GDP by approximately 4%. David E. Bloom et al., *Health, Wealth, and Welfare*, in *HEALTH AND DEVELOPMENT: A COMPILATION OF ARTICLES FROM FINANCE & DEVELOPMENT* 10–15 (Jeremy Clift ed., 2004). Meanwhile, prevention and control measures frequently more than pay for themselves through averted treatment costs. For example, a dollar spent on family planning typically will save at least four dollars in treatment costs of pregnancy-related complications. See Ban Ki-moon, *supra* at 6 (citing Jennifer J. Frost et al., *The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings*, 19 J. HEALTH CARE FOR POOR & UNDERSERVED 778 (2008)).

242 See *Joint Action and Learning Initiative*, *supra* note 12, at 4.

the right to health. If an FCGH is achieved, although state recognition of their interests in such a treaty will be important, ultimately it will be possible because their people demand it. Such social mobilization will also be at the heart of ensuring treaty compliance, once states ratify it.

The treaty will face challenges beyond political resistance. One is ensuring that the treaty will in fact address the health priorities and favored solutions by the populations in the global South—along with marginalized communities in wealthier countries—whose right to health is today further from being fulfilled. JALI is committed to a broad, inclusive process in drafting a treaty, recognizing that the urgency of an FCGH must be balanced by a process that will ensure the treaty's strength and effectiveness.

JALI is steering this broad consensus process, with the intent of helping launch a broader International Campaign for a Framework Convention on Global Health, of which JALI will be one member of many. JALI places critical importance on an extensive, inclusive process of input, including through community, regional, and global consultations, online consultative processes, and targeted research. We invite readers to join JALI's efforts through <http://www.jalihealth.org>, and once it is underway, the broader campaign.

There will be substantive challenges in developing every aspect of the treaty. One such challenge will be defining financing obligations, which will need to encompass multiple sectors, not only health (also, for example, water and sanitation, and agriculture). Should each sector have a target, or should countries have considerable leeway in allocations across sectors? A cross-sector target might threaten accountability, but would include needed flexibility. For instance, while investments in agriculture will be critical for food security in some countries, agriculture may be negligible in other countries—or, in countries where tobacco is a major crop, ultimately harmful to health. How would different approaches affect accountability?

Further, should financing targets differ across countries at different income levels with respect to their own national health investments? For example, wealthier countries would likely need to spend a far lower percentage of their GNI on water and sanitation. And should all countries have international financing responsibilities, small as these might be for poorer countries, in the spirit of solidarity and shared responsibility? Or given the health needs of poorer countries, along with the possibility that they would simply get their contributions back through the international support they receive, should these contributions be limited to wealthy countries? What of the growing economic middle-income powers, such as the “BRICS” (Brazil, Russia, India, China, and South Africa)?

Few challenges will be greater than establishing an effective regime of incentives and sanctions to address failure to comply with treaty requirements, beyond several possibilities that we have described. We believe far stronger

sanctions could be justified given that the scale of death from a government's failure to meet its population's right to health can match or exceed that of the atrocities that may lead the UN Security Council to impose targeted sanctions, particularly asset freezes and travel bans, on abusive government officials. Yet even with strong social movements, the prospects of countries agreeing to the possibility of such sanctions would seem dim. Meanwhile, measures such as reduced international support where countries fail to meet their own responsibilities risks harming the health of the very populations who are in greatest need of such support, and whose health is already being harmed by their own government's failings—something that would be unacceptable in a global health treaty. One possibility would be to re-channel funding from governments to civil society organizations, but this would risk deepening duplication and fragmentation, one of the concerns the FCGH is meant to address. Another is to re-channel some funds—beyond additional funds that might already be provided through a right to health capacity-building mechanism—to support civil society organizations and social movements seeking to hold their governments accountable, though governments might respond by limiting foreign funding that NGOs can receive.

Yet there is a wealth of experience to build on, from existing commitments (e.g., the Abuja Declaration) to accountability mechanisms from the community level (e.g., community scorecards, budget transparency) to the global level (e.g., the WTO regime). The FCGH will be able to draw upon the best of other legal regimes, as well as innovative thinking. We are confident that a sufficiently extensive process of research and consultation will find the best solutions—even as sometimes, there will be no perfect solution.

B. Legal Pathways

Several forums could be home to the FCGH. One is WHO, building on its success with the Framework Convention on Tobacco Control and utilizing WHO's underused, yet powerful, treaty-making powers through the World Health Assembly, WHO's governing body comprising all member states.²⁴³ Given that one of the treaty's goals would be to strengthen global health leadership, particularly through WHO, and the treaty's subject matter, WHO would be a natural home for such a treaty. It would also mean that health ministers negotiate the treaty, desirable given the treaty's potential to significantly advance their own goals.

However, the scope of an FCGH—affecting regimes far beyond health—

243 Under the WHO Constitution, a two-thirds vote of the World Health Assembly is required to adopt a convention. Member states of WHO are then required, within eighteen months, to either ratify the convention or inform the WHO Director-General why they have not (yet) accepted it. WHO Const., *supra* note 72, at arts. 19-20.

may make the United Nations the proper home. With the treaty's grounding in human rights, the UN Human Rights Council could draft the treaty in the first instance, before forwarding a draft treaty to the General Assembly for all UN members to consider. The Human Rights Council could include civil society in a working group that develops the treaty, as the Council's predecessor, the Human Rights Commission, did when drafting the Convention on the Rights of the Child.²⁴⁴ Alternatively, the General Assembly could, in the first instance, designate a committee or working group of the full General Assembly to draft the treaty.

Another possibility would be to develop the treaty outside of either the United Nations or WHO, as was the case for the Land Mines Treaty.²⁴⁵ Although the United Nations General Assembly endorsed the need for such a treaty and urged countries to ratify it once it was adopted,²⁴⁶ and the treaty was intricately linked to the United Nations,²⁴⁷ the process itself was atypical. In a rapid series of events known as the Ottawa Process, launched by fifty like-minded states in Ottawa in 1996, Austria drafted the treaty in close collaboration with the International Campaign to Ban Landmines and the International Committee of the Red Cross, with the treaty adopted in Oslo in September 1997, opened for signature in Ottawa in December 1997, and entering force in March 1999.²⁴⁸

Whatever the formal process, civil society must be at the heart of developing the FCGH to ensure that it captures the ambition required to resolve the immensity and complexity of the problem that it aims to address. Although traditionally states have initiated and negotiated treaties, recent history suggests that bottom-up processes are not only possible, but also increasingly necessary. Along with the central role of civil society in the Mine Ban Treaty and

244 *United Nations Background Note: Children's Rights*, UNITED NATIONS (1995), <http://www.un.org/rights/dpi1765e.htm>; *Children's Rights History*, CHILDREN'S RIGHTS PORTAL, <http://childrensrightsportal.org/childrens-rights-history/> (last visited Nov. 29, 2012).

245 Mine Ban Treaty, *supra* note 4.

246 General and Complete Disarmament, U.N. General Assembly Res. 51/45, at S, U.N. Doc. A/RES/51/45 (1996), *available at* <http://www.un.org/depts/dhl/resguide/r51.htm> (international agreement banning anti-personnel landmines); General and Complete Disarmament, U.N. General Assembly Res. 52/38, at A, U.N. Doc. A/RES/52/38 (1999), *available at* <http://www.un.org/depts/dhl/resguide/r52.htm> (Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on Their Destruction).

247 *See* Mine Ban Treaty, *supra* note 4, at art. 7 (requiring state reports to be filed with the U.N. Secretary-General); *id.* at art. 8 (allowing states to submit a Requests for Clarification regarding compliance to the U.N. Secretary-General); *id.* at art. 11 (empowering the U.N. Secretary-General to call special meetings of the state parties); *id.* at art. 12 (directing the U.N. Secretary-General to convene a review conference); *id.* at art. 21 (designating the U.N. Secretary-General as the treaty repository).

248 *Ban History*, INTERNATIONAL CAMPAIGN TO BAN LANDMINES, <http://www.icbl.org/index.php/icbl/Treaty/MBT/Ban-History> (last visited Nov. 29, 2012); *What is the Ottawa Process or the Mine Ban Treaty?*, UNITED STATES CAMPAIGN TO BAN LANDMINES, <http://www.uscbl.org/about-landmines/mine-ban-treaty/> (last visited Nov. 29, 2012).

Convention on the Rights of the Child, a coalition of NGOs proposed and successfully advocated for the Convention on the Rights of Persons with Disabilities.²⁴⁹

An FCGH will need to follow this pathway as well. Like these other treaties, the role of civil society will be central at all stages, from developing the concept and populating the treaty, to advocating for its adoption and ratification, to monitoring its implementation. The Framework Convention Tobacco Alliance, for example, has driven the implementation and expansion of the FCTC. As the overwhelming majority of deaths attributable to health inequities occur in the global South—even as health inequities kill in the global North as well—it is imperative that Southern civil society, along with states of the global South, drives this process.

VII. CONCLUSION

Most people understand that the defining issues of our time—among them climate change, food security, and global health—demand collective action, normative standards, and compliance mechanisms. It is hard to envisage fundamental change without the force of international law.

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

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

A far-reaching process of developing an FCGH is needed not only to ensure the strongest possible treaty, but also to develop a social movement behind it.

²⁴⁹ *History*, UNCPR INDIA, <http://uncrpdindia.org/about/history/> (last visited Nov. 29, 2012); Janet E. Lord, *NGO Participation in Human Rights Law and Process: Latest Developments in the Effort to Develop an International Treaty on the Rights of People with Disabilities*, 10 ILSA J. INT'L & COMP. L. 311, 316-318 (2004).

FCGH advocates face overwhelming challenges in securing the treaty, with resistance likely from powerful governments and influential transnational corporations. As much as progressive government leadership will be needed to navigate the FCGH from the conceptual realm to binding international law, the treaty's adoption and widespread ratification will require pressure from below, in both the global South and North. With a purview that extends far beyond health care services, the social movement behind an FCGH—like the FCGH itself—will need to encompass not only more traditional health movements, but also other social movements that intersect with the right to health, such as the labor movement, movements around food security, the environment, and climate change, and movements for the rights of women, indigenous communities, and sexual minorities.

With fifty-four thousand deaths every day connected to global health inequities,²⁵⁰ developing international legal solutions should become a global priority. The United Nations Secretary-General's call to action for a Framework Convention on Global Health will test the international community's oft-reiterated commitment to global health and human rights. The question remains: Are states prepared to take the bold steps necessary to silence the daily drumbeat of preventable illness, suffering, and early death?

250 See Garay, *supra* note 2.