Global health: What it has been so far, what it should be, and what it could become

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This working paper brings together (and further develops) ideas and findings that have been published before. These can be divided roughly into three themes: the inefficiency and inefficacy of the past and current development assistance paradigm for improving public health in poorer countries; the right to health and what it should mean for international co-financing of efforts to improve public health in poorer countries; and recent evolutions in the international political scene and the opportunities they create to move ‘global health’ closer to what it should be. Due to the usual constraints on length imposed by academic journals, it has been difficult to discuss these themes together even though some of their added value springs precisely from their interaction. In hopes to correct that in this working paper, I first want to thank the many co-authors of these earlier papers, in alphabetical order: Yibeltal Assefa, Wang Chenguang, Kristof Decoster, Eric A. Friedman, Thomas Gebauer, Lawrence O. Gostin, Anand Grover, Narendra Gupta, Rachel Hammonds, Mark Heywood, Peter S. Hill, Degu Jerene, Sileshi Lulseged, Katabaro Miti, Sabine Rens, John-Arne Røttingen, David Sanders, Ted Schrecker, Devi Sridhar, Marleen Temmerman, Wim Van Damme, Luc Van Leemput, Peter Vermeiren, and Paul Zeitz.

It has been an honor and a pleasure to work together with these distinguished scholars, who share a willingness to think outside of the usual boxes. They may or may not agree with the way I’m trying to connect the dots in this working paper; the responsibility for that remains entirely my own.

I would also like to thank the external reviewers and the editors of this working paper series.

Finally, I would like to thank in advance everyone who will take the time to read this, and particularly those who will take even more time and share their comments with me (rooms@itg.be). This is a working paper.
General introduction

In March 2011, introducing a consultation on ‘global health governance’, the Director-General of the World Health Organization (WHO) said: “Commitment to the health-related [Millennium Development Goals] has unquestionably brought results. But many wonder if we are getting the best possible results from these increased investments. In other words, aid is still not as effective as it ought to be.” It puzzled me that most of the consultation participants seemed to be taking for granted that ‘global health’ is about richer countries contributing to efforts to improve the health of inhabitants of poorer countries, and that therefore the main challenge is to convince the decision-makers of richer countries how they can use their resources more effectively and efficiently. Whereas, in my opinion, global health so far has been mainly about richer countries advancing their own interests and about politicians in richer countries bowing to the sometimes more altruistic concerns of their constituencies.

According to Martin, “[t]heories of international cooperation ... made a big leap forward by accepting the assumption that states are self-interested and have conflicts of interest with one another.” For some reasons - perhaps the highly ethical aspects of health itself - many global or international health debates remain immune to this assumption. It seems simply unconscionable to posit that the past decade’s increase in life-saving efforts supported by richer countries in poorer countries, may have been motivated by anything other than the noble intention of saving lives. However, refusing to accept the assumption that states are self-interested, if only as a working hypothesis, may lead to sterile arguments. I realize that my own previous work on the right to health may have created the impression that if international human rights law prescribes something, we may safely assume that governments will eventually do what they agreed they would do, whether it serves their interests or not. That may be wishful thinking.

The realist approach, however, has its own pitfalls. Explaining why states do what they do - and accepting the assumption that states are essentially self-interested - may lead to accept the status quo, or to suggesting that reality is what it is and that nothing can be done about it (except running for the presidential office).

To avoid that dead end, in this working paper I shall propose two separate accounts of global health: a descriptive account and a prescriptive account - or global health as it has been so far and global health as it should be. Then, in a third section, I will try to expand on several opportunities I see for moving global health a bit closer to what it should be. Each of these three sections draws on a different methodology; it is important for the reader to keep that in mind.

The first section - global health, what it has been so far - draws on the methodology of international political economy. International political economy “at its most fundamental, in short, is about the

complex interrelationship of economic and political activity at the level of international affairs.”

Although drawing on international political economy, this section is fundamentally about the complex interrelationship of public health and political activity at the level of international affairs. The discipline of international political public health has not yet been established. There is an emerging discipline, called global health diplomacy: “Global health diplomacy is at the coal-face of global health governance - it is where the compromises are found and the agreements are reached, in multilateral venues, new alliances and in bilateral agreements.” Global diplomacy, however, contains many opinions on how governments and other agents ought to behave. There is really nothing wrong with that, except that I think it is important to distinguish between discussing how agents do behave and why, and discussing how agents ought to behave, if only to avoid confusion. If “[i]nternational political economy is deeply embedded in the standard epistemological methodology of the social sciences which, stripped to its bare bones, simply means stating a proposition and testing it against external evidence”, that is exactly what I will try to do in the first section, but applied to politics and public health at the level of international affairs. I will propose that the shift from ‘international health’ to ‘global health’ marks a difference between an era in which governments of richer countries felt little direct responsibility for poor public health in poorer countries, but instead counted mostly on the theory that the economic development of poorer countries would eventually enable them to take care of their own public health problems, and an era in which governments of richer countries accept a degree of shared responsibility for poor public health in poorer countries, but mostly to seek to advance shared interests (that is: interests that are interests for the inhabitants of richer countries too). In addition, I will try to explain why this approach is not working very well. Drawing on elements of political philosophy, I will highlight a crucial challenge for international political public health; i.e. the need for a global social contract on health, agreed between sovereign states.

The second section - global health, what it should be - draws on international human rights law. In this section, I will explore how agents of international public health ought to behave, to comply with international human rights law, including the agreements they negotiated, signed and ratified. International human rights law is mostly a prescriptive science, rather than a descriptive science: it tells us something about how governments ought to behave, but that does not mean that governments do behave as they ought to. Law in general is prescriptive, but in areas of law where effective enforcement mechanisms exist, it is descriptive too: it tells us something about how agents will be ‘corrected’ if they do not behave as they should. There is a dearth of effective enforcement mechanisms with regards to international human rights law obligations. This section will therefore depart from present reality and describe how the right to health could create a basis for a global social contract on health. But I will keep present reality in the back of my mind, and describe how agents ought to behave noting that this may also advance the objectives they seek from the way they do behave.


The third section - global health, what it could become - draws on the science of policy advice. Some will argue that policy advice is an *art*, rather than a *science*.\(^6\) Policy advice tries to transform society as it is into society as it should be, while aiming for society as it could be. It takes into account reality and its constraints - accepting some constraints, while challenging other constraints. Of course, the constraints one wishes to challenge are those one believes are vulnerable to being challenged, and this is inevitably a subjective assessment (which is why some call it an art and not a science). So the third section really is about global health diplomacy, "the coal-face of global health governance... where the compromises are found and the agreements are reached".\(^7\) In this section, I will explore how a global social contract on health is within reach, even if we assume that most agents are predominantly preoccupied with pursuing their own interests.

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\(^7\) Kickbusch I., Silberschmidt G., Buss P. (2007) See footnote 4 above
SECTION 1: GLOBAL HEALTH, WHAT IT HAS BEEN SO FAR

1.1. Introduction: the shift from ‘international health’ to ‘global health’

‘International health’ is passé, ‘global health’ is hot. That is the simplistic conclusion we can draw from Brown and colleagues’ search on databases of medical journals, using both as search terms. Even if global health had not yet grasped the lead from international health in the period 2000 until July 2005 - international health 52169; global health 39759 - it was well on its way of doing so,8 as Grepin later confirmed.9 But what exactly is the difference between these two concepts? Is the shift from international health to global health real, that is, more than “meaningless jargon”?10 I will first explore some definitions and qualifications offered by others, and then propose a working definition of global health further below, in section 1.4.

Elmendorf argues that “[i]nternational health appeared largely as an issue of cooperation between developing countries and their partners in developed countries.”11 The Association of Schools of Public Health asserts that “[t]he field of international health focuses primarily on the health problems of low- and middle-income countries (sometimes known as developing countries”).12 International health is thus essentially the international assistance dimension of national public health efforts of poorer countries. Its declared intention is to enable poorer countries to improve public health. When using an interest-based approach,13 international health appears to serve the interests of the inhabitants of poorer countries.

For Elmendorf, global health is based on the realization that countries can no longer “see health as a concern limited by national borders, as they often did in the past.”14 Or, as Grepin expresses it, “global health is the study and practice of health issues that transcend international borders.”15 When using an interest-based approach, global health appears to serve the interests of the inhabitants of the whole world, whether they live in poorer or richer countries.

How would global health efforts, implemented in poorer countries, serve the interests of the inhabitants of the whole world? Briefly, as I will return to this later under point 1.2., health challenges can transcend the borders of poorer countries in many ways:

- Emerging health threats, like communicable diseases, do not respect borders;

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10 Brown T.M., Cueto M., Fee E. (2006) See footnote 8 above
15 Grepin K. (2011) See footnote 9 above
Possible consequences of poor health, like discontentment and social instability, cannot easily be contained within country borders;\textsuperscript{16} The benefits of improved health, like economic growth, are not contained within country borders;\textsuperscript{17} If a slogan like ‘we all have AIDS’ gets picked up and carried by civil society groups all over the world,\textsuperscript{18} it turns poorer countries’ AIDS scourge into an international issue, one that politicians of richer countries must consider if they want to be reelected.

Health challenges thus transcend borders in different ways, and each of these can lead us to reframe almost every effort to improve the health of the inhabitants of poorer countries as a simultaneous effort to serve the interests of all the inhabitants of the world. At first sight, this broad perspective on shared interests does not allow me to draw a meaningful distinction between international health and global health.

Fidler, who presents the shift from international health to global health as a “global health revolution”,\textsuperscript{19} provides three subtly different understandings of this revolution:\textsuperscript{20}

- ‘Foreign policy as health’ “maintains that foreign policy now pursues, and should in the future pursue, health as an end in itself” - or, in simpler words, that governments of richer countries now want to contribute to improved public health in poorer countries, for only one reason: their desire to improve public health in poorer countries;
- ‘Health and foreign policy’ “holds that health’s rise on foreign policy agendas merely indicates that foreign policy is shaping health, not vice versa” - or, in simpler words, that richer countries discovered that contributions to improve public health in poorer countries are a promising way to protect and advance their own interests;
- ‘Health as foreign policy’ “stakes out a middle ground between the previous two perspectives and maintains that health’s rise as an issue in world affairs creates a relationship between health and foreign policy under which neither completely transforms the other” - or, in simpler words, that the truth is somewhere in the middle: richer countries want to contribute to improving public health in poorer countries, but their willingness is influenced by their own interests.

According to Fidler, ‘health as foreign policy’ or the middle ground “provides the best perspective on health’s political revolution”, but one that “only precariously emerges as the perspective that best describes health’s political revolution over the last decade.”

Like Fidler, I assume that the shift from international to global health has not transformed foreign policy, and that all foreign assistance by richer countries still serves, in the words of Brainard, “to

\begin{itemize}
  \item \textsuperscript{18} Berwick D. (2002) “We all have AIDS”: case for reducing the cost of HIV drugs to zero.’ British Medical Journal, 324(7331): 214-218
\end{itemize}
advance national security, national interests, and national values”.

The health of all people has not become an end of foreign policy in itself. However, I also assume that the shift from international health to global health reflects a growing understanding that the health status of inhabitants of poorer countries affects, to varying degrees and in different ways, the wellbeing of inhabitants of richer countries. Thus international co-financing, by richer countries, of efforts to improve public health in poorer countries, can serve to advance the interests and the values of richer countries. I would therefore disagree with Fidler when he opposes “epidemiological evidence” against “concepts of health as a humanitarian or human rights issue”, as he does in this line: “One striking thing about the last decade is the extent to which arguments for more foreign policy attention on health connected epidemiological evidence with adverse material consequences for states were relied upon rather than traditional concepts of health as a humanitarian or human rights issue.”

In as much as a slogan like ‘we all have AIDS’ reflects global health as a human rights issue, richer countries’ governments acting upon that slogan can also be an example of advancing national interests and values. This approach fits within a ‘health as foreign policy’ model and as such global health has indeed not become an end in itself, but it allows for a more generous view of ‘health as foreign policy’.

Finally, Koplan and colleagues define global health as “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide”, but offer this more as a definition of what global health should be than as a definition of what global health really is. I will return to this under point 2.10.

So far, exploring the definitions and qualifications used by others has not allowed me to propose a clear distinction between international health and global health. I will therefore return to the historical context in which global health emerged.

1.2. The shift from international health to global health: historical context

The advantage of sharp definitions is that they help us to make up our minds. Do we agree that global health is about health challenges that transcend borders? Do we agree that international health is about health challenges that affect people living in poorer countries? Do we agree that, around the beginning of the new millennium, the global health approach superseded the international health approach?

The problem with sharp definitions is that we may never be able to fully agree with them. Quite obviously, the international health concept of the previous millennium was about health challenges that transcend borders too. The history of the World Health Organization (WHO) stretches back to the first International Sanitary Conference of 1851, and that conference was all about communicable diseases transcending borders. And when in 2010 leaders of the eight most powerful economies of the
world (G8) committed US$5 billion to efforts to improve maternal, newborn and child health worldwide,\textsuperscript{25} did they do so because they feared that the main causes of poor maternal, newborn and child health would spread beyond borders? I would like to believe they did so because they care about health issues that affect people living in poorer countries. Thus global health existed well before the year 2000, and international health continues to exist after the year 2000. An interest-based black-and-white picture does not capture the shift, and one may wonder if it is in fact real. Would a grey-scale picture better capture a real shift?

For a gray-scale picture, we have to return to the Second World War, when the leaders of the future victors mapped out the guiding principles of post-Second World War international relations. According to Kapstein, the ‘grand design for the postwar era’ was built on two pillars: the welfare state at the national level; free trade at the international level.\textsuperscript{26} Politicians from the U.K. and the U.S.A. may have truly wanted ‘freedom from fear and freedom from want’ for all humans, as they declared - if only to protect the inhabitants of their countries from the dangerous effects of increasing inequalities in other countries, like popular support for Nazism. But they counted on free trade to lead to “convergence in economic performance”.\textsuperscript{27} Once convergence in economic performance was achieved, in theory all countries would have sufficient means to create welfare states. Public health, one may assume, belongs to the realm of the welfare state: an element of ‘freedom from want’ to be achieved at the national level.

Not all agreed that international free trade would lead to convergence. Some argued it would not, and that richer economies would become richer, and poorer economies would become poorer (and less able to create welfare states). In the end, a compromise was found around ‘development assistance’: international assistance intended to help poorer countries develop their economic potential.

International health can be understood as an element of this development assistance. From the end of the Second World War until the end of the Cold War, richer countries may have financed public health efforts in poorer countries to keep poorer countries on the ‘right’ side of the global political divide: West or East. But as soon as the Cold War was over, richer countries may have mainly wanted poorer countries to develop their economic potential, so as to be capable of assuming financial responsibility for their own social issues. That meant that poorer countries had to ‘adjust’ to international free trade realities; for many poorer countries, that meant they had to reduce social expenditure, to reduce public deficits, to become reliable trading partners.\textsuperscript{28} That also meant that financial assistance from richer countries to poorer countries for public health efforts was intended to be temporary: in the end, governments of poorer countries had to take responsibility for the health of their inhabitants. The Declaration of Alma-Ata of 1978, on which the ‘Health for all by the year 2000’ campaign was built, is not an exception to that rule, as it states that primary health care should be provided “at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-

\textsuperscript{27} Kapstein E.B. (1999) See footnote 26 above
reliance and self-determination.” Economic development was seen as the precondition for financing health efforts, domestically.

The role of international assistance for public health, in this world view, was limited. A central tenet of this view was that health efforts in any given country should not become more expensive than that which the country itself would be able to finance, within a reasonable future. Hence the model of primary health care promoted by the Declaration of Alma-Ata was soon replaced by a ‘interim’ strategy of selective primary health care: “selective primary health care may be a cost-effective interim intervention for many less developed areas.” The idea behind the word ‘interim’ is the presumption that poorer countries would see their economies grow and that they would become able to provide comprehensive primary health care.

However, convergence in economic performance did not happen. Poorer countries, on average, remained poorer countries. In his studies on the evolution of global wealth inequalities, Milanovic found that wealth inequalities between countries, expressed as an inter-country ‘Gini’ coefficient, are steadily growing. A Gini coefficient of zero for inter-country wealth distribution would mean that all countries have exactly the same average Gross Domestic Product (GDP) per capita; that is, full inter-country equality. A Gini coefficient of one for inter-country wealth distribution would mean that one single country would enjoy the entire GDP of the world’s economy (or maximum inequality). Figure 1 illustrates how wealth inequality between countries is in fact progressively moving toward maximum inequality and away from maximum equality. Ranking countries in accordance with their wealth in 1978, putting them together in ten groups of an equal number of countries, and measuring their growth by 2000, Milanovic found economic growth in all groups, but much more in the groups that were richer in 1978 already, which is what figure 2 illustrates. If health efforts were to mirror the pace of economic growth, health gaps would be expected to widen at the same pace as wealth gaps.

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Like several scholars I trace the shift from international health to global health to the global response to the HIV/AIDS pandemic. According to Elmendorf, “HIV/AIDS was the first disease to make health a truly global issue in our time”; and according to Kickbush, “[a]ll the elements that we can characterize as defining features of global health governance were first played out in the HIV/AIDS arena.” The global response to HIV/AIDS was exceptional, in that it set out to provide AIDS treatment in countries that would not be able to finance such treatment from national resources alone. It was clear, from the beginning, that it would create a relationship of dependence, or a relationship of mutual and shared responsibility beyond borders: something that did not fit in Kapstein’s ‘grand design for the postwar era’. It created something like the beginning of a “global welfare paradigm”. How did that happen?

First, the ‘we all have AIDS’ slogan was more than just a slogan, it reflected a sense of solidarity and interconnectedness beyond borders that may not have started with the global movement against AIDS, but that grew exceptionally strong around the issue of AIDS treatment. Within a decade or two, AIDS had been turned from a death sentence into a manageable chronic disease, for most people living with AIDS in richer countries. For people living in poorer countries, HIV infection remained a death sentence. People living with AIDS and their allies living in richer countries, notably in the U.S.A., were simply not interested in the conventional wisdom of international health, and saw the inaccessibility of AIDS treatment for millions as a gross injustice. As Cameron expressed so powerfully at the 13th International AIDS Conference in Durban, South Africa, in July 2000: “My presence here embodies the injustices of AIDS in Africa because, on a continent in which 290 million Africans survive on less than one US dollar a day, I can afford monthly medication costs of about US$400 per month”, and: “No more than Germans in the Nazi era, nor more than white South Africans during apartheid, can we at this Conference say that

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we bear no responsibility for more than 30 million people in resource-poor countries who face death from AIDS unless medical care and treatment is made accessible and available to them.”  

Without underestimating the impact of AIDS activists, there was a second reason for this shift. Security experts in richer countries, again notably in the U.S., feared the long term consequences of HIV/AIDS. The National Intelligence Council of the U.S., in January 2000, issued a report in which it stated: “As a major hub of global travel, immigration, and commerce, along with having a large civilian and military presence and wide-ranging interests overseas, the United States will remain at risk from global infectious disease outbreaks, or even a bioterrorist incident using infectious disease microbes.”  

De Swaan argues that social protection in today’s richer countries evolved around two factors: ‘external effects’ and ‘chains of human interdependence’. In using the term ‘external effects’, he refers to objective elements of interdependence: “the indirect consequences of one person’s deficiency of adversity for other not directly afflicted themselves”, like how the death of poor peasants during winter may lead to wealthier farmers not finding laborers during the harvest season. With the term ‘chains of human interdependence’, he refers to subjective elements of interdependence: “referring to individual human beings and to the social entities they make up together”, like poor peasants and richer farmers forming a community or a social entity.  

AIDS created a global community. As Kramer, one of the first AIDS activists in the U.S. expressed it: “I must put back something into this world for my own life, which is worth a tremendous amount. By not putting back, you are saying that your lives are worth shit, and that we deserve to die, and that the deaths of all our friends and lovers have amounted to nothing.” ‘Putting back’ meant fighting against the discrimination of gays and lesbians worldwide, but also against discrimination and for treatment of all people living with AIDS worldwide, and thus creating subjective interdependence.  

At the same time, the U.S. National Intelligence Council highlighted the objective interdependence: the epidemic of HIV/AIDS threatened American investments overseas, could destabilize societies, and people living with AIDS and receiving poor treatment could develop untreatable strains of other diseases like tuberculosis, which would sooner or later appear on American territory. So what we had here was a rare ‘alignment of the stars’ around a single health issue, the same ‘stars’ around which social protection in richer countries originally evolved. All of a sudden, the idea that public health in a given country should be financed solely from resources from that country no longer made sense. It made perfect sense for the U.S. to finance AIDS treatment in Africa, as a way to advance its national security, interests and values.  

If the global response to HIV/AIDS marked the shift from international health to global health, did it also signal a change in objectives, from focusing on the interests of the inhabitants of poorer countries towards focusing on the interests of all of the world’s inhabitants? I would argue that both the

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international health and the global health paradigms contain a blend of serving the interests of the inhabitants of poorer countries and serving the interests of all the world’s inhabitants. What really changed, in my opinion, was:

- An increasing awareness of how at least some of the interests of all the world’s inhabitants (and the interests of the inhabitants of richer countries in particular) coincide with the interests of the inhabitants of poorer countries;
- A new dimension to those coinciding interests, one that was (and is) subjective rather than objective, namely the emergence of a global community sharing a common goal, specifically fighting a particular disease.

1.3. How do health issues transcend borders (elements of objective interdependence)?

If increasing awareness of how at least some of the interests of all the world’s inhabitants (and the interests of the inhabitants of richer countries in particular) coincide with the interests of the inhabitants of poorer countries may mark the shift from international health to global health, and if the reality of such increasing awareness is undisputable for HIV/AIDS, is global health then, in essence, confined to the global AIDS response? Or has this increasing awareness of coinciding interests spread beyond HIV/AIDS, and does global health include other global health efforts?

There certainly is no lack of statements made by leaders and decision-makers of richer and poorer countries that try to emphasize how improved health in poorer countries also benefits richer countries. One may take issue with the implied message - encouraging or justifying increasing efforts by richer countries on the grounds of the benefits for richer countries - and argue that such efforts ought to be based on more generous objectives, advancing the interest of inhabitants of poorer countries only. Let me remind the reader that I am not trying to describe global health as it should be here; I am trying to describe global health as it has been so far. Furthermore, I tend to agree with Martin when she wrote that “[t]heories of international cooperation ... made a big leap forward by accepting the assumption that states are self-interested and have conflicts of interest with one another.”

Let us have a look at three documents that try to explain why richer countries should finance public health efforts in poorer countries, thus advancing their own (richer countries’) interests:

I. The “Oslo Ministerial Declaration” by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Senegal, South Africa, and Thailand;


III. A paper by Jones of the U.S. Department of State, “New Complexities and Approaches to Global Health Diplomacy: View from the U.S. Department of State”.

41 Martin L.L. (1999) See footnote 2 above
These three documents do not use exactly the same terminology, so I have formulated a common terminology that captures the key ideas behind the arguments advanced. Some arguments are used as a single argument in one document, and disaggregated into two or three separate (narrower) arguments in another document. For the sake of precision, I use the narrowest descriptions, even if that creates overlaps and some redundancy. Table 1 below lists eight arguments for international assistance for health, as advancing the interests of richer countries.

**Table 1. Arguments for international assistance for health, advancing the interests of richer countries**

<table>
<thead>
<tr>
<th>Arguments</th>
<th>I</th>
<th>II</th>
<th>III</th>
</tr>
</thead>
<tbody>
<tr>
<td>International assistance for health helps reduce the risk of communicable diseases spreading from poorer to richer countries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>International assistance for health can improve social cohesion and reduce the risk of political instability and armed conflict within poorer countries, and avoid armed conflict in poorer countries affecting the well-being of inhabitants of richer countries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>International assistance for health creates ‘goodwill’ towards countries providing it</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>International assistance for health eases undesired migration towards richer countries</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>International assistance for health contributes to economic growth within poorer countries, and ultimately richer countries benefit from that</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>International assistance for health can have a long term positive impact on the global environment</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>International assistance for health is needed to realize the right to health</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>International assistance for health is needed for human security</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

Let me try to unpack these arguments, without examining their validity in detail.\(^{45}\)

**Containing communicable diseases**

The argument that international assistance for health can be an effective way for richer countries to protect their inhabitants against communicable diseases spreading from poorer countries seems undisputed. There is a long history of international cooperation driven by the objective of controlling communicable diseases. The World Health Report 2007, ‘A Safer Future: Global Public Health Security’, explores this argument in depth and at length.\(^{46}\) Wilson uses a sharp metaphor: “Canada should

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formulate a foreign and domestic policy focused on establishing health security at national and international levels. Like the mission in Afghanistan this policy will involve taking action abroad to tackle security risks at their source."47 This argument has been employed to advocate for focused disease control efforts, but also for strengthening wider health systems, as the World Health Report 2007 suggests: “These 57 countries, most of them in sub-Saharan Africa and South-East Asia, [facing a dramatic shortage of health workers] are struggling to provide even basic health security to their populations. How, then, can they be expected to become a part of an unbroken line of defence, employing the most up-to-date technologies, upon which global public health security depends?”48

Avoiding armed conflicts

Could international assistance for health coverage be a “neglected counterterrorist measure”, as Horton implies?49 The High-level Panel on Threats, Challenges and Change explains one element of this argument: “International terrorist groups prey on weak States for sanctuary. Their recruitment is aided by grievances nurtured by poverty, foreign occupation and the absence of human rights and democracy; by religious and other intolerance; and by civil violence - a witch’s brew common to those areas where civil war and regional conflict intersect.”50 McInnes and Lee explain the other element: “Poor health provision may contribute to social disorder by highlighting inequalities; but it may also present a government as ineffective regardless of whether it has the resources to deal with vital health issues. Poor health may also contribute to economic decline, fuelling discontent, by: forcing increased government spending on health as a percentage of GDP; reducing productivity due to worker absenteeism and the loss of skilled personnel; reducing investment (internal and external) because of a lack of business confidence; and by raising insurance costs for health provision.”51

Creating diplomatic goodwill

Armitage and Nye argue - about the U.S., but many richer countries could make the same reflection - that: “America should have higher ambitions than being popular, but foreign opinion matters to U.S. decisionmaking. A good reputation fosters goodwill and brings acceptance for unpopular ventures. Helping other nations and individuals achieve their aspirations is the best way to strengthen America’s reputation abroad.”52

Avoiding undesired migration

Jones briefly mentions that one of the arguments for international assistance for health is to “ease pressure for migration.”53 There seems to be “rising concern about a potential flood of African migrants bridging Europe’s southern moat and washing under America’s door”.54 How would international assistance for health ease pressure for migration? The most obvious hypothesis would be that some migrants are motivated by seeking better health care than they can obtain in their home countries. But this hypothesis is not supported by evidence. On the contrary, several studies report a so-called ‘healthy immigrant’ effect: healthier people are more likely to migrate than people struggling with their health.55,56 This refutation is compatible with the findings of Hatton and Williamson, that “emigration rates out of really poor countries are very low, while they are much higher out of moderately poor countries”, and one of the explanations they provide is that extreme poverty constrains migration since financing investment in a long-distance move is difficult for the very poor.57 Likewise, poor health may constrain migration.

According to Hatton and Williamson, the main factors driving emigration from Africa are the same that drove emigration from Europe to the U.S. in the nineteenth century: “real wage gaps between sending and receiving regions and demographic booms in the low-wage sending regions”.58 Extreme poverty constrains migration only temporarily; eventually migration takes off - as the first successful adventurers send remittances home to support family members and friends to join them - and decreases when the wage gaps between sending and receiving regions decrease. So one could argue that if richer countries want to ease pressure for migration, and accept that all very poor countries will eventually become moderately poor countries (from where migration pressure will inevitably increase), they may find that it would serve their own interests to help countries transition from moderate poverty to moderate wealth rapidly. In as much as improved health accelerates economic growth, this

58 Hatton T.J., Williamson J.G. (2003bis) See footnote 57 above
argument would indirectly justify the co-financing of health efforts in poorer countries by richer countries, as serving richer countries’ interests.

**Contributing to economic growth**

The World Bank's World Development Report 1993, ‘Investing in Health’, made the case that increased health expenditure in developing countries could contribute to faster economic growth. It marked the beginning of a paradigm shift, described by Mills and colleagues: “In recent years there has been a significant shift in the attention being paid to health within development policies. Once seen as a ‘non-productive sector’, to be given resources only to the extent permitted by economic growth, it is now viewed as an important driver of economic growth.”

What is the evidence? Rivera and Currais, in 1999, provided empirical evidence in support of the ‘shift in the attention paid to health’, showing a positive effect of improved health on economic growth, not merely a ‘reverse causation’ (economic growth having a positive effect on health). The argument that international health financing would yield a substantial return on investment for all countries was forcefully made by the WHO Commission on Macroeconomics and Health. The WHO Commission estimated that a sustained investment of US$66 billion per year in priority health interventions in the poorer countries of the world would yield direct benefits exceeding US$500 billion per year.

Bloom and Canning conclude that “[m]acroeconomic evidence for an effect on growth is mixed, with evidence of a large effect in some studies”, and highlight three mechanisms through which “health may be not only a consequence but also a cause of high income”:

- “Healthy workers lose less time from work due to ill health and are more productive when working”;
- “Childhood health can have a direct effect on cognitive development and the ability to learn as well as school attendance”;
- “A longer prospective lifespan can increase the incentive to save for retirement, generating higher levels of saving and wealth.”

Protecting the environment

This argument is mentioned as an area for further exploration in the Oslo Ministerial Declaration: “Human health and the environment are both outcomes of complex systems that exist in dynamic balance. Given the severity of health threats related to climate change, biosecurity, and biosafety, the linkage between global health and environment should be considered.”\(^{64}\) If it seems clear that a degrading environment has negative impacts on health, it only highlights the importance of measures to slow down climate change being in the interest of the health of the already vulnerable (the inhabitants of poorer countries). But that is not an argument that refers to richer countries’ own interests. Can an argument be made that improving health in poorer countries will have a positive impact on the global ecosystem, thus serving the interests of richer countries too?

The Millennium Ecosystem Assessment points at that potential, albeit in passing (and surprisingly under the heading education, not health): “A better-educated population is likely to be in a stronger position to protect, preserve and restore essential ecosystem services, including by accelerating the demographic transition in countries where fertility rates remain high or above replacement level.”\(^{65}\) McMichael and Butler briefly mention that “[g]ood health and social development slows population growth” in an illustration, but not in the text of their paper.\(^{66}\) This is surprising as the evidence that desired fertility levels are strongly influenced by perceived infant mortality levels seems undisputed.\(^{67/68/69/70}\) This phenomenon is known as the ‘demographic transition’: when infant mortality goes down, the population starts to grow rapidly, but after a while it stabilizes because parents choose to have fewer children. Efforts to improve health can have a double impact on the demographic transition: reducing desired fertility rates and providing the birth control methods needed to act upon such a desire.

As long as the ecological footprint of inhabitants of poorer countries remains low, accelerating the demographic transition there will have only very limited impact on climate change. But if richer countries accept that the inhabitants of poorer countries will legitimately seek and ultimately succeed in securing a higher living standard, then encouraging the demographic transition through efforts that improve public health could be a wise investment, and thus serving the interests of richer countries too, at least in the long run.

Realizing the right to health

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Realizing the right to health seems so obviously in the interest of the inhabitants of poorer countries that the argument seems odd in a list of arguments in the interest of richer countries. But it could make sense to view it as serving the interests of both. The human rights discourse of richer countries is often met with skepticism in poorer countries. Mahbubani, for example, compares the focus on civil and political rights in present human rights advocacy and the relative neglect of economic, social and cultural rights - including the right to health - with “affluent, well-fed, and well-intentioned onlookers”, criticizing the captain of a boat that is overcrowded with hungry and diseased passengers for not respecting freedom of speech, while refusing to help provide food and health care. If richer countries want to advance human rights, it would increase their credibility if they promoted and supported all human rights, including the ones to which they would have to contribute financially.

This argument is quite different from the previous ones. It supports international efforts to improve public health in poorer countries, for the sake of improving the health status of inhabitants of poorer countries. What it seeks is universal acceptance and endorsement of human rights, which would indirectly benefit the inhabitants of the whole world.

*Promoting human security*

Like the right to health argument, the human security argument seems to serve the interest of those living in the worst insecurity, not the interests of richer countries. The use of a broad human security argument for international assistance for health appeals to a combination of richer and poorer countries’ benefits; the human security argument essentially holds that it may not be possible to distinguish between richer and poorer countries’ interests. The Commission on Human Security defines human security - or its objective - as “to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment”. Most proponents of human security trace its roots back to the United Nations Development Program (UNDP) Human Development Report 1994, which mentions: “In the final analysis, human security is a child who did not die, a disease that did not spread, a job that was not cut, an ethnic tension that did not explode in violence, a dissident who was not silenced”.

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**Conclusion**

Taken together, all these arguments seem to build a strong case for richer countries’ co-financing efforts to improve public health in poorer countries, while simultaneously serving the interests of richer countries. But if these arguments are valid in 2011, they were valid in 1978 too. Why then did the promise of the 1978 Declaration of Alma Ata,⁷⁴ or ‘health for all by the year 2000’ not become reality? Was it simply an error of judgment, and can we now hope that the enlightened self-interest of richer countries will lead to health for all, by the year 2020 perhaps?

There are several possible answers to those questions. One of those answers is that co-financing by richer countries of efforts to improve public health in poorer countries creates new challenges that have not yet been resolved. Common interests are no guarantee for successful cooperation. I will return to that later, under point 1.9. A different answer is that the arguments above may all be valid, but carry different weight. Even if all richer countries accept, for example, that improving health in poorer countries will help to develop the economies of poorer countries faster, the potential benefits to richer countries may not be considered important enough, not certain enough, and the results not rapid enough, to justify the expenditure (considering competing demands). The fear of new epidemics, crossing borders, may provide a stronger incentive. So if global health efforts are motivated by the shared interest of all inhabitants of the world, some efforts may more clearly advance the interests of richer countries - and be more genuinely shared - than other efforts, which would predominantly advance the interests of poorer countries. The third possible answer is that one ‘star’ is not enough: arguments for objective elements of interdependence may only work when there are subjective elements of interdependence too. The fight against AIDS created a global community; the fight for better public health in poorer countries, so far, has not. The two ‘stars’ of objective and subjective elements of interdependence may need to be aligned for mutual social protection - like the sun and the moon need to be in line with the earth for spring tides to occur - and at the global level, so far that only happened for the global response to HIV/AIDS. If the third answer is the right one - which may not be scientifically verifiable - then recent findings, suggesting that the global HIV/AIDS epidemic does not constitute a security threat,⁷⁵ may signal imminent de-intensification of the global response to HIV/AIDS.⁷⁶ One of the ‘stars’ is losing its power, and to compensate for that, AIDS activists may need to build a broader coalition, for a broader purpose.

1.4. Global health (as it has been so far): a proposition

Based on the considerations above, I propose to examine global health (as it has been so far) as the practice of richer countries co-financing health efforts in poorer countries with the explicit intention of advancing shared interests - interests that are shared between richer and poorer countries.77

My analysis will also be tied to the presumption that international health is the practice of richer countries trying to enable poorer countries to address their own health issues, thus advancing the interests of poorer countries. As such, global health did not really replace international health, it supplemented international health.

This is a grayish proposition; it contains no black or white. Under international health efforts, richer countries keep their own interests at the back of their minds, but their primary intention is to enable poorer countries to address their own health challenges. And under global health, richer countries don’t necessarily give up their intention of enabling poorer countries to advance their health related goals, but the direct advancement of shared interests comes first.

If we could rank international efforts to improve public health in poorer countries on a horizontal axis, giving them a score between 0 and 100 on enabling poorer countries to take care of their own health challenges, and on a vertical axis giving them a score between 0 and 100 on providing direct results, international health efforts would end up at the lower right, and global health efforts would end up at the upper left, as figure 3 illustrates. For example, I would consider an intervention by the U.S. President’s Plan For Emergency AIDS Relief (PEPFAR) that creates its own structures for the provision of AIDS treatment as a typical example of a global health effort: aiming for immediate results, without enabling the country where the intervention takes place. An effort to create Community-Based Health Insurance (CBHI) schemes in poorer countries would be an example of an international health effort: the immediate results in terms of improved health outcomes may be expected to be rather limited - because the process is slow, and the potential financial contribution from communities limited - but the effort is expected to survive the termination of international assistance. The distinction is far from perfect. Efforts undertaken by the Ministry of Health of Ethiopia with funding from the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), aimed at direct results and at increasing Ethiopia’s capacity at the same time: a mixture of an international health and a global health effort.78

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77 By ‘shared interests’, I mean those interests that are perceived as interests of richer and poorer countries at the same time. Health-promoting efforts in poorer countries that advance only the interests of the inhabitants of poorer countries - without advancing the interests of inhabitants of richer countries in any way - do not advance ‘shared interests’. Some may argue that global health, as it is, also advances interests that are otherwise non-shared: promoting efforts in poorer countries that only benefit the inhabitants of richer countries, like creating jobs for inhabitants of richer countries as providers of health services in poorer countries, or like increasing the profit margins of pharmaceutical companies based in richer countries. That seems a bit too cynical, even for my taste. I’m not ignoring the fact that global health has created more jobs within richer countries; perhaps I have one of these myself. But richer countries could also have spent the money they spent on global health efforts on domestic projects, creating even more domestic jobs.

Thus the distinction between international and global health appears primarily as a shift in the intentions of richer countries: from enabling poorer countries to address their health challenges to seeking direct results to advance shared interests. Would one expect to see this shift mirrored by a chronological shift, as I suggested under points 1.1. and 1.2. above? Not necessarily, and I have argued that the chronological shift that seems to have taken place around the year 2000 is as blurred as the shift in the intentions of richer countries. However, I do believe that the willingness of richer countries to co-finance AIDS treatment in poorer countries, as demonstrated by the creation of the Global Fund in 2001, marks an increasing awareness of shared or coinciding interests and a new dimension to those coinciding interests (the emergence of a global community sharing a common goal of fighting a particular disease). Because of that shift, I would expect more global health efforts and relatively fewer international health efforts since 2001.

1.5. Testing the proposition against external evidence: expected changes in the volume of international assistance

In as much as the shift from international health to global health is real, and about a move towards richer countries co-financing health efforts in poorer countries seeking to advance shared interests, we would expect changes in the volume of international financial assistance for health provided by richer countries.

As long as international assistance for health was intended to enable poorer countries to address their own health challenges, it would have been intended to be temporary. A correlative of this intention would have been that international financial assistance for health should not have financed efforts beyond poorer countries’ future government revenue prospects, and that would have limited the scope for international assistance. As soon as international assistance for health is seen as something advancing the interests of the contributing richer countries too, we would expect an increase in international financial assistance for health. Importantly, the assumption that the assistance would be provided for a finite period, i.e. until countries become self-sufficient, would no longer operate, or operate in a more flexible manner.
When we look at the ‘World Health Statistics’ data of the WHO, a selection of which is represented in table 2 and to which I added some simple calculations, we have to conclude that in low income countries, health remains first and foremost a national affair - either international nor global. In 2007, external resources accounted for only 17.5% of total health expenditure in low income countries, on average. However, external resources accounted for only 10.2% of total health expenditure in 2000. Furthermore, when we calculate what this means in terms of per capita annual expenditure, we find that external resources increased from US$1.4 to $4.7: still a modest amount, but nonetheless a 235% increase.

Table 2. Global health in figures

<table>
<thead>
<tr>
<th>Income group</th>
<th>Total expenditure on health as % of gross domestic product</th>
<th>General government expenditure on health as % of total expenditure on health</th>
<th>Private expenditure on health as % of total expenditure on health</th>
<th>General government expenditure on health as % of total government expenditure</th>
<th>External resources for health as % of total expenditure on health</th>
<th>Social security expenditure on health as % of total government expenditure</th>
<th>Out-of-pocket expenditure as % of total expenditure on health</th>
<th>Private prepaid plans as % of total expenditure on health</th>
<th>Per capita total expenditure on health at average exchange rate (US$)</th>
<th>Per capita government expenditure on health at average exchange rate (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower middle income</td>
<td>2000 6.7 2007 3.7</td>
<td>2000 27.5 2007 24.4</td>
<td>2000 7.0 2007 5.8</td>
<td>2000 1.3 2007 1.1</td>
<td>2000 0.3 2007 0.4</td>
<td>2000 0.3 2007 0.3</td>
<td>2000 1.0 2007 0.6</td>
<td>2000 1.5 2007 0.8</td>
<td>2000 2.0 2007 1.0</td>
<td>2000 3.0 2007 2.0</td>
</tr>
<tr>
<td>Upper middle income</td>
<td>2000 5.5 2007 3.5</td>
<td>2000 23.0 2007 21.0</td>
<td>2000 7.0 2007 5.8</td>
<td>2000 0.4 2007 0.3</td>
<td>2000 0.0 2007 0.0</td>
<td>2000 0.0 2007 0.0</td>
<td>2000 1.0 2007 0.6</td>
<td>2000 1.5 2007 0.8</td>
<td>2000 2.0 2007 1.0</td>
<td>2000 3.0 2007 2.0</td>
</tr>
<tr>
<td>High income</td>
<td>2000 10.2 2007 11.2</td>
<td>2000 13.9 2007 6.2</td>
<td>2000 23.4 2007 12.3</td>
<td>2000 5.3 2007 3.2</td>
<td>2000 0.0 2007 0.0</td>
<td>2000 0.0 2007 0.0</td>
<td>2000 1.0 2007 0.0</td>
<td>2000 1.5 2007 0.0</td>
<td>2000 2.0 2007 1.0</td>
<td>2000 3.0 2007 2.0</td>
</tr>
</tbody>
</table>

Source: WHOIS 2010

To understand the significance of this increase, we also have to consider that 58.1% of total health expenditure in low income countries is private. When we add data about government expenditure on health as percentage of total health expenditure to data about private health expenditure as a percentage of total health expenditure, we always obtain 100%. Therefore, in these data, external resources are spread over both categories. If we assume that most external resources are allocated to government expenditure (about 15% of total health expenditure, out of 17.5% of total health expenditure that comes from external resources), we can roughly estimate that in low income countries, on average, in 2007:

- 27% of total health expenditure was public, from domestic resources;
- 15% of total health expenditure was public, from external resources;
- 56% of total health expenditure was private, from domestic resources;
- 2% of total health expenditure was private from external resources.

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If we then make similar assumptions about the data for 2000, we can roughly estimate that in low income countries, on average:

- 30% of total health expenditure was public, from domestic resources;
- 8% of total health expenditure was public, from external resources;
- 60% of total health expenditure was private, from domestic resources;
- 2% of total health expenditure was private from external resources.

Figures 4 and 5 illustrate the shift that took place.

**Figure 4. Composition of total health expenditure in low income countries, in 2000**

**Figure 5. Composition of total health expenditure in low income countries, in 2007**

Therefore, not only did international assistance for health increase, it also contributed to a move away from national self-reliance and towards shared responsibility.

1.6. Testing the proposition against external evidence: expected changes in international assistance priorities

If global health is about richer countries co-financing health efforts in poorer countries with the intention of advancing shared interests, we would expect to see changes in the priorities of international assistance for health, away from the priorities of the countries receiving the assistance towards priorities that are shared between richer and poorer countries.

It is difficult to assess whether this has happened since 2000. As explained under point 1.3., all health challenges in poorer countries could be worth supporting from the perspective of richer countries advancing their own interests. And if we were to find (as we know we will) that most incremental international assistance for health has been allocated to fighting HIV/AIDS, that does not necessarily mean that it is ‘disproportionate’, or not aligned with poorer countries’ priorities.

One approach could be to examine whether international assistance, disaggregated per health issue, is commensurate with the burden of each health issue, assuming that this is how governments would allocate their own resources. This approach is often used to show that international assistance is not in
accordance with the burden of disease of poorer countries.\textsuperscript{80} But it may be misleading. Imagine a country with only two causes of premature death; half of the population is affected by the first disease, and it costs $10 per person per year to treat people effectively; the other half of the population is affected by the other disease, and it costs $90 per person per year to treat people effectively. The health ministry of this country has a health budget of $50 per person per year, and can treat everyone. Would one then argue that this country is spending too much on the second disease - nine times more than on the first, while the burden of both diseases is the same? ‘Disproportionate’ international assistance for AIDS treatment may reflect richer countries’ first priority to contain a communicable disease, but it may also reflect the simple reality that AIDS treatment is relatively expensive.

Perhaps the most convincing evidence that richer countries are prioritizing the containment of communicable diseases comes from Lane and Glassman. Examining indicators that predict the volume of international assistance for health, they found that “{\textit{Only HIV/AIDS and tuberculosis (TB) disease burdens are positively and significantly associated with aid per capita after allowing for the effects of commitment, governance, income, and population.}}”\textsuperscript{81} If countries providing international assistance for health were motivated by poorer countries’ health challenges, one would expect all disease burdens to be associated with assistance levels - there may still be more assistance for AIDS and tuberculosis because these are relatively expensive to treat, but one would expect maternal mortality, for example, to have an impact on assistance levels too.

1.7. Testing the proposition against external evidence: expected changes in the relational dynamics between richer and poorer countries, and other actors

If global health is about richer countries co-financing health efforts in poorer countries with the intention of advancing shared interests - and distinct from international health, which tries to enable poorer countries to address their own health issues - would we expect to see changes in the respective roles of the actors? We would, but in different ways that may contradict each other.

On the one hand, we could expect richer countries to see poorer countries as necessary partners in the advancement of shared interests, and thus an evolution away from an uneven relationship between donors and beneficiaries, towards a more equal partnership. On the other hand, we could expect richer countries seeking direct results to use Non-Governmental Organizations (NGOs) as service providers, by-passing perceived weaknesses in government health systems and services. I think we can find evidence of both, but have to admit that I may be interpreting available evidence subjectively, in ways that support my proposition.

Ravishankar and colleagues found that the “\textit{proportion of [Development Assistance for Health (DAH)] channelled via UN agencies and development banks decreased from 1990 to 2007, whereas the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization (GAVI),}

\textsuperscript{81} Lane C., Glassman A. (2007) ‘Bigger And Better? Scaling Up And Innovation In Health Aid.’ \textit{Health Affairs,} 26(4):935-948
and non-governmental organisations became the conduit for an increasing share of DAH.”

The decreasing role of UN agencies seems to contradict the expectation of an evolution towards genuine partnership. If partnership between equals had been the objective, what better channel to use than the WHO, where every country has one vote? The answer could be that at least some richer countries have never considered the WHO - or any other organization where they are outnumbered by poorer countries - as an acceptable multilateral body that would monitor, coordinate or steer billions of dollars of international assistance. As long as international assistance was about enabling poorer countries to address their own health challenges, and involved relatively low levels of financial assistance, they may have accepted the leading role of the WHO as a technical advisor. However, when international financial assistance started to increase substantially, the WHO was no longer the preferred multilateral body.

Following this logic, richer countries would have wanted the World Bank - where their shares guarantee a majority position - to become the main channel for international health assistance, and that was indeed the U.S.’s preferred option. One of the initial ideas that was floated in the discussions that led to the creation of the Global Fund was indeed a Global AIDS Trust Fund hosted by the World Bank. But some experts from poorer countries vehemently opposed the idea, like Arhin-Tenkorang in her testimony to the U.S. Congress, about IMF and World Bank Policies in Africa: “Given the urgency of the situation, I urge that a Global AIDS Trust Fund should be granted autonomy from these institutions and their policies.”

If global health diplomacy is “at the coal-face of global health governance - it is where the compromises are found and the agreements are reached, in multilateral venues, new alliances and in bilateral agreements,” then the creation of the Global Fund can be seen as a ‘coal-face compromise’. The Global Fund is a non-profit foundation, governed by its own by-laws and the law of Switzerland, where it is based. It has a board consisting of 20 voting members and six non-voting members. Richer countries have eight voting members; poorer countries have seven voting members. Three voting members represent civil society organizations - they are considered to be on the side of the poorer countries. One voting member represents the private sector and another represents private foundations - they are considered to be on the side of the richer countries. Combined, that makes two voting groups of 10 members each.

Compared with the WHO, the Global Fund can be seen as an entity in which the influence of poorer countries is reduced, or a move away from genuine partnership between richer and poorer countries. However if compared with the World Bank - of which it can be argued that it assumed the international or global health leadership from the WHO during the 1990s, as Abbasi argued in 1999: “Through its influence in ministries of finance as well as ministries of health it has displaced the World Health

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Organisation as the major player in international health in terms of funding⁶⁶ - the Global Fund increased the influence of poorer countries, and can be seen as a move towards genuine partnership.

In the process, NGOs obtained (or were given) a stronger position - with voting rights - than they had at the WHO, stronger than they had ever had before, as allies of poorer countries’ governments.⁶⁷ From a different perspective, however, we could also view them as allies of richer countries, in their capacity as service providers that advance shared interests where governmental health services and systems fail. In any case, the role of NGOs changed, and that seems to confirm a shift from richer countries enabling poorer countries to address their health challenges to richer countries trying to advance shared interests by all available means.

Can the same be said about the changing role of the private sector? It is clear that its role changed as well: like NGOs, the private sector obtained or was given voting rights on the board of the Global Fund. Harmer considers this as an ideational shift, rather than a shift in interests; a wide-spread belief that ‘there is no alternative’ for cooperation between private and public forces.⁶⁸ In as much as this ‘consensus’ pertains to achieving direct results, more than to enabling poorer countries to address their health challenges, it would confirm the shift from international health to global health, as proposed in this working paper. However, if one assumes that a more important role for the private sector also helps enable poorer countries to address their health challenges - for example, through seeking solutions to reduce the prices of patent-protected medicines or to increase the availability of vaccines or medicines that are more adapted to the conditions in poorer countries - the changing role of the private sector does not confirm a shift from international health to global health.⁶⁹

1.8. Testing the proposition against external evidence: measures against free riding

Is global health, as defined above, a global public good? Opinions among scholars vary, and depend on how narrowly or broadly one applies the definition of public goods. Proponents of the narrower definition, according to which public goods must be non-rival (once provided to some, a public good can be used by all) and non-excludable (nobody who wants to benefit from the public good can be excluded from benefitting) argue that efforts to improve health are typically rival and excludable: a pill

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⁶⁷ The by-laws of the Global Fund stipulate: ‘In order to pass, motions require a two-thirds majority of those present of both: a) the group encompassing the eight donor seats and the two private sector seats and b) the group encompassing the seven developing country seats, the two non-governmental organization seats, and the representative of an NGO who is a person living with HIV/AIDS or from a community living with tuberculosis or malaria.’ Global Fund to fight AIDS, Tuberculosis and Malaria (2011) See note 85 above
⁶⁹ It is tempting to expand the proposition about global health beyond the interest-based approach I am using, to include an etymological interpretation. International health would be about health as an issue for relations between nations, while global health would be about health as an issue for relations between all relevant global actors. The changing role of the private sector would then confirm the shift from international health to global health. However, the explanatory relevance of the shift from richer countries enabling poorer countries to address their health challenges to richer countries advancing shared interests seems more important than the explanatory power of governments including the private sector because they feel they cannot solve the problem on their own. I consider the ‘from-nations-to-all-relevant-global-actors’ interpretation of the shift from international to global health less important, but I am not arguing it is completely irrelevant.
taken by one cannot be taken by someone else, and any person can be excluded from health care services, for example because he or she did not pay a health insurance fee.\textsuperscript{90} Proponents of the broader definition argue that the externalities of improving health for all people worldwide are typically non-rival and non-excludable.\textsuperscript{91} For example, if a newly emerging epidemic can be contained within a geographical area (for instance a province of South Africa), all people living outside of that area will benefit; there is no rivalry for that benefit and it is non-excludable: inhabitants of France will enjoy it as much as inhabitants of Germany, even if only South Africa and France paid for the efforts required to contain the epidemic (the governments of South Africa and France cannot exclude inhabitants of Germany from enjoying the benefit).

Global health is far from a perfect global public good. If some elements of improving health for all people worldwide, like fighting communicable diseases, are widely acknowledged as global public goods, other elements like decreasing maternal mortality are less obvious candidates for qualification as global public goods. Yet proponents of the broader definition of global public goods may argue that even fighting maternal mortality is a global public good. Some of these proponents argue that all serious health inequalities are a matter of injustice, and communities subjected to injustice will ultimately revolt, causing negative effects for all other people.\textsuperscript{92} Reducing global inequalities in health - and thus reducing the chances of revolt - produces externalities that are non-rival and non-excludable.

No matter how imperfectly global health (as proposed here) fits into the definition of global public goods, it contains some elements of a global public good. And that means one should be on the alert for free riding behavior. As Kanbur and colleagues phrased it: \textit{“the presence of these international public goods raises free-riding considerations, since, once provided, potential donor countries receive the benefits whether or not they fund these goods.”}\textsuperscript{93} All richer countries may understand that global health efforts will serve their interests, but as they can benefit from efforts made by other richer countries, they may try to promote global health without contributing to it. Thus the shift from international health to global health could lead to free riding behavior, and to attempts to reduce free riding behavior.

An interesting attempt to avoid free riding behavior is the condition imposed by the U.S. Congress on American contributions to the Global Fund: they cannot exceed 33% of total contributions from all donors.\textsuperscript{94} By doing so, the U.S. Congress made sure that all other richer countries contribute at least 67%. The existence of this condition thus seems to confirm the shift from international to global health.

\textbf{1.9. Global health: does it work?}

\textsuperscript{91} Arhin-Tenkoran D., Conceição P. (2003) See footnote 16 above
\textsuperscript{92} Arhin-Tenkoran D., Conceição P. (2003) See footnote 16 above
Under point 1.4., I proposed a formulation to capture the shift from international health to global health - not sharp enough to be called a definition - and under points 1.5., 1.6., 1.7., and 1.8., I tested this proposition against external evidence. I hope this exercise validated the proposition. However, a crucial question remains: does it work? Do global health efforts produce the desired results?

To avoid misunderstandings, I am still discussing global health as it played out so far; I am not yet discussing global health as it should be. I am accepting, for a while, that global health efforts seek to advance the interests that are shared between richer and poorer countries, and thus do not cover the interests of poorer countries that are not shared by richer countries. (But I am not endorsing this proposition of global health as my understanding of what global health should be.)

Does it work? We have already seen under point 1.5., table 2 and figures 4 and 5, that international assistance for health increased, particularly to low income countries, and came to account for a third of government health expenditure. While this increase allowed more - and more expensive - efforts to improve public health in low income countries, it may also have created a rather uncomfortable position for ministries of health and finance of low income countries. Is this international co-financing reliable in the long run? Has international assistance become more predictable? Lane and Glassman found that “aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments”, and argue that “aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care”. However, they also found that “[p]arts of the new institutional architecture, such as the Global Fund, appear to deliver stable and predictable financing”.95

Table 2 also shows that domestic government health expenditure in low income countries (defined as total health expenditure, minus external resources, minus private out of pocket expenditure) increased from 1.7% of GDP in 2000 to 1.8% of GDP in 2007. This very modest increase may be statistically insignificant but seems to contradict findings that external resources ‘displace’ or ‘crowd out’ domestic government expenditure.96,97 Were these finding wrong? Not necessarily. Average data for low income countries may obscure trends within these countries. To keep it simple, let us imagine three low-income countries will the same population, all allocating $10 per capita per annum from government revenue to public health efforts in 2000, all receiving $1 per capita per annum from international assistance for health.

- By 2007, country A receives $11 per capita per annum from international assistance (plus $10). But the government of country A decides to decrease its domestic government allocation to $5 per capita per annum (minus $5).
- By 2007, country B receives $6 per capita per annum from international assistance (plus $5). The government of country B decides to maintain its domestic government allocation at $10 per capita per annum (minus zero).

• By 2007, country C receives $1 per capita per annum from international assistance (plus zero). But the government of country C decides to increase its domestic government allocation to $15 per capita per annum (plus $5).

By 2007, all three countries spend $16 per capita per annum on health. On average, international assistance increased from $1 per capita per annum to $6 per capita per annum, and on average government revenue allocation remained stable at $10 per capita per annum. But nonetheless, we can say that the more international assistance for health increased, the more government revenue allocation to health decreased.

This is not merely a theoretical exercise. When we measure changes in external resources for individual low income countries, and compare them with changes in domestic government expenditure, we find that increasing international assistance does inhibit domestic government health expenditure, as figure 6 illustrates.
Almost all low income countries benefited from increasing external resources for health; the handful that did not are represented by dots below the horizontal axis. Some of them nonetheless increased domestic government health expenditure (dots on the right of the vertical axis), while others decreased (dots on the left of the vertical axis). The trend line, however, indicates that the more external resources increase, the less domestic government expenditure does.

This finding may be linked with the previous observation, about the long-term unreliability of international assistance. Imagine a low income country with 10 million inhabitants, an average GDP in 2011 of $666 per inhabitant, a government revenue of 20% of GDP or $133 per inhabitant, and an allocation of 15% of government revenue to health, or $20 per inhabitant. This country wants to spend $40 per person per year on health as soon as possible, and considering its economic growth perspectives, it plans to increase government domestic health expenditure to $205 million in 2012, $210 million in 2013, and so on, to reach $245 million in 2020. This country receives $100 million in international assistance per year for health starting in 2011, but that level of assistance is guaranteed until only 2015. After 2015, international assistance is expected to decline.

In their handbook ‘Health Financing Revisited: A Practitioner’s Guide’, Gottret and Schieber of the World Bank describe how this low income country should react to the situation.\(^\text{98}\)

“… assume that donor grants are committed to a country in an unrestricted manner until 2020 and that the country does not have absorptive capacity constraints. The restraining factor to increased social expenditures would be the recipient country’s commitment to expand domestic resources up to 2020 to progressively substitute for the donor funds. If it is estimated that the domestic envelope will allow such an expansion of health expenditures, the donors funds would be accepted, and the program of increased health expenditure with grant financing, later

replaced by domestic resources, would be allowed. If, however, it is unlikely that the additional margin generated in the domestic envelope will accommodate such increases in health expenditures by 2020, or there is unwillingness in the recipient country to make such a commitment to health, expenditures would not be allowed to increase as much.”

Figure 7 illustrates the application of these rules to our hypothetical country. By 2020, international assistance is not guaranteed and our country may not be able to spend more than $250 million on health. Therefore, from 2011 already, expenditure beyond $250 million ‘would not be allowed’, even if $300 million is readily available. Our country should refuse $50 million international assistance; it cannot spend it. However, it has an alternative option: it can accept all international assistance for health and allocate $50 million of its government revenue to other sectors, reserves, or to reducing earlier budget deficits. If international assistance really decreases after 2015, it can reallocate government revenue to health expenditure. That is what figure 8 illustrates.

The lack of reliability of international assistance in the long run thus appears as counter-productive. Richer countries may expect increasing international assistance to trigger increasing national efforts, but a rational reaction from poorer countries’ governments - if not imposed by the World Bank and the IMF99 - is to decrease national efforts.

As mentioned above, Lane and Glassman found that “[p]arts of the new institutional architecture, such as the Global Fund, appear to deliver stable and predictable financing”.100 Or, as Dodd and Lane found: “The [Global Health Partnerships] and their funders have been at the forefront of this trend, pioneering many of the new approaches.”101 Why do these new aid instruments perform better on long term reliability? First, it is because some of them explicitly set out to do so. As Michel Kazatchkine, executive director of the Global Fund, expressed it: “The Global Fund has helped to change the development

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100 Lane C., Glassman A. (2008) See footnote 95 above
paradigm by introducing a new concept of sustainability; one that is not based solely on achieving domestic self-reliance, but on sustained international support, as well.”\(^{102}\) Second, because pooling contributions from many richer countries allows them to be more reliable: an unexpected shortfall from one richer country can be buffered by contributions from other richer countries, and perhaps an unexpected windfall too. In as much as this international assistance is truly reliable in the long run, it should not discourage poorer countries from increasing their efforts.

However, international assistance through the Global Fund is ‘earmarked’: it can only be used to fight AIDS, tuberculosis and malaria. As long as the international assistance received through the Global Fund remains below what poorer countries want to spend on these diseases in any case, there is no problem. As soon as international assistance received through the Global Fund exceeds what poorer countries want to spend on AIDS, tuberculosis and malaria, it makes sense for governments of poorer countries to decrease their domestic contributions to fighting these diseases.

Therefore, if global health is about richer countries co-financing health efforts in poorer countries, with the intention of advancing shared interests, and hoping to create a genuine partnership, then richer countries have adopted a pretty clumsy approach. Considering the tools they created (and the tools they did not create), they can either provide international assistance that is unreliable in the long run or international assistance that is earmarked for specific diseases: both options provide incentives for poorer countries to respond by decreasing national efforts, i.e. domestic health expenditure. The net result is that the available financial resources hardly increase at all. Richer countries are becoming aware of the problem, and are proposing new solutions. As an illustration, I mention the recent recommendation of the Institute Of Medicine to the U.S. Government: “The Office of the Global AIDS Coordinator should emphasize a more binding, negotiated contract approach at the country level whereby additive donor resources are provided largely as matching funds for partner countries’ investments of their own domestic resources in health.”\(^{103}\) It could make sense, but as long as international assistance from the U.S. Office of the Global AIDS Coordinator remains earmarked for fighting AIDS, it is not in a strong position to demand an increasing effort from governments of developing countries that is focused solely on fighting AIDS too.

It may not be possible to issue an overall judgment on the efficacy of the first decade of global health - even if we assume that it only aimed at promoting those efforts that would serve shared interests, i.e. including the interests of inhabitants of richer countries. Considerable controversy remains, in particular with regards to the impact of new health co-financing instruments, their specific mandates resulting in earmarking of international assistance, and their contribution to making international co-financing more reliable in the long run. Developing a ‘counterfactual’ scenario is not feasible, we can at best develop some elements of it. What if international assistance for health had not increased? Poorer countries would probably have allocated more domestic resources to health, but perhaps not as much as international assistance for health increased. What if the international assistance had been channeled differently, as un-earmarked bilateral support to health sector budgets? Perhaps it would


not have become available in the first place, if it had not been attached to specific targets or efforts; it may not have been as reliable in the long run and thus it may have crowded out more domestic government health expenditure. If a counterfactual on the financial side of things is impossible to make, a broader and deeper counterfactual that includes such matters as ‘internal brain-drain’ (health workers leaving positions they had, providing comprehensive health care, to seek better paid jobs working on specific health issues) and survival of health workers because AIDS treatment has been prioritized, seems totally out of the question.

What we can do, however, is to imagine that all countries would have agreed on global health priorities, on mutual responsibilities, and on reliable commitments, or in a nutshell, what Fidler described as “the nascent formation of a new global social contract for health”.104 All countries would have agreed on the shared interest of global health efforts. Poorer countries would have made a commitment to increase their contribution to global health efforts, but in return, they would have demanded that global health efforts include their own priorities, not only the priorities that serve the interests of richer countries. Richer countries may have accepted, if that was the condition for poorer countries’ commitment.

Fidler is well aware of the challenges, which he described as “the tragedies of the global health commons”.105 It would advance the collective interests of all actors to respect, protect and promote the commons; yet “actors’ rational, self-interested calculations”106 encourage them to keep their contributions to the commons as limited as possible, and to seek maximum benefits. It may be tempting to blame mainly richer countries’ governments for ‘exploiting’ the global health commons. But poorer countries’ decreasing domestic government health expenditure, in reaction to increasing international assistance for health, can be seen as a form of exploiting the global health commons too: rational, and self-interested.

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105 Fidler D.P. (2007) See footnote 104 above
106 Fidler D.P. (2007) See footnote 104 above
1.10. Conclusion: global health in search of a global social contract

Can we envisage a global social contract for health? We may have to start with acknowledging that some of the main proponents of ‘contractarianism’ do not believe in global social contracts. Contractarianism is the political philosophy school of thought that sees and understands states as social contracts, under which inhabitants agree to support a governing authority that collects contributions from all to provide benefits to all; benefits like defense, police, collective infrastructure, social protection and education. A social contract requires that there is a mutually agreed way for the governing authority to obtain ‘consent of the governed’; an elected parliament, for example. At the global level, it is not that easy to imagine something equivalent.

Rawls, a contemporary ‘contractarian’ philosopher, argued that if representatives of civil society groups, under a ‘veil of ignorance’ (without knowing which group they represent), were to elaborate a social contract, that contract would include respect for essential freedoms and a minimum level of ‘distributive justice’. In his ‘Theory of Justice’, Rawls assumed that all would consent to distributing income in a way that guarantees equal opportunity for all, as a condition for a stable society. ¹⁰⁷ Some of Rawls’ intellectual heirs extended his arguments to the global level. A global society, they argued, would also require respect for essential freedoms, and a minimum level of distributive justice, across borders. Rawls dismissed these ideas in his ‘Law of Peoples’. ¹⁰⁸ At the core of his rejection lies contractarianism: all states should negotiate their own social contract; no state should interfere with the terms of the social contract of another state; and therefore no state should be obliged to assist another state dealing with the consequences of the social contract it has adopted. ¹⁰⁹

Although contractarianism can easily serve as an alibi for nationalistic selfishness, essentially it aims for country autonomy as a precondition for consent of the governed. Contractarianism holds that it is up to the inhabitants of a country to determine the level of resources they will allocate to public health - perhaps very little, or a lot, whatever the majority decides. Then other countries should not have to come to the rescue of a country where a majority has decided that public health is unimportant. Similarly, no country should be in the position of relying on resources over which it has no control. From this perspective, international assistance is undesirable. If unavoidable, it should be temporary. ¹¹⁰

International health functions on contractarian lines. Unlike solidarity systems within states, like social protection or state sponsored health insurance - which is intended to be perennial: all contribute and all receive benefits for ever - assistance between states is intended to be temporary. It thus limits the scope for international financial assistance for health to any given country in accordance with this country’s expected capacity to generate additional national financial resources for health. But it has the advantage of clarifying that the ultimate responsibility for health remains national, and thus the concept of states as social contracts worked well for international health: in every country

¹⁰⁹ Rawls referred to ‘peoples’, not states, as he believed that many contemporary states did not match with peoples sharing a common identity, and that such states did not provide a good foundation for social contracts.
(individually), a social contract has to be reached on how people will work together to improve their health, and on the level of resources they were willing to pool to improve their health. Under global health, however, international assistance for health should be understood as advancing the interests of the inhabitants of richer countries too. The concept of states as separate social contracts does not work well for global health. The inhabitants of some richer countries would want the inhabitants of other richer countries to contribute their fair share to the effort, as these other richer countries will also benefit from the results. But the inhabitants of some richer countries have nothing to say about how much the inhabitants of other countries should contribute.

Furthermore, the inhabitants of all these richer countries would like their assistance to be spent on issues that matter most to them, which may or may not be the priorities of the inhabitants of the poorer countries receiving and implementing the assistance. The Paris Declaration on Aid Effectiveness, according to which international assistance should be aligned with poorer countries’ priorities,\(^{111}\) may have fitted international health - assuming that richer countries are trying to enable poorer countries to address their health challenges - but is at odds with global health - accepting that richer countries are advancing shared interests. When inhabitants of richer countries co-finance health efforts in poorer countries to advance shared interests, they have some legitimacy in deciding how that funding should be used. Under the Paris Declaration, endorsing countries reaffirmed their commitment to “[e]nhancing donors’ and partner countries’ respective accountability to their citizens and parliaments for their development policies, strategies and performance.”\(^{112}\) For richer countries that essentially means they will allocate international assistance as their citizens and parliaments want them to. For inhabitants of poorer countries, increasingly relying on international assistance for health means they have to rely on priorities set by parliaments in which they have no voice.

Therefore, even if we were to accept global health as it has been so far - i.e. trying to advance the interests that are truly shared, and therefore excluding public health efforts that only serve the inhabitants of poorer countries - we would need a global social contract that clarifies the relative contributions from richer countries and the corresponding efforts from poorer countries.

The realization by richer countries that they cannot advance their interests without a genuine partnership with poorer countries may create a window of opportunity, in which poorer countries can more forcefully negotiate the terms of agreement of a global social contract. So far, poorer countries have mainly used their right to say no: no to increased public health expenditure, as long as international assistance remains unreliable in the long run; no to the increased allocation of domestic resources for priorities decided by richer countries, as long as these priorities are not aligned with poorer countries’ own priorities. During the next decade of global health, poorer countries could use their right to say yes, under specific conditions: yes to increased overall public health expenditure, if and only if international assistance becomes reliable in the long run; yes to increased domestic public health expenditure, if and only if these priorities are aligned with poorer countries’ priorities.

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\(^{112}\) Ministers of developed and developing countries responsible for promoting development and Heads of multilateral and bilateral development institutions (2005) See footnote 111 above
SECTION 2: GLOBAL HEALTH, WHAT IT SHOULD BE

2.1. Introduction: unexpected advantages of a treaty based approach

As mentioned in the general introduction, this second section is about what global health should be, and draws on international human rights law. I will not explain here how states and other agents do behave, I will explain how they ought to behave, to comply with their obligations arising from the right to health.

The right to health is affirmed in several international and regional human rights treaties, as I will explain under point 2.4. below. But they lack enforcement mechanisms. Some countries - not all - that ratified these treaties have included the right to health in their national law, and some of them have been condemned by their courts for not trying hard enough to realize the right to health, and have been forced to try harder. With regards to national obligations, the right to health has some teeth, in some countries. However, the countries that did include the right to health in their national law used their own language, and omitted including international obligations as mentioned in international human rights treaties. Belgium, for example, included the right to health in its constitution as a right for all citizens of Belgium and - to a certain extent - to all inhabitants of Belgium. The constitution of Belgium does not mention that the state of Belgium has any responsibility for the right to health of people living elsewhere, or that people living outside of Belgium can claim efforts from the government of Belgium to realize their right to health.

So what is the point of explaining how states ought to behave at the international or global level, if there is no mechanism to make them behave as they ought to? First, there is some merit in stating clearly what is wrong and what is right, even if it does not change reality immediately. Slavery was perfectly legal in some countries until quite recently, nonetheless it made sense to uphold the right to freedom. Second, states are not immune to claims made by the constituencies that elect or otherwise support or condone their governments. If we can clarify what states ought to do, domestically and internationally, chances are that a coalition of civil society organizations will make them do it. Third, as I tried to argue in the first section, global health - as it is - is in search of a global social contract. All countries, richer and poorer, would benefit from a global social contract that clarifies the responsibilities of all other countries. Even countries that are notoriously reluctant to acknowledge they may have any obligation that has not been decided by their own parliament may be willing to accept internationally agreed obligations, if that acceptance is a precondition for the acceptance of reciprocal obligations by all other countries. International human rights treaties, as weak as they are, may form the basis for a global social contract.

To be sure, I do consider national and international obligations arising from the right to health as binding, even if there is no international court to enforce compliance with such obligations. I also believe that civil society organizations can force their governments to live up to national and

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international obligations arising from the right to health. But ultimately, I expect the right to health to
become most forceful whenever governments of richer and poorer countries come to understand that
business as usual does not work, and when they will start looking for a firmer grip on national and
international obligations arising from the right to health.\textsuperscript{114}

As Dodgson and colleagues wrote: \textit{“The first, and perhaps the most fundamental [challenge for Global
Health Governance (GHG)], is the need to agree the normative framework upon which GHG can be
built.”\textsuperscript{115}} As Hunt and Backman wrote, the right to health is \textit{“the only perspective that is both
underpinned by universally recognized moral values and reinforced by legal obligations.”}\textsuperscript{116}

2.2. The right to health, a bottomless pit?

Many global (or international) health practitioners are skeptical about the right to health approach,
because it has been defined as the right to the \textit{“enjoyment of the highest attainable standard of health”}
in the constitution of the WHO, while health is defined there as \textit{“a state of complete physical, mental
and social well-being and not merely the absence of disease or infirmity.”}\textsuperscript{117} A commitment to realize
that right sounds like a commitment to fill a ‘bottomless pit’. Another reason for skepticism is the lack
of clear attribution of responsibility: if all countries are responsible for the health of all people, in the
end no country is responsible for anyone anymore (as there is always some other country to be blamed
- richer countries blame poorer countries for not trying hard enough and vice versa).

Using the right to health as the basis for a normative framework does not have to lead to a
commitment to fill a bottomless pit, if one acknowledges only a few of its inherent principles:
- The principle of ‘progressive realization’, which entails that the highest attainable standard must
  consider scarcity of resources;
- The principle of ‘primacy of national responsibility’, which entails that all states are first and
  foremost responsible towards their own inhabitants;

\textsuperscript{114} The second section of this working paper draws on two papers I wrote with Rachel Hammonds, which focused on
the potential of a right to health approach to find a balance between national and cosmopolitan approaches to health
justice. Although I continue to support the arguments advanced in these papers, when considered in isolation from the
search for a global social contract for health, they may suggest that governments of richer and poorer countries will live
up to their obligations simply because our understanding of the right to health and our concept of global health justice
requires them to do so. That is not what I believe in. Governments of richer and poorer countries will live up to their
obligations because their constituencies force them, and because they share an interest in agreeing on mutual
\textsuperscript{115} Dodgson R., Lee K., Drager N. (2002) \textit{Global Health Governance: a conceptual review.} London: London School of
Hygiene and Tropical Medicine; Geneva: World Health Organization. Available from:
\textsuperscript{116} Hunt P., Backman G. (2008) ‘Health systems and the right to the highest attainable standard of health.’ \textit{Health and
Human Rights}, 10(1): 81-92
• The principle of ‘core content’ entails that all people are entitled to a minimum level of health efforts, even if they live in a country that is too poor to provide them without relying on international assistance.

Before moving to these principles, we first need to answer the ‘big question’: can something like health be a human right at all? We also need to look at the key sources of international human rights law, with regards to the right to health.

### 2.3. ‘Positive’ and ‘negative’ rights

Some would argue that claiming a right to health makes as much sense as claiming a right to become a professional basketball player (that is, no sense at all). Some are born with a talent to become a professional basketball player, some are not; some are born with a talent to be and remain healthy, some are not. Surely, children born HIV positive cannot claim a right to be born HIV negative, or can they? No, they cannot. But they can claim efforts from the states they live in - and, as I will argue, from other states too - that will allow them to lead a life that comes as close as possible to the lives of children born HIV negative.

Many legal scholars distinguish between ‘positive’ and ‘negative’ rights - although the terminology may be misleading. Negative rights are rights one can have when others are obliged to do nothing that could interfere with those rights. Freedom of speech could be a typical example of a negative right: if everyone else is obliged to do nothing that could bother you when expressing your opinion, your freedom of speech is secured. Positive rights are rights one can only have when others are obliged to do something. The right to education could be a typical example of a positive right: many people can only have a right to education, if most others are obliged to do something like paying taxes to the government, and if the government is obliged to use those taxes to subsidize education.

Some human rights scholars argue that only negative rights can be human rights. Negative rights do not cost a government anything - or so they are assumed; the only thing a government needs to do is refraining from violating that right. Positive rights, however, require positive action, and governments may have legitimate reasons for not taking such action. Governments may be too poor, for example. Or they may apply the will of the majority when deciding not to raise taxes to finance education.

In my opinion, this distinction is exaggerated. My freedom of expression does not just rely on my government refraining from bothering me, whenever I want to express an opinion my government does not like. It also relies on my government protecting me whenever I want to write an article about organized crime in my neighborhood and when the criminals involved would like to see me end up at the bottom of the ocean: when I need protection. Thus, to secure my freedom of expression, I need positive efforts from my government: efforts to protect me, efforts that will cost money and for which all my neighbors will have to pay taxes, if they are serious about my right to freedom of expression. Likewise, to secure my right to health, I need positive efforts from my government too, like financing a hospital that will take care of me when I am ill. There may be a difference in intensity of the efforts required: low intensity when it comes to securing freedom of expression; high intensity when it comes
to securing the right to health. But there is no fundamental difference. That does not mean that international human rights law considers negative and positive human rights on a par; it does not.

2.4. Key sources of the right to health

What are the key sources of international human right law, with regards to the right to health? They include:
1) The 1948 Universal Declaration of Human Rights;
2) Two derivative international covenants, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights;
3) The 1989 Convention on the Rights of the Child; and
4) The comments of the Committee on Economic, Social and Cultural Rights (general comment on the right to health).

While the Universal Declaration of Human Rights is the foundation of international human rights law, it is not a legally binding document in itself, but expresses values later embodied in legally binding obligations through international human rights treaties that are based on it. The International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights are two treaties derived from the Universal Declaration of Human Rights that contain legally binding obligations for the states that ratify them. Article 12 of the International Covenant on Economic, Social and Cultural Rights defines the right to health as “the right to the highest attainable standard of physical and mental health” and the related obligations include the provision of health care services and of preconditions of health, including access to safe water, food security and housing. This basic definition is affirmed and expanded in later international conventions, including the Convention on the Rights of the Child and other national and international legislation. A further important development occurred in 2000 when the Committee on Economic, Social and Cultural Rights issued a general comment on the right to health, addressing the scope of the right to health and the importance of international cooperation in achieving the right to health. Whereas the language of article 2(1) of the International Covenant on Economic, Social and Cultural Rights does not allow distinguishing between national and international obligations - governments are bound “to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources” - the general comment on the right to health clarifies the scope of national and international obligations.

121 International Covenant on Civil and Political Rights (1966) See footnote 112 above
2.5. Progressive realization of the right to health

A key element of the Economic, Social and Cultural Rights is that they are expected to be realized in a progressive manner, over time: a state must take steps “to the maximum of its available resources”. This is not the case for Civil and Political Rights, which are expected to be realized immediately. This difference is based on the idea that Civil and Political Rights are ‘negative’ rights, as discussed above under point 2.3.: it is implicitly, and erroneously, assumed that it does not cost governments anything to realize them, they simply should refrain from violating them. Whereas the right to health, for example, requires governments to collect taxes and to develop a system of health care services, provision of safe water, sanitation and so on. As this relates to the right to health, the Committee on Economic, Social and Cultural Rights notes: “The concept of progressive realization constitutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time.”

The concept of progressive realization may considerably weaken any claim based on the right to health. While it can be easy to formulate a claim like ‘I have this disease, I need that treatment and I cannot afford to pay it, so the government must pay it for me’, it will often be relatively easy for a government to argue that it is taking steps, but that it does not have sufficient resources to finance a given treatment for all who need it. And there ends the discussion? Not necessarily. Progressive realization should not be misinterpreted to justify endless delays in realizing social rights. It is not to be viewed as “an escape hatch (for) recalcitrant states.” Such an interpretation would deprive social rights of any meaningful value. Thus, the Committee on Economic, Social and Cultural Rights notes that governments have “an obligation to move as expeditiously and effectively as possible.” Against any idea that ‘progressive realization’ might imply ‘no immediate obligations’, the Committee on Economic, Social and Cultural Rights emphasizes a series of concepts and principles that define the nature of obligations, including the principle of non-retrogression (a state should not take steps backwards), the principle of non-discrimination, and the concept of core content. I will focus here on the concept of core content, as it is the key principle of international human rights law that can clarify the relationship between national and international responsibilities.

2.6. Primacy of national responsibility

Article 2(1) of the International Covenant on Economic, Social and Cultural Rights does not allow distinguishing between national and international obligations: governments are bound “to take steps, individually and through international assistance and co-operation”. So when we try to measure whether a government has used “the maximum of its available resources”, should we look at its domestic resources only, or also include resources available from international assistance? Or can we

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take it one step further, and argue that the inhabitants of a given country can also turn to governments of richer countries, and claim that each of them has an obligation to provide international assistance “to the maximum of its available resources” too?

The confusion in the text allows for two extreme interpretations:

- On the one hand, one could argue that all governments have an obligation to use the maximum of their available resources to realize the right to health (and other economic, social and cultural rights) for their inhabitants. As the right to health is defined as “the right to the highest attainable standard of physical and mental health”, and as innovations in medical science provide ever more expensive solutions for incremental improvements, all governments can spend their entire budgets on domestic health without ever achieving the highest standard. In conclusion, even the richest countries of the world would have no resources left for international assistance, because of their efforts to realize the right to health for their own inhabitants.

- On the other hand, one could argue that all governments have an obligation to use the maximum of their available resources to realize the right to health (and other economic, social and cultural rights) for all people around the world, either individually or through international assistance. Then governments of richer countries should not finance any effort to improve the health of their inhabitants, without trying to make sure that all people around the world will benefit from exactly the same effort.

The very idea that governments of richer countries have a legal obligation to provide international assistance remains controversial. Scholars who confirm the existence of such an obligation also confirm the primacy of national responsibility. As Alston notes: “The correlative obligation [to provide assistance] would, of course, be confined to situations in which a developing country had demonstrated its best efforts to meet the [Millennium Development] Goals and its inability to do so because of a lack of financial resources.” One can disagree with Alston about the Millennium Development Goals providing the appropriate standards, but it is difficult to disagree with the primacy of national responsibility expressed in this paragraph. If richer countries had an obligation to assist poorer countries in realizing the right to health, even those countries that do not try to use the maximum of their available resources, we would create a situation in which no government is responsible for anything, as any government could simply hide behind other countries not doing what they should. So we need to clarify where national and international responsibility meet each other, and the principle of ‘core content’ can help us.

2.7. The core content of the right to health

Örücü elaborated the notion of the ‘core content’ of human rights: the essential substance of a right, its raison d’être, without which it would have no meaning. The focus of Örücü’s original paper was on civil and political rights, more than on economic, social and cultural rights. She examined how

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governments ought to behave, when different human rights were at stake and competing with each other, for example when radical religious groups promote a vision of society in which women would be subordinated to men and when the government wants to curtail the freedom of expression of such groups. Örüçü argued that every human right has a core content, without which it would have no meaning. So in all circumstances, a minimum of freedom of expression would have to be guaranteed. Nonetheless, propaganda for violations of other human rights cannot be legitimized by referring to freedom of expression.

The 1997 Maastricht Guidelines, drafted by international legal experts expanded further on this idea, applying it to economic, social and cultural rights. The concept of ‘core content’ was endorsed by the Committee on Economic, Social and Cultural Rights’ General Comment which clarified that there are limits to the compromises that states can make with regards to realizing economic, social and cultural rights by invoking the explicitly acknowledged impossibility of realizing all of them completely and at once. There is a minimum threshold, a minimum essential level or a core content, which must be realized without further delay. The Committee defined the core content of the right to health through its definition of the core obligations that arise from the right to health. Core obligations include obligations to ensure access to essential health services and promotion of the preconditions of health. Essential health services include the provision of essential drugs, as defined by the WHO.

For most health practitioners in developing countries, this definition sounds like a wild dream. Low-income countries are simply too poor to provide a basic package of health services, which is estimated by WHO to cost US$40 per person per year. Given the principle of ‘ultra posse nemo obligator’, that is, the idea that no person (or country) can be obligated beyond what he, she or it is able to do, does it make sense to define core obligations that are unaffordable for low-income countries? It does, in light of article 2, para. 1 of the ICESCR, which states that each government “undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources.” (emphasis added) As Hunt remarked at the May 2000 Committee session in which the general comment on the right to health was drafted: “if the Committee decided to approve the list of core obligations, it would be unfair not to insist also that richer countries fulfill their obligations relating to international cooperation under article 2, paragraph 1, of the Covenant. The two sets of obligations should be seen as two halves of a package.”

If the right to health is meaningless without the realization of at least its core content, and if some countries lack the resources needed to realize the core content of the right to health, then the right to health itself cannot exist without international obligations to provide assistance. Without international obligations to provide assistance - without internationally shared responsibility - the right to health is not a right but a privilege reserved for those who are born outside of the world’s poorest countries.

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130 Committee on Economic, Social and Cultural Rights (2000) See footnote 123 above


132 International Covenant on Economic, Social and Cultural Rights (1966) See footnote 120 above

But as we discussed under point 2.4., the international obligations are very imprecise; some interpretations even provide that they are only triggered when richer countries have realized the highest attainable level of all human rights at home (which will never happen). How then does the principle of core content help us?

I would argue that the principle of core content imposes a hierarchy: that it is more urgent to realize the core content of the right to health for all people than to aim for the very highest attainable standard of health domestically. This hierarchy would disappear as soon as the core content of the right to health were realized everywhere. At that point, in accordance with the principle of the primacy of national responsibility, all countries can give priority to the highest attainable standard domestically.

2.8. Where national and international responsibilities meet

If the principles of progressive realization, primacy of national responsibility and core content were accepted, we would still need to agree on some basic parameters to operationalize them. In the discussion below, I will outline a simple framework, drawing on two separate assumptions, in addition to the 2001 pledge by African Heads of State and Government to allocate at least 15% of their budget to the health sector (the Abuja Declaration).

First, I assume that in order to realize the core content of the right to health, governments must be willing and able to spend at least the US$40 per person per year on health-related goods, identified by WHO as necessary for an “adequate package of healthcare interventions.” This core content would become a ‘global priority entitlement’, for which governments are responsible individually, but for which richer countries would also be responsible, through international assistance. Second, I assume that government revenue, even in low income countries, can reach 20% of GDP. If we then integrate the second of these two assumptions with the Abuja Declaration, we can identify a general benchmark for low income countries: they would have to raise and allocate the equivalent of 3% of their GDP for government health expenditure, before they can claim they have exhausted their resources to the maximum. If we then go on to integrate the second assumption, towards all countries that would still be unable to achieve a government health expenditure of $40 per person per year, richer countries would have an obligation to provide assistance. Figure 9 illustrates how these assumptions would clarify where national and international responsibilities meet.

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135 Carrin G., Evans D., Xu K. (2007) See footnote 131 above
Figure 9. Where national and international responsibilities meet

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<td>$333 per person per year</td>
<td>$1000 per person per year</td>
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<tr>
<td>$60</td>
<td>$50</td>
<td>minimum cost of global priority entitlement</td>
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Country A has a GDP per person of $333. The government of country A is assumed to be able to spend 3% of this amount, or $10 per person per year, on health. That would be its national responsibility. The international responsibility would be to provide reliable assistance, as long as needed, to make sure that the government of country A is able to spend $40 per person per year on health. In the first years, that international responsibility would amount to $30 per person per year: it would gradually decrease as the GDP of country A grows.

Towards country B, the international responsibility would be limited to financing $10 per person per year, as country B has a GDP per person of US$1,000 and is able to spend 3% of that amount (or $30 per person per year) on health. Towards country C, there would be no international responsibility, as it is able to finance $60 per person per year.

Of course, these parameters would have to be fine-tuned. There would have to be an agreement on how the resources should be spent, in line with the right to health. As Hunt and Backman argue, “human rights require that states take effective measures to progressively work toward the construction of an effective health system that ensures access to all”, and “states have a human rights responsibility to establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities.” Furthermore, some countries may have legitimate reasons for not being able to allocate 3% of GDP to health, while others may have reasons to argue that $40 per person per year is not enough, given the prevalence of diseases that are more expensive to treat.

The point here, however, is to show how the right to health can provide the foundation for a global social contract on health. It would clarify how to use ‘the global health commons’. For all or most richer countries currently involved in co-financing efforts to improve public health in poorer countries, there would be a price to pay, in the form of increasing international assistance. But the benefit for each of them would be that they could count on burden sharing between all richer countries, and that they could rely on more efforts from the poorer countries themselves. For all or most of the poorer

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countries currently receiving international assistance for health, there would be a price to be paid too: they would have to increase their own efforts. But in return, they would receive reliable international assistance, based on mutual and reciprocal responsibility, and they would be able to use it for their own priorities.

2.9. The right to health and fair trade

Some would argue that what I propose above is a very conservative or reductionist view of international responsibility for the right to health. Katz, for example, would argue that this is just another version of ‘trying to increase the size of the crumbs from the rich man’s table’. And she would have a point. To understand it, we have to return to point 1.2. above, and to what Kapstein called the ‘grand design for the postwar era’, built on two pillars (the welfare state at the national level; free trade at the international level), assuming that free trade would lead to convergence in economic performance.

We have already seen that free trade has not led to economic convergence. The premises on which this economic convergence theory were based are challenged by economists like Chang and Reinert, who argue that imposed openness to the global market prevents poorer countries from industrializing their economies. By imposing free trade, or opposing measures that poorer countries can use to protect their emerging industries from competition with similar products made cheaper elsewhere, richer countries are ‘kicking away the ladder’ they once used to foster their domestic industrialization. As the Universal Declaration of Human Rights declares that “everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized”, one can argue that rather than co-financing health efforts in poorer countries, richer countries should allow poorer countries to really develop their economic potential, by putting an end to the current international economic world order that does not lead to convergence but to divergence.

But is this really a question of one or another solution? As Deacon and colleagues argue: “Global, regional and national social policies are needed to secure the ‘three R’s of redistribution, regulation and rights, which are fundamental to our wider social vision. These policies should provide for:
• systematic resource redistribution between countries and within regions and countries to enable poorer countries to meet human needs,
• effective supranational regulation to ensure that there is a social purpose in the global economy, and

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• enforceable social rights that enable citizens and residents to seek legal redress where necessary against unjust or ineffective governments at whatever level.

The three R’s are mutually dependent, each upon the others. Social rights in some poorer countries can only be secured if a) resources are redistributed between countries and b) international business activities everywhere are effectively regulated.”

The proposal made here would create a very modest beginning of global redistribution of income, to enable poorer countries to meet essential human needs. It would not ensure supranational regulation of market forces. In itself, it would not be sufficient to secure the right to health. However, as De Swaan found, many social protection mechanisms in today’s richer countries stemmed from basic efforts to improve public health. In as much as we can learn from how social justice progressed in today’s richer countries to trace a route for achieving global social justice today, health is a good candidate. I am hopeful that global redistribution for health will lead to global regulation for health, to the right to health and ultimately to other social rights.

2.10. Conclusion: human rights, justice, and security

As I mentioned above under point 1.1., Koplan and colleagues define global health as "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide", but offer this more as a definition of what global health should be than as a definition of what global health has been so far. What I propose in this section is a view of global health as it should be, like Koplan and colleagues do. However, my understanding of what global health should be, in accordance with international human rights law, may or may not be more conservative than what Koplan and colleagues have in mind. It all depends on how one defines equity.

Simply put: inequalities are differences that can be measured, most often, objectively. For example; there is an objectively measurable difference in life expectancy between children born in Belgium and children born in Mozambique; that is an inequality. But it may or may not be an inequity. Inequities are inequalities that are also unjust. To argue that the difference in life expectancy between children born in Belgium and children born in Mozambique is not only an inequality but an inequity too, one needs a concept of justice that allows one to make a distinction between unjust or ‘not unjust’ inequalities. And the right to health tolerates a lot of ‘not unjust’ inequalities, because of its focus on national responsibility and national duties. International human rights law does not wipe out borders of states, and therefore does not aim for equality in health for all. On the contrary, if equality in health is about “variation in the distribution of the health outcome”, while inequity in health is about “underlying unfairness”, then international human rights law and its primacy of national responsibility justifies a whole lot of inequality as ‘not unjust’: it somehow legitimates health outcomes in richer countries being much better than health outcomes in poorer countries.

However, the idea that each human right has a core content does draw a line: if health outcomes in some poorer countries are so bad that they undermine the very core of the right to health, they are not only inequalities, but inequities too: they are unjust.

Some will argue that even this very modest account of global health justice - global health, what it should be - is at odds with my account of global health in the first section - global health, what it has been so far. Global health has so far mainly been about richer countries seeking shared benefits. There is even an academic journal, ‘Global Health Governance’, using “The Scholarly Journal for the New Health Security Paradigm” as its sub-title. What, if anything, does security have to do with justice?

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148 As the impact of globalization on increasing inequity between nations and people within nations becomes more clear many would argue that the human rights movement needs to respond to this challenge to remain relevant. The focus on the nation state as the primary duty bearer found in key international instruments like the International Bill of Human Rights, Social and Cultural Rights often provides insufficient guidance for addressing issues with transnational implications; including human rights, climate change, fair international trade rules, tax havens and money laundering. An introduction to how different human rights scholars view this challenge can be found in Salomon M., Tostensen A., Vandenhole W. (eds.) (2007) Casting the Net Wider: Human Rights, Development and New Duty Bearers. Antwerp: Intersentia.
I strongly believe that justice and security are intimately related. I do not believe in a world that is unjust, but nonetheless secure. Human rights did not fall from the skies; they were not invented at a green table. They reflect a natural sense of justice that can be traced back to minimum conditions for cooperation within small tribes of hunting and gathering nomads, before they created cities and states. ¹⁵⁰ If richer countries do not display a minimum willingness to cooperate with poorer countries in securing the very basic levels of human rights, they should not count on cooperation from poorer countries when it comes to protecting the human rights of inhabitants of richer countries. For example, richer countries should not count on inhabitants of poorer countries denouncing suspicious behavior, the kind of behavior that could lead to airplanes exploding above European or American skies. If richer countries reject all responsibility for avoidable deaths in poorer countries, they should expect poorer countries rejecting responsibility for avoidable deaths in richer countries. These are two sides of the same coin.

All in all, a ‘global health security’ paradigm may not lead to political imperatives that are substantially different from the imperatives of a ‘global health justice’ paradigm. The tone of these paradigms is very different, of course, and those who intuitively embrace the ‘global health justice’ paradigm may intuitively reject the ‘global health security’ paradigm. However, for governments of poorer countries struggling to improve the health outcomes of their inhabitants, and their allies, there are two important lessons to be learnt from understanding that global health, as it is, is more about richer countries trying to advance the interests they consider as shared (or, their own interests) than about richer countries trying to promote ‘global health justice’ as an end in itself, but that both are closely related:

- Governments of poorer countries and their allies should not count on the benevolence of governments of richer countries - except, perhaps, when benevolent civil society organizations based in richer countries push their governments to do things they would not do otherwise;
- Governments of poorer countries should no longer see and position themselves as grateful recipients of richer countries’ charity, but as essential partners in a process that aims for greater justice for all, and therefore to greater security for all.

The new global health partnership between richer and poorer countries should steer clear of woolly language suggesting that inhabitants of poorer countries are the center of their concern: they are not. At the center of their concern is a global society that is unstable because of its huge and deepening inequalities, and governments of richer and poorer countries need to work together to address those inequalities. Such cooperation cannot be taken for granted; it requires a global social contract, and the right to health can provide a basis for such a global social contract - or at least for part of it.

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SECTION 3: GLOBAL HEALTH, WHAT IT COULD BECOME

3.1. Introduction

In the general introduction to this working paper, I announced that the third section - global health, what it could become - really is about global health diplomacy, or “the coal-face of global health governance... where the compromises are found and the agreements are reached”. Global health diplomacy takes into account reality and its constraints, accepting some constraints, while challenging others. And of course, the constraints one wishes to challenge are those one believes are vulnerable to being challenged, and that is inevitably a subjective appreciation. Therefore, I do not pretend that my choices about constraints vulnerable to being challenged and constraints not vulnerable to being challenged have much academic validity. They are subjective, and probably reflect my skepticism about the willingness of governments of richer and poorer countries to create a less unjust world. I do not expect the reader to share the skepticism underlying my choices; I hope to have my stance challenged. But I do want to warn the reader against wandering too far in the direction of global health as it should be, when thinking about global health as it could become.

I hope to have convinced at least some readers, that global health is in search of a global social contract. Even if we assume that global health, what is has been so far, is focused on shared interests - interests shared between richer and poorer countries - it does not seem to work all that well; it does not produce the outcomes expected by richer countries because poorer countries are responding to increasing international efforts by decreasing domestic efforts (and understandably so). Global health, what it could become, requires a global social contract that gives due consideration to the priorities of poorer countries.

I also hope to have convinced at least some readers that international human rights law provides a basis for a global social contract, as several fundamental international human rights treaties have been ratified by most richer and poorer countries. But I acknowledged too that international human rights law is far too unspecific. It confirms a few principles: that the primary responsibility for the right to health is a national responsibility; that there is a core content of the right to health that should be a reality for all humans; and that if some countries are unable to realize that core content, the international community should step in. But the devil is in the detail:

• How hard should poorer countries try; at which point can we say they tried hard enough?
• What exactly does the core content of the right to health include, and what does it require?
• When we know what the core content of the right to health includes and requires, do we know what richer countries should provide to poorer countries?
• How should richer countries provide whatever they ought to provide to poorer countries?

The answers to these questions will have to be negotiated; they cannot be derived directly from international human rights law. The outcomes of these negotiations would have to be reliable for all partners involved in the global social contract; they should be more than declarations of good

intentions that governments can unilaterally change due to changing circumstances (like financial crises) or a new government being elected and embracing priorities other than global health.

Where can such a global social contract be negotiated? Rather than looking directly to the General Assembly of the United Nations, I propose to look at some of the new ‘instruments’ that have been created during the first decade of global health - the IHP+, the Global Fund, and in less detail GAVI - in combination with the WHO. These instruments represent only a fraction of international co-financing of health efforts in poorer countries, but they may contain the essential ingredients of a global social contract. Furthermore, their erratic genesis may illustrate some of the less rational obstacles on the path towards a global social contract.

3.2. Learning from the global response to HIV/AIDS: towards a Global Fund for Health?

I agree with Elmendorf that “HIV/AIDS was the first disease to make health a truly global issue in our time”, and with Kickbush, I agree that “[a]ll the elements that we can characterize as defining features of global health governance were first played out in the HIV/AIDS arena.” The global response to HIV/AIDS created the Global Fund. If the global response to HIV/AIDS was the pioneer for global health, we may have to consider how the Global Fund could become a platform for negotiating a global social contract for health.

The Global Fund invites poorer countries to submit proposals to fight AIDS, tuberculosis and malaria, and mentions that applicants do not have to demonstrate their ability to continue the interventions for which a grant is sought without external financing, once the grant period is over. It is assumed that the Global Fund will provide sustained international co-financing - and thus that richer countries will continue to finance the Global Fund - for as long as needed.

The Global Fund can be seen as an exponent of richer countries’ desire to drive global health efforts towards shared interests. When financing the Global Fund, richer countries tell poorer countries that they want their co-financing to be used for efforts to fight HIV/AIDS, tuberculosis and malaria. Nonetheless, I believe that the Global Fund could be characterized as a nascent global social contract for health, for reasons related to its structure, governance and functioning. As described above under point 1.7., the Global Fund is a non-profit foundation, governed by its own by-laws and the law of Switzerland. It has a board consisting of 20 voting members: richer countries have eight voting members and two other voting members (one representing the private sector and the other representing private foundations) are considered as being on the side of richer countries; poorer countries have seven voting members, and three voting members representing civil society organizations are considered to be on the side of the poorer countries. Decisions require a two-thirds

155 Global Fund to fight AIDS, Tuberculosis and Malaria (2011) See footnote 85 above
majority of both groups. Poorer countries are invited to submit proposals, which are then reviewed by an independent Technical Review Panel (TRP). Finally, it is the board of the Global Fund that approves the proposals, following the recommendations by the TRP.

To use the Global Fund as a platform where a global social contract for health can be agreed upon, and implemented, would require at least three fundamental changes:

- Richer countries would have to accept a burden sharing mechanism, including mandatory contributions they cannot walk away from whenever the board of the Global Fund takes a decision they do not like;
- Poorer countries would have to accept that firm and reliable commitments from richer countries are contingent on firm and reliable commitments on their part;
- The mandate of the Global Fund would have to be broadened, to encompass all health efforts.

The Global Fund tried to secure a ‘burden sharing’ agreement between all richer countries in 2005, but failed.156 Does it make sense to try again, only six years later? Perhaps it does. As mentioned above under point 1.9., at least some richer countries are starting to understand that their co-financing efforts will not achieve desired results, unless they are additional to the domestic efforts of poorer countries.157 Therefore, they may be willing to consider mandatory contributions as the counterpart to demanding guaranteed efforts from poorer countries.

The Global Fund also tries to make sure that its financing is truly additional, and encourages poorer countries to increase their national contributions. So far, the success of these efforts has been limited. As UNAIDS reports, “[i]n low-income countries, however, 88% of spending on AIDS comes from international funding”, and “one third of all countries make investments at a level that is commensurate with their national income levels and share of the global epidemic burden”,158 which is a diplomatic way of saying that two thirds of all countries are not. At a recent meeting, the board requested the secretariat to “[f]urther reinforce the tracking and enforcement of additioanality, working with other bodies as appropriate”.159 We may therefore expect measures, in the near future, guaranteeing increasing commitment from poorer countries. If they negotiate those wisely, poorer countries should demand that, in return, richer countries increase the reliability of their contributions too.

The toughest requirement (to use the Global Fund as a global social contract for health) will be to expand its mandate, beyond three diseases. It tried, in 2005, but failed, and the failure teaches us a lesson about the reality of international political public health, or the complex interrelationship of public health and political activity at the level of international affairs.

157 Institute of Medicine of the National Academies (2010) See footnote 103 above
In 2005, the Global Fund’s fifth call for proposals, or Round 5, included a specific ‘window’ for proposals to strengthen health systems and services. It was not particularly successful: only Cambodia, Malawi and Rwanda saw their health systems proposals approved. But it was enough to show the potential of having a global fund for financing health systems and services. Rwanda saw its proposal for a grant to subsidize health insurance for orphans and widows approved. In effect, this was a subsidy to Rwanda’s social health insurance mechanism, which is the core of its health system.\(^{160}\) Malawi obtained a grant for its health workforce program. As Malawi has opted for a tax-based social health protection system, a grant for health workers’ salaries is, in fact, a contribution to Malawi’s broader health system.\(^{161}\) These grants show how the Global Fund could fairly easily be transformed into a channel for international co-financing of health systems, or a Global Fund for Health.\(^{162}\)

However, Round 5 raised concern among some richer countries and other international organizations, like the World Bank. The World Bank, together with the Global Fund (under pressure from some richer countries), commissioned a report about the comparative advantages of the Global Fund and the World Bank, with regards to supporting health systems. Shakow, a former World Bank employee, produced a report arguing that the Global Fund had no business in supporting general health services or systems.\(^{163}\) In a public debate, he confirmed his position: “I specifically suggest that the Global Fund not include a special health services or health systems strengthening category in their request for proposals, as they did in this last fifth round of proposals.”\(^{164}\) The Global Fund closed its window for proposals to strengthen health systems and services by Round 6, in 2006.

Not all members of the Board of the Global Fund agreed with this decision. Civil society organizations and poorer countries in particular challenged it, and wanted the Global Fund to keep a window for health systems. In the end, the WHO was called upon, to act as a referee on the matter. The WHO held a consultation in July 2007, and delivered a lukewarm report. Sure, the report confirmed the Global Fund had to support the global health commons: “The question is therefore not whether the Global Fund invests in strengthening health systems, but how.”\(^{165}\) The WHO did not recommend the Global Fund keep a window for health systems strengthening. However, only a few weeks later, in September 2007, the International Health Partnership Plus Related Initiatives (IHP+) was launched. The IHP+ has two principal actors, the World Bank and the WHO: together, they compose the core team of the IHP+.\(^{166}\) One tried hard to steer the Global Fund away from health systems strengthening, the other failed to support it, in its role as a referee, that the Global Fund maintain a health systems strengthening

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window. But as the IHP+, they emphasize the crucial importance of health systems: “Comprehensive and strengthened health systems are the basis by which effective health care can be delivered in developing countries and ultimately results achieved. IHP+ will provide a mechanism for a more balanced joint effort to improve health services as a whole.”

To conclude this story: in December 2010, the board of the Global Fund decided that Round 11 would again have a specific window for health systems and services. But the wording of this decision is very cautious: “applicants are encouraged, wherever possible, to integrate requests for funding for [health systems strengthening] actions within the relevant disease component(s)”, and “[w]hen requesting funding for such crosscutting [health systems strengthening] actions applicants are still required to articulate how they address identified health systems constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, tuberculosis and malaria.” It is not clear whether the abovementioned proposals that were successful under Round 5 would again be successful under Round 11, as the link between the actions and the fight against HIV/AIDS, tuberculosis and malaria may be considered as insufficiently strong. But the Global Fund is starting to support health systems in a different way, which will be discussed under point 3.4.

3.3. Learning from the ‘antithesis’ of the global response to HIV/AIDS: towards an International Health Partnership with real money?

The IHP+ can be seen as the antithesis of the Global Fund. It does not seek to raise additional international co-financing, but promotes “more effective use of the development assistance already being provided through improved coordination.” It does not focus on specific diseases but wants to “provide a mechanism for a more balanced joint effort to improve health services as a whole.”

Essentially, the IHP+ encourages poorer countries to elaborate a long term comprehensive health sector plan, the so-called ‘Compact’, and then tries to broker a so-called ‘Joint Financing Agreement’ under which richer countries and international organizations like the World Bank, GAVI, UNICEF and UNFPA commit to co-finance the Compact. The website of the IHP+, consulted in May 2011, lists five completed Compacts: Benin, Ethiopia, Mali, Mozambique and Nepal. Ethiopia and Nepal have also concluded a Joint Financing Agreement.

The Ethiopian Compact illustrates how the IHP+ could become a platform to agree on a global social contract for health, but also highlights the challenges that the IHP+ will have to overcome. The Compact contains a relatively detailed overview of the “Health Sector Development Programme” (HSDP) of the Government of Ethiopia, and includes a firm commitment from the Government of Ethiopia to “[f]und the health sector in accordance with [the Plan for Accelerated and Sustainable Development to End Poverty] and HSDP3 financing scenarios and increase the domestic allocation to the

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169 International Health Partnership Plus Related Initiatives (2011bis) See footnote 168 above
health sector over time”. The commitment of the ‘Development Partners’ is far less precise: they promise to “[c]ollectively increase development assistance to the health sector during the years 2009-2015” and to provide “information on expected future commitments and disbursements of sector’s budget support and project aid for as far ahead as it is feasible”. That reveals a fundamental problem of the IHP+: while poorer countries are required to make specific commitments, richer countries are not. They promise to finance health-promoting efforts that have been proposed by the poorer countries and approved together - and, ideally, not to push for other efforts - but made no co-financing commitments.

The IHP+ could, and - to become a platform for a global social contract - should revise its funding strategy. To obtain a Joint Financing Agreement under the IHP+, poorer countries are expected to make binding commitments, or so it seems. To become members of the IHP+, both richer and poorer countries must endorse the so-called ‘Global Compact’, under which richer countries make a commitment to provide “[l]ong-term predictable financing for strengthening health systems”. Would it be possible to demand from richer IHP+ members that they too make firm commitments, not only about the quality of their co-financing, but also about the quantity - for example, to commit 0.1% of GDP to international health co-financing? It certainly seems reasonable, but is it also feasible?

The IHP+ is not a formal institution or organisation; it is a virtual organisation. At the top of its governance mechanism, we find the IHP+ Core Team, a “[s]mall joint WHO and World Bank team in Geneva, Washington, working in close cooperation with WHO and World Bank country representatives.” At the level below, we find the IHP+ Executive Team, composed of 12 members, representing the constituencies included in the Scaling up Reference Group (SuRG) of the IHP+. Of the 12 members of the Executive Team, four represent the so-called Health 8 (H8): an informal group of eight health-related organizations, including WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Bill and Melinda Gates Foundation, and the World Bank. Two other Executive Team members represent civil society organizations: three represent poorer countries and three represent richer countries. The SuRG itself includes all signatories of the Global Compact. It is not clear at which level a modification of the Global Compact - to include binding commitments from richer countries - would have to be discussed, probably at the level of the SuRG, as all signatories would have to agree with a new version of what they agreed to. Poorer countries are clearly in the majority on the SuRG - in May 2011: 25 poorer countries, 13 richer countries - and would have a strong argument that partnerships require reliable commitments from both sides. However, changing the Global Compact would probably require a unanimous vote.

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172 International Health Partnership Plus Related Initiatives (2011) See footnote 167 above
3.4. Thesis, antithesis, and synthesis: combining the IHP+ with the Global Fund and GAVI?

If the IHP+ started as the antithesis of the Global Fund, there are encouraging signs of synergies between both, and with GAVI. One of the innovations introduced by the IHP+ is the Joint Assessment of National Strategies (JANS). In essence, JANS involves a group of stakeholders that assesses a poorer country’s Compact, or long-term comprehensive health program. When JANS became available, the Global Fund adapted its pre-existing National Strategy Application (NSA) system to allow countries with JANS-approved Compacts to use the AIDS, tuberculosis and malaria components of the Compact as NSAs. With my sincere apologies for this alphabet soup, this essentially means that long term comprehensive health programs become the starting point of proposals to the Global Fund, even if only the components focused on AIDS, tuberculosis and malaria are eligible.

But there are more synergies. One of the - probably unintended - effects of the IHP+ was the creation of a new ‘health systems funding platform’. The creation of the IHP+ confirmed what is common knowledge: not enough funding is available to finance health systems in poorer countries. A Taskforce on Innovative International Financing for Health Systems was launched in September 2008 as a kind of IHP+ spin-off - using the IHP+ secretariat and website, for example. This task force, as its name suggests, tried to find a solution for the health systems funding gap in low-income countries. Towards the end of the proceedings, the Executive Director of the Global Fund and the Chief Executive Officer of GAVI addressed a letter to the chairs of the task force, in which they expressed their belief that “combining [their] respective funding streams for health systems, in collaboration with the World Bank and others, [was] the practical next step required to make the health architecture more effective globally and at the country level, in line with the International Health Partnership (IHP) process.” The task force acknowledged the letter and, in its final report, recommended “a health systems funding platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies.”

In December 2010, the board of the Global Fund decided not only that Round 11 would have a specific window for health systems, as already discussed above, but that it would also launch a pilot, allowing four or five countries to submit funding requests that were not developed specifically for the Global Fund, but based on their IHP+ Compact. In the words of the Policy and Strategy Committee of the Global Fund: “Following the JANS assessment and the finalization of the national health plan, the country would submit a formal ‘funding request’ with the national health plan as the key document; a

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174 Peter S Hill P.S., Vermeiren P., Mirt K., Ooms G., Van Damme W. (2011) “The Health Systems Financing Platform: Is this where we thought we were going?” Globalization and Health, 7(16)


177 Global Fund to fight AIDS, Tuberculosis and Malaria (2010) See footnote 169 above
common (short) proposal form would be devised between all partners. Proposals would be submitted to the Global Fund, GAVI, the World Bank and other partners, indicating the financing gap, areas where funding is required, and the amount requested from each partner." If the pilot is successful, the Global Fund and GAVI could become essential financing arms of the IHP+, which would require the Global Fund and GAVI to revise their ‘replenishment’ strategies, and to aim for more reliable commitments from richer countries.

It may seem somewhat ironic that the IHP+, which was created - among other reasons - to support co-financing health systems because the Global Fund and GAVI experienced difficulties in doing so, and which then became an argument for not expanding the Global Fund’s role in health systems strengthening, ultimately turns towards the Global Fund and GAVI to finance health systems through a new funding platform. It may have been a lot easier, back in 2006, to encourage, the Global Fund to keep its ‘window’ for health systems, and to encourage GAVI to expand its health systems support. Some will argue that this was a necessary detour, to make sure that the Global Fund and GAVI would not consider health systems as ‘stepchildren’. Others will argue that it was an incredible waste of time, and that proposals for the health systems funding platform will not be significantly better than the ones for which Malawi and Rwanda obtained grants under Round 5 of the Global Fund (see point 3.2. above), only less ambitious, as richer countries now exert additional control - and moderation of expectations - through the JANS. But perhaps this was simply “global health governance as a complex adaptive system” at work. Perhaps the international community needed to first experience that supporting health systems, even more than supporting disease control efforts, requires the pooling of international co-financing streams.

3.5. The difference between an international regime and international organizations

The new and fragile synergies between the IHP+, the Global Fund and GAVI raise a fundamental question: would it not be wiser to merge these new instruments into a single one, perhaps incorporating other instruments too? Would it not be easier for all stakeholders if poorer countries would elaborate a single national comprehensive health plan, including its own contribution, and propose it to a single international organization for approval and funding? To understand why this may not be realistic, a bit of theory may help.

So-called ‘international regimes’ represent one way of promoting cooperation between sovereign states. An international regime is a combination of “implicit or explicit principles, norms, rules and decision-making procedures around which actors’ expectations converge in a given area of international relations.” International regimes can function independent of idealistic expectations on the part of

the actors involved: “the norms and the rules of regimes can exert an effect on behavior even if they do not embody common ideals but are used by self-interested states and corporations engaging in a process of mutual adjustment.” 181

International organizations represent a different way of promoting cooperation between sovereign states. International organizations have their own headquarters, bureaucracies, and some level of autonomy from their members - more autonomy than regimes have - to facilitate the fine-tuning of agreed rules and to provide incentives for adherence. 182 If we imagine that, once agreed upon, all governments will happily and merrily adhere to a global social contract in the form of a regime, an organization would not be needed. But if we fear that some governments may try to dodge their responsibilities, an organization may work better. Table 3 compares how a global health regime (like the IHP+) and global health organizations (like the Global Fund or GAVI) can react to problems and opportunities that may occur.

Table 3. Comparing a global health regime with global health organizations

<table>
<thead>
<tr>
<th>Challenges or opportunities</th>
<th>A global health regime (like the IHP+)</th>
<th>Global health organizations (like the Global Fund or GAVI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A richer country government does not live up to its commitments</td>
<td>There is not much a global health regime can do, except denounce the country government that is not honoring its commitment</td>
<td>There is not much a global health organization can do, but all known examples of effective burden sharing of international assistance over time are attached to organizations&lt;sup&gt;183&lt;/sup&gt;</td>
</tr>
<tr>
<td>A poorer country government refuses to include civil society in the elaboration of a national health plan</td>
<td>A global health regime can inform richer countries and advise them to consider the problem, and eventually to reduce contributions, but any response still requires concerted action among all richer countries involved</td>
<td>Global health organizations can consider proposals from this country’s government as non-eligible</td>
</tr>
<tr>
<td>A poorer country government does not honor its domestic contribution pledge, or cannot account for earlier grants received</td>
<td>A global health regime can inform richer countries and advise them to consider the problem, and eventually to reduce contributions, but any response still requires concerted action among all richer countries involved</td>
<td>Global health organization can freeze future grants to this country’s government</td>
</tr>
<tr>
<td>A poorer country government is not popular with richer countries for reasons unrelated to its national health plan</td>
<td>A global health regime can encourage richer countries to help this ‘donor orphan’, but cannot enforce such behavior</td>
<td>Global health organizations can ignore the unpopularity of a given country government, and rely on its own internal procedures to decide whether the country deserves support or not</td>
</tr>
<tr>
<td>All countries agree on a solidarity levy on international financial transactions, centralized in a Global Solidarity Fund&lt;sup&gt;184&lt;/sup&gt;</td>
<td>A global health regime cannot receive funding from a Global Solidarity Fund; it can at best indicate which countries should receive funding from a Global Solidarity Fund, if such a fund is willing and able to finance individual countries</td>
<td>Global health organizations can receive funding from a Global Solidarity Fund, and propose their own accountability procedures to satisfy the conditions of a Global Solidarity Fund</td>
</tr>
</tbody>
</table>

Global health organizations can do things a global health regime cannot do. Some things global health organizations can do and a global health regime cannot do will please poorer countries, displease richer countries, and vice versa. Therefore, it seems likely that poorer and richer countries together will prefer a combination of both, rather than aiming for a ‘master plan merger’.


3.6. The changing role of the WHO

If a combination of a global health regime and several global health organizations is unavoidable, how can we promote synergies between them? Is there a role for the WHO, given the fact that its constitution gave it a mandate “to act as the directing and coordinating authority on international health work”?185

In a report to the January 2011 Executive Board of the WHO, the WHO Director-General seemed rather reluctant about the WHO taking on a role in negotiating a global social contract for health: “The global governance role of WHO in the field of development is much less clear. In recent years, development has attracted growing political attention, increasing resources, and a proliferation of global health initiatives. Partly as a result, this area of work has attracted an increasingly crowded array of actors with little, if any, effective institutional architecture at the global level.”186

At the end of the Executive Board meeting, the Director-General proposed this: “A plan for strengthening WHO’s central role in global health governance, comprising a proposal to hold a regular multi-stakeholder forum (the first in May 2012, subject to the guidance of the World Health Assembly); a proposed process for addressing other aspects of global health governance, possibly also including an overall framework for engagement in global health.”187 This proposal in fact contained two separate but related proposals: a regular multi-stakeholder forum, and an overall framework for engagement in global health.

By the time of the World Health Assembly (WHA), in May 2011, the multi-stakeholder forum proposal became a World Health Forum proposal, providing that the first session would be held in Geneva in the last quarter of 2012, and its deliberations would be reported to the Executive Board of the WHO at its session in January 2013. Furthermore, the World Health Forum would be “established in the first instance for a time-limited period, after which its work will be evaluated”, and participants would “include Member States, civil society, private sector, academia and other international organizations”.188 In reply, the WHA requested the Director-General to “present a detailed concept paper for the November 2012 World Health Forum, setting out objectives, numbers of participants, format and costs to the Executive Board at its 130th session in January 2012.”189 The overall framework for engagement in global health has disappeared from the radar.

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It is not clear whether this reply should be understood as conditional approval or as preliminary disapproval. What is clear is that some NGOs mobilized efforts to criticize the idea of a World Health Forum, out of fear that it would turn the WHO in a public-private partnership, and that “these [private] donors might see their role in governance enhanced as a result of the reforms”, as they wrote in an open letter to the Executive Board of the WHO.190 While the NGOs’ fear of the legitimization of the voice of private companies - pharmaceutical companies in particular - seems warranted, the position they take raises the question whether it would not be preferable to listen to their position and arguments, and to be able to respond, rather than trying to deal with them through ‘backdoor diplomacy’. As the letter acknowledges, public health institutions like the WHO cannot avoid having relations with the private sector, and those relations will involve making arguments heard and defending positions. Then it could make sense to have the private sector arguments expressed and discussed at a table where civil society, academia, other international organizations, and member states of the WHO have a seat too.

But more importantly, this skepticism about a World Health Forum may well lead to the stillbirth of an initiative that could foster greater synergies between global health initiatives that have recently emerged, and others that will emerge in the near future. Did it really make sense to abort the Global Fund’s move towards health systems and services support in 2005, to create the IHP+ in 2007, to launch a Taskforce on Innovative International Financing for Health Systems in 2008, and to return to the Global Fund with a request to finance health systems in 2010? I cannot help thinking that valuable time has been lost in this process. Perhaps a World Health Forum, with WHO at the helm, could help to streamline these processes, and to foster synergies.

3.7. Conclusion: the birth of ‘hypercollective action’ and how to deal with it

Severino and Ray argue that the future of international assistance will be one of “hypercollective action”, marked by a “double trend of proliferation (i.e. the increase in the number of donors) and fragmentation (i.e. the scattering of donor activity)”\(^{191}\). They warn against attempts to coordinate ‘hypercollective action’: “Another popular misconception, particularly fashionable in development aid bureaucracies, is that the solution will come from the establishment of a vast aid coordination/harmonization machinery, composed of regular high-level meetings on donor coordination, permanent headquarter collaboration structures and their equivalents in the field, plus a series of donor ‘codes of conduct’.” What they propose as an alternative for coordination is to use “instruments available to steer the coalition of actors of global public policies” and they identified five: “rules, systems of incentives, discourses, networks and norms or standards.”

Each of the four ideas mentioned above - transforming the Global Fund into a Global Fund for Health; endowing the IHP+ with real money; a combination of the Global Fund, GAVI and the IHP+; a World Health Forum with WHO at the helm - may be criticized by Severino and Ray as “a vast aid coordination/harmonization machinery”. To avoid misunderstandings, I do not believe that a Global Fund for Health replacing or usurping all international assistance for health will ever happen. I do not believe either that the IHP+ will ever be in a position to steer or coordinate all international assistance for health. But I do believe that a triumvirate including the IHP+, the Global Fund and GAVI, the latter two with a broader mandate, and with the WHO at the helm, could create sufficient momentum to force all others to follow. Further, if this triumvirate could negotiate and conclude a global social contract for health, all others would be forced to comply.

As mentioned above, under the general introduction, global health diplomacy, like policy advice, is an art, rather than a science,\(^{192}\) and therefore deeply subjective. But I cannot help thinking that governments of poorer countries and their allies have missed some important strategic opportunities:

- In 2005, the Global Fund geared up to become an important player in health systems strengthening, and thus to become a Global Fund for Health. AIDS activists may have opposed the idea then, as they did later, because the Global Fund does not have enough funding to realize its core mandate, let alone to co-finance health systems.\(^{193}\) In 2005 too, the Global Fund tried to secure a ‘burden sharing’ agreement between all richer countries, but failed.\(^{194}\) Here, support from proponents of primary health care would have been useful, but they saw - and most of them continue to see - the Global Fund as a disease-control effort. The combination of both attempts - the Global Fund’s expansion into health systems and services, backed up with mandatory contributions - could have satisfied both camps. But neither of them became reality.


\(^{192}\) Srinivasan T.N. (2000) See footnote 6 above


\(^{194}\) Global Fund to fight AIDS, Tuberculosis and Malaria (2005) See footnote 157 above
• In 2007 and later, when the IHP+ was created and demanded reliable commitments from poorer countries, governments of poorer countries and their allies could have demanded reliable commitments form richer countries too, but they did not.

• In 2011, the board of the Global Fund requested the secretariat to “[f]urther reinforce the tracking and enforcement of additionality, working with other bodies as appropriate”. It could have been an opportunity for poorer countries to demand that richer countries clarify their commitments at the same time, but this opportunity was not used.

• In 2011, the Director-General of the WHO proposed a World Health Forum that would include the Global Fund, GAVI and the IHP+, and that could encourage them to work together under an overall framework for engagement in global health, or a global social contract for health. However, poorer countries’ governments, who have a majority at the WHA, reacted lukewarmly.

The points above are not intended to be exhaustive; they are merely illustrative of the lack of consensus among poorer countries’ governments and their allies.

As mentioned above, global health diplomacy takes into account reality and its constraints, accepting some constraints while challenging others, and the constraints one wishes to challenge are those one believes are vulnerable to being challenged, which inevitably requires a subjective appreciation. When I propose a triumvirate including the IHP+, including the Global Fund and GAVI, both with a broader mandate, and with the WHO at the helm, to negotiate and implement a global social contract for health, there is one challenge I did not address and that is the crucial challenge of global health governance. I am accepting that the IHP+ is governed by the World Bank, where richer countries have the majority of votes, and by the WHO, where poorer countries have the majority of votes. I am accepting that the Global Fund and GAVI aim for a balance between richer and poorer countries, and their respective allies. I am aware of the fact that the result of this ‘shake’ puts richer and poorer countries on par, whereas a ‘one country, one vote’ principle would demand that poorer countries have a majority. But this is a constraint imposed by reality, and which I do not believe is vulnerable to being challenged. In a different field, the recently created Green Climate Fund, which “will initially use the World Bank as a trustee - as the [United States of America, the European Union] and Japan had demanded - while giving oversight to a new body balanced between developed and developing countries”, confirms my belief that a balance between richer and poorer countries is the best achievable option.

195 Global Fund to fight AIDS, Tuberculosis and Malaria (2011bis) See footnote 160 above
General conclusion

Fidler warned that “[u]ltimately, the fate of any new global social contract for health will be determined in the course of the permanent foreign policy dialogue between Rousseau and Kant”, and that “[t]his reality is sobering, given the tension between interests and ideals at the heart of the dialogue and the responsibilities still resting with governments.” According to Fidler, building on Hoffman, “Rousseau was a deeply pessimistic realist, who could see little more than competition, conflict and enmity in intercourse between countries”, and “[b]y contrast, Kant saw the potential for perpetual peace, achievable through revolutionary transformations of domestic and transnational politics.”

The first section of this working paper aims to analyze global health, as it has been so far, and confirms Rousseau’s pessimism. Global health, as it has been so far, is not about richer countries supporting poorer countries; it is about richer countries advancing their own interests abroad. However, it should be added that politicians in richer countries are easily swayed by the demands of their constituencies (i.e. voters), who may be more altruistically inclined.

The second section tries to explain what global health should be, from an international human rights perspective, and may reflect Kant’s idealism. Although global health as it should be, in accordance with international human rights law, remains far more unegalitarian than some may want, it is far more egalitarian than the present situation. I do believe that my understanding of global health as it should be is a necessary condition for ‘perpetual peace’, and thus I join Kant’s optimism.

I hope that the third section describes how the “permanent foreign policy dialogue between Rousseau and Kant” may further evolve. For some, I will have erred on the side of Kant, in the third section; for others I will have erred on the side of Rousseau. If so, I have succeeded in what I tried to do. Too many involved in debates on international or global health err on the side of Kant. I do not want them to err on the side of Rousseau, but they should acknowledge some of Rousseau’s pessimism. A healthy combination of Kant’s optimism and Rousseau’s pessimism leads me to believe that a global social contract for health is both desirable and essential, and that the right to health can serve as a basis for it.

When I propose a triumvirate including the IHP+, including the Global Fund and GAVI, both with a broader mandate, and with the WHO at the helm, to negotiate and implement a global social contract for health, I am not suggesting that civil society should stand by and watch. On the contrary, I think a civil society movement uniting NGOs based in richer and poorer countries can and should create a political atmosphere that allows politicians to agree to such a global social contract for health. Gostin and colleagues, including myself, are leading a “Joint Action and Learning Initiative: Towards a Global

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197 Fidler D.P. (2007) See footnote 104 above
Agreement on National and Global Responsibilities for Health’. This initiative tries to answer the questions mentioned above, under point 3.1.:

- How hard should poorer countries try; at which point can we say they tried hard enough?
- What exactly does the core content of the right to health include, and what does it require?
- When we know what the core content of the right to health includes and requires, do we know what richer countries should provide to poorer countries?
- How should richer countries provide whatever they ought to provide to poorer countries?

But we are not trying to answer these questions from the perspective of governments of richer and poorer countries. We are trying to answer these questions from the perspective of civil society organizations, because we believe that only a civil society coalition, uniting NGOs based in richer and poorer countries, can insist that governments enter into a global social contract for health.

Meanwhile, how should governments of poorer countries position themselves? In my opinion, they should first and foremost comply with the demands arising from the right to health: they should mobilize all reasonably available domestic resources to improve the health of their inhabitants, in an egalitarian and non-discriminatory manner. If they fail to do so, they are in a weak position to claim international assistance, based on the right to health. But if they succeed in doing so, they cease to be in the position of ‘beggars for charity’, and can instead claim the position of rights-owners entitled to international support, within a global economic order that favors richer countries and disadvantages poorer countries.

If that does not work, government of poorer countries should understand that governments of richer countries are mainly interested in supporting disease-control or ‘vertical’ efforts, because that allows richer countries to target their co-financing towards efforts that serve their own interests most. Rather than demanding support for primary health care or ‘horizontal’ efforts on the grounds of efficiency and equity, a diplomatic compromise would be to plan ‘diagonal’ efforts: aiming for disease control, while strengthening health systems in an opportunistic manner.

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