

# GLOBAL HEALTH GOVERNANCE

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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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# Global Health Governance and A Framework Convention on Global Health

Lance Gable, Ames Dhai, Robert Marten, Benjamin Mason Meier, and Jennifer Prah Ruger

Global health governance continues to be a complex and challenging undertaking. A remarkably complicated patchwork of institutions at the international, national, and local levels contribute to global health outcomes. The formal, global-level international organizations and agencies that have traditionally taken prominent roles in global health governance—such as the United Nations, the World Health Organization (WHO), UNAIDS, the World Trade Organization, and the World Bank—now vie for funding and influence with non-governmental funders and non-governmental organizations like the Bill and Melinda Gates Foundation and Doctors Without Borders.<sup>1</sup> National governments continue to have significant influence on health, but health must also compete with other national priorities. Numerous human rights treaties and national laws recognize some form of the right to health, yet operationalizing this right remains an elusive task.<sup>2</sup>

This special issue of *Global Health Governance* examines in detail a proposal that seeks to address many of these global health governance shortcomings: a Framework Convention on Global Health (FCGH). The FCGH is an international legal framework—grounded in the international human right to health—that would support health at the local, national, and global levels.

The concept of an FCGH has evolved substantially since it was first proposed by Lawrence O. Gostin in 2008.<sup>3</sup> Initially designed as a structural mechanism that would pull together the multiplicity of actors in global health to help achieve the basic survival needs of the world's least healthy people and address “intolerable” disparities in health outcomes, the FCGH proposal has—with transnational civil society input from the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)<sup>4</sup> and its successor, the FCGH Platform<sup>5</sup>—refocused on the primacy of the right to health in global health governance and the need for multilateral and multisectoral participation in determining the appropriate norms and goals for improving global health outcomes.<sup>6</sup>

Creating a framework convention that would establish a set of global health norms and an infrastructure to implement these norms is an attractive idea in a world where such large disparities in health outcomes persist. An FCGH seeks to marshal existing resources for health, coordinate between disparate actors in global health governance, set standards and goals for health outcomes, and solidify the centrality of the right to health in law and policy. However, this ambitious idea will be hard to accomplish given the complexities of international politics, resource constraints, and competing priorities. While there is widespread consensus that the existing infrastructure and capacity of global health governance is insufficient to solve global health problems, whether a framework convention is the right approach to improve governance is a matter of debate.

The contributors to this special issue address these topics and explore the implications of an FCGH. The special issue begins with several articles that discuss the proposed normative content of an FCGH, outlining important substantive considerations that must be addressed. Brigit Toebes proposes a series of normative considerations for the FCGH that track closely to the norms established by General Comment 14 on the International Covenant of Economic, Social, and Cultural Rights—which comprises the most extensive articulation of the right to health—and builds on these existing norms to more firmly situate global health inequalities within the international agenda.

The next two articles explore the challenges of financing global health and provide a series of proposals that seek to contextualize these financing challenges within developing norms of global health governance. Sharifah Sekalala describes the current state of financing in global health governance and proposes the recognition of extra-territorial financial obligations for national governments based on human rights norms. Her proposals include provisions for long-term funding mechanisms that are designed to be representative, participatory, and accountable. Jalil Safaei makes the case for viewing health as a common good, grounded in the normative imperatives of social responsibility, human rights, social justice, equity, and human flourishing.<sup>7</sup> Recognizing the potential obstacles to achieving health equity, he proposes a funding mechanism—a global welfare fund—that could be integrated into or aligned with an FCGH.

The proposal for an FCGH is situated within an energetic debate on whether a framework convention or other structures provide an appropriate model for addressing global health governance challenges.<sup>8</sup> Three articles in the special issue explore these issues directly. Anuj Kapilashrami, Suzanne Fustukian, and Barbara McPake provide a cautious assessment of the FCGH proposal, highlighting the likely structural constraints and political pressures that make achieving global health goals difficult and advocating for a bottom-up strategy that gives primacy to the contributions and influence of local people and communities in developing global health norms and programs. They support this idea with several case studies that demonstrate both the perils of neoliberal policies driven by international institutions detached from local realities and the potential value of allowing people-led movements to develop applicable health norms. Sebastian Taylor also provides a strong critique of neoliberal policies, focusing his discussion on how market forces deter investment in infrastructure that will effectively reduce non-communicable diseases. His solution is to apply the International Health Regulation's definition of "public health emergency of international concern" broadly enough to authorize international action to counter the impacts of non-communicable diseases. Debra DeLaet provides another critical assessment of the FCGH idea, finding the idea of establishing more international instruments in the form of a framework convention to be duplicative of existing international human rights treaties and likely to divert resources from other important global health efforts. In her view, the potential for redundancy and inefficiency outweighs the potential benefits of a framework convention.

Under a legal regime established by a framework convention, implementation and accountability will be significant challenges, just as they are

under existing models of global health governance. Where the institutional infrastructure for implementing a proposed FCGH is not yet clear, the next two articles in the special issue address the role of institutional actors in the design of an FCGH. Mara Pillinger proposes a broad application of the right to health that goes beyond traditional state obligations. The responsibility for protecting, respecting, and fulfilling the right to health, she argues, should apply to international organization as well as states and private actors. Florian Kastler outlines the case for why the WHO should be the lead agency in implementing an FCGH, provided that it undergoes necessary reforms to improve its capacity to lead effectively under a new framework convention.

The final two articles in the special issue provide detailed analyses and recommendations for areas that would be covered under an FCGH. Belinda Bennett considers the cross-cutting linkages between women's health, women's rights, and human rights. Based upon this human rights analysis, she provides an extensive catalog of issues an FCGH should incorporate to ensure women's health receives sufficient support in the framework convention and its subsequent implementation. Finally, Emilie Aguirre describes the connection between an FCGH, the right to health, and the right to adequate food. She offers suggestions for how the role of adequate food and adequate nutrition as a determinant of good health should be included in an FCGH.

Taken together, the articles in this special issue shed light on numerous important questions within global health governance. This robust debate over the FCGH proposal appears at a fortuitous time. With the recent release of the United Nations' Sustainable Development Goals as a backdrop,<sup>9</sup> the FCGH Platform group has begun drafting initial language for what could become an FCGH and has been forming a collaborative group of participants that include international experts, national governments, NGOs, and local health and human rights advocates. Many challenges lie ahead for this proposal, and its success is far from assured. Yet, the aspirations and objectives of an FCGH challenge us to continue to work together to seek more effective and just models of health governance that will allow all people to live in better health.

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- <sup>9</sup>United Nations, Sustainable Development Goals (2015). Available online at: <https://sustainabledevelopment.un.org/sdgs>

# **The Framework Convention on Global Health: Considerations in Light of International Law**

Brigit Toebes

*The proposed Framework Convention on Global Health (FCGH) is an important initiative that has the potential to place global health inequities more firmly on the international agenda. Ideally, it will become an instrument implemented by law and policy makers at the domestic level while it is used as an accountability mechanism when violations occur. However, for this instrument to be adopted and implemented successfully, many obstacles will need to be removed. This paper discusses a number of preliminary legal questions that arise with regard to the nature and scope of the treaty, from the perspective of international law. Subsequently, it makes a number of concrete proposals for the legal content of the suggested treaty, which are, to some extent, derived from General Comment 14 on the Right to the Highest Attainable Standard of Health.*

## **INTRODUCTION**

The World Health Organization (WHO) reports shocking statistics on persisting and avoidable global health problems. For example, while 6.6 million children under the age of 5 still die each year, every day 800 women die due to the complications of childbirth.<sup>1</sup> Further, in addition to infectious diseases, non-communicable diseases are on the rise, especially in the developing world.<sup>2</sup> These and other health problems affect the dignity and well-being of individuals worldwide and they have a profound impact on their ability to participate effectively in society. What is more, these health issues disproportionately target the most vulnerable in our global society, leading to serious health inequalities both within and between countries.<sup>3</sup>

Given the gravity of these global health concerns, the protection and promotion of global health should be one of the key concerns of international society. However, health is not always given equal weight or priority to issues such as the fostering of international trade or the prevention of terrorism. It is, therefore, understandable and laudable that there is a call from scholars and civil society to adopt an instrument that regulates the responsibility of governments and other actors in the field of health. The proposed Framework Convention for Global Health (FCGH) is an important initiative that has the potential to place global health justice more firmly on the international agenda. Ideally, it will also become an instrument that is implemented by governments and by non-state actors, while individuals and groups use the instrument as an accountability mechanism when health injustices occur.

Although the idea of such a convention is both attractive and promising, the project raises thorny and challenging questions from the perspectives of law, governance, politics and public health. In order to contribute to a better understanding of these difficulties—and how they can be overcome—this

contribution addresses some of these questions. Given the legal background of this author, the focus will mainly be on the legal nature of the envisaged treaty, its implementation by responsible actors, and on the issue of accountability. Some inspiration is drawn from the field of international environmental law, where there is considerable experience with the adoption of so-called framework conventions.

After addressing these preliminary questions, an attempt is made to speculate on the legal content of the FCGH. In this regard, the preparatory work that has been carried out by the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) is very helpful.<sup>4</sup> This network proposes that the FCGH be grounded in the right to health, an approach that, according to this author, has considerable merit. As a legal norm, the right to health can feature as the core unifying standard in the proposed instrument, and it can affirm that all global health issues should ultimately be brought back to questions of health justice, health equality, or fairness in health. Below, it will be argued that the right to health should be a core principle underpinning this Convention. To make some concrete suggestions, inspiration is drawn, *inter alia*, from General Comment 14 on the Right to the Highest Attainable Standard of Health, an explanatory document on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the most elaborate and authoritative explanation of the right to health that is currently available.

This being said, the question arises whether there are important broader issues of global or public health, outside the realm of the right to health, which should be addressed as well; mirroring this question is the difficulty of whether the right to health, as an individual right, can and should also embrace public health concerns. Both of these questions will be further addressed below.

### **THE NECESSITY OF THE FCGH: AVOIDING DUPLICATION**

Some of the public health considerations for adopting the treaty were mentioned above. From a legal perspective, the question arises of whether the treaty is a necessary new instrument, or whether it would, rather, duplicate already existing international law.<sup>5</sup>

There is currently no international treaty focusing entirely on the protection and promotion of global health justice. What comes closest to such a treaty is the definition of the 'right to health' in international human rights law and under constitutional law. Many States have committed themselves to the right to health through the ratification of international human rights treaties, and the right to health is also embedded in a range of domestic constitutions.<sup>6</sup> While this commitment is, in itself, hugely important, it remains rather general and open-ended for a state to commit to a 'right to health' and to a limited number of state undertakings. In 2000, General Comment 14 was adopted, which gives an elaborate explanation of the meaning and scope of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This document, which carries considerable authority and legal weight, has made an extremely important contribution to the understanding of the meaning and implications of the right to health. It has a considerable amount of specificity and it provides a



number of helpful tools and instruments that clarify the scope and nature of the right to health. Nonetheless, despite its authority, it remains a soft-law instrument, which is, strictly speaking, not legally binding. A framework convention could turn General Comment 14 into binding law. It could build on, and further specify, the tools mentioned in General Comment 14, including the further specification of legal state obligations, and add a few important new dimensions.

While duplication in terms of the substance of the framework convention is, therefore, not inherently an issue, there is a risk that existing commitments to human rights law could be diluted in the new instrument. While ideally this should, of course, be avoided, the FCGH will be the result of a fragile compromise between many different states. States may not be willing to agree on a concrete list of State undertakings, such as those stated in Article 12 ICESCR and further elaborated on in General Comment 14. To avoid existing commitments being watered down, the FCGH could contain a so-called ‘conflict clause’, which regulates its relationship to existing treaties. States could agree on a text in the FCGH declaring something along the lines that the treaty ‘shall not affect the rights and obligations under any existing (...) international agreements’.<sup>7</sup>

One further concern in terms of duplication is the potential overlap between monitoring mechanisms, especially if a reporting procedure is adopted under the FCGH. As States have already considerable reporting obligations under the human rights treaties, some streamlining would be required.

### **THE FORMAT OF THE FCGH: FRAMEWORK CONVENTION**

Drafting and adopting a multilateral treaty is a complex, cumbersome and time-consuming process comprising many stages, including the preparation of the initial draft, negotiations of terms and text, and consultations with governments and with the public. Subsequently, apart from the risk that States will be reluctant to ratify the instrument or accede to it, there is the risk that the treaty remains general and inoperable, especially now that it is addressing a broad theme such as global health. It would, therefore, be important to learn from past positive and negative experiences when it comes to the legal scope and nature of the instrument, and to identify a few criteria for a successful convention.

The format chosen for this instrument is a so-called ‘framework convention’. Framework conventions are relatively recent phenomena appearing mostly in the field of international environmental law, e.g. the Framework Convention on Climate Change, the Vienna Convention for the Protection of the Ozone Layer and the Convention on Biological Diversity.<sup>8</sup> Examples of framework conventions outside the environmental field are the European Framework Convention for the Protection of National Minorities<sup>9</sup> and the Framework Convention on Tobacco Control (FCTC).<sup>10</sup> As the latter Convention has been adopted within the framework of the WHO, it serves as an important example for the FCGH.

While framework conventions have certain specific characteristics, they are considered as ‘normal’ treaties under international law.<sup>11</sup> As the Vienna Convention on the Law of Treaties (VCLT) was adopted in 1969, before the

appearance of the framework convention as an instrument, it does not mention this instrument specifically. It is, however, generally accepted that the rules on the law of treaties as stipulated in the VCLR apply fully to framework conventions.<sup>12</sup> This implies that rules concerning reservations to the treaty, its interpretation, amendment, termination, and suspension, would have to be considered with the adoption and implementation of the FCGH.

Despite framework conventions being treated as “normal treaties,” they do have certain specific characteristics. Generally speaking, while the specifics of the regime are left to the more detailed rules in subsequent agreements or protocols, the framework convention typically identifies the objectives of the regime, the broad commitments for its parties and a system of governance.<sup>13</sup> According to Bodanski, the framework regime accordingly serves two functions: it allows states to work in an incremental manner and it can produce positive feedback loops which ease the (gradual) adoption of specific commitments.<sup>14</sup> States can begin to address a problem despite there being consensus over the existence of the problem and the possible solutions. As Bodanski explains, with the adoption of the Vienna Ozone Convention, certain states were not convinced of the need for action, but still acquiesced in its adoption.<sup>15</sup> Once States have acquiesced to the process, and the framework convention has been adopted, the “international lawmaking process takes on a momentum of its own.”<sup>16</sup>

Given that the envisaged FCGH addresses broad and still unspecified principles such as health justice, health inequalities and the right to health, a framework convention could be a suitable approach to launch and to solidify these principles internationally. It would allow the drafters to create a regulatory regime with a two-step procedure: a framework convention setting out the broad standards underpinning the right to health, and more specific protocols regulating a number of health-specific issues. An alternative would be to leave the specifics to domestic legislation, as is done in the European Framework Convention for the Protection of National Minorities, which serves as a legally binding guidance for national regulation adjusted to the specific needs of the parties.<sup>17</sup>

In this regard, it is encouraging that the Framework Convention on Tobacco Control and the aforementioned framework conventions in the field of environmental law and climate change have yielded mildly positive results. However, the topic of “global health” is much broader and much more open-ended than tobacco control and, therefore, much more difficult to make operable and to implement as a tool. When it comes to climate change and other environmental concerns, these have much stronger international and inter-state dimensions and effects than global health inequalities, which largely occur at the domestic level and do not really affect the health and wellbeing of populations in other countries. Addressing “global health” in a treaty, even in a general and open-ended framework instrument, therefore remains a difficult undertaking, the risks of which must be considered very carefully.

Subsequently, the question arises of what the subsequent protocols could potentially regulate. There could be a protocol regulating the state’s duty to combat domestic health inequalities, setting specific targets for countries with varying levels of development; a protocol stipulating the state’s transnational

obligations in the field of health; and a protocol engaging states' parties to regulate the private industry in the field of health, on the basis of the "obligation to protect." More specific health-related themes that the protocols could address include maternal mortality, non-communicable diseases, alcohol abuse, nutrition, and obesity.

### **THE SCOPE OF THE TREATY: TITLE AND HEALTH TOPICS TO BE COVERED**

The term "global health" in the title of this Convention is quite general and potentially embraces many topics that are already regulated, including the existing FCTC and the International Health Regulations. The term "global health" also overlaps with health topics covered by other branches of international law, including the detrimental health effects of climate change and environmental degradation, (as regulated under international environmental law), and occupational health (which is regulated under the conventions of the International Labor Organization). As the core issue addressed by the envisaged instrument are health inequalities, a more specific title to the treaty could be the "Framework Convention on Global Health Inequalities." Alternatively, to bring the focus more on justice, equity or fairness in health, the title "Framework Convention on Global Health Justice" could be adopted.

As to the substantive scope of the right to health, the question arises regarding which health-related concerns the instrument should cover. General Comment 14 takes a broad approach to the definition of health as a right, by stating that the right to health is:

“(...) an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. (...)”<sup>18</sup>

With this statement, General Comment 14 recognizes that, for the realization of health, not only is healthcare required, but also a set of so-called “underlying determinants to health.” The “underlying determinants” as defined in General Comment 14 have a considerable overlap and congruity with the so-called “social determinants of health” as recognized in the field of public health.<sup>19</sup>

With the adoption of this approach, the FCGH would acknowledge that a broad range of social determinants are crucial for the improvement of the health of individuals. While this is a very important recognition indeed, it will be very difficult to make this notion concrete and tangible and to translate this notion into concrete legal obligations. It would mean obliging governments and other responsible actors to improve housing and living environments more generally, as well as education, working conditions and, more generally, the socio-economic inequalities in society. This potentially overlaps with other commitments under human rights law, including the rights to housing, education, and the right to a healthy living environment. To solve this matter, the FCGH could stipulate a

limited range of underlying conditions in the substantive provisions of the FCGH (e.g. health information, and sexual and reproductive health), and express concern about the social determinants more generally in its preamble.

### **THE LEGAL CONTENT OF THE FCGH: ADOPTION OF THE RIGHT TO HEALTH FRAMEWORK**

In the preamble to the framework convention, certain guiding principles could be mentioned, including the principle of domestic and global solidarity in health, and possibly the idea of protecting the health of future generations. Furthermore, the preamble could refer to the “AAAQ,” the understanding that health-related services have to be provided on the basis of the notions of availability, accessibility, acceptability, and quality.<sup>20</sup> In addition, it could stress the decisive influence of the social determinants on health, and the resulting health inequalities. It could point to the increasing role and influence of the market on the health of individuals, the increasing privatization of health systems, the ongoing and persistent problem of health sector corruption, and the vulnerable position of the poor, women, children, disabled persons, prisoners, migrants and other potentially marginalized and disadvantaged groups in society. As a preamble to a treaty is not legally binding, it could also be a space where states’ parties address an issue over which there is no agreement, such as the international (or extraterritorial) obligations of developed states towards developing states, or the importance (or level) of regulating the private industry.

To single out one specific area of concern, this author would consider it particularly important for the FCGH to demonstrate cognizance of the issue of health sector corruption, a serious issue hampering the realization of the right to health, yet often ignored. Health systems across the globe are vulnerable to abuse because they are complex in character and because they face many uncertainties.<sup>21</sup> There are countless examples of actions that reveal a lack of transparency and integrity, and that may ultimately be defined as health sector corruption. Such abuses take place in all the branches of the health sector, varying from health ministries, to hospitals and pharmaceutical companies. While General Comment 14 does not touch on the issue of health sector corruption, the links between human rights and (health sector) corruption have been increasingly addressed.<sup>22</sup> This author would encourage the drafters of the FCGH to find the language to address this serious matter. The FCGH could indicate that acts of corruption, as identified under international law, occurring in the health sector could potentially lead to a violation of the right to health. Milder forms of corruption, often identified as “petty corruption,” could also be identified as a lack of integrity of the persons involved. More generally, the FCGH could stress the importance of maintaining a certain level of moral integrity for everyone involved with a sensitive issue like the protection of the health of individuals.<sup>23</sup>

If we take the right to health as a starting point for the substantive rights in the Convention, it would be important to take a close look at General Comment 14, which contains a number of important formulations and tools, including the notion of “progressive realisation,” the definition of minimum core obligations,

the so-called definition of legal obligations to respect, protect and fulfill the right to health.<sup>24</sup> These tools have the potential to form important guideposts or building blocks for the further definition of the FCGH. Without being exhaustive, a number of these elements are presented here, and an attempt is made to explain how they could be implemented in the envisaged FCGH.

To organize this discussion, this author makes a distinction between four different types of undertakings flowing from the right to health and that could be embedded in the FCGH: 1) the state's duty to realize the right to health of its residents; 2) the state's duty to realize the right to health extraterritorially; 3) the state's duty to regulate non-state actors in the health sector; and 4) the (potential) correlative duties of non-state actors in the field of health.

### *The state's domestic duties under the FCGH*

The FCGH should take as a starting point that the state carries the primary responsibility for the realization of the right to health on its territory.<sup>25</sup> This means that the FCGH should identify the legal obligations imposed on States' parties for the realization of the right to health for everyone residing on their territory. The primary challenge for the FCGH, therefore, seems the definition of a set of concrete and implementable undertakings for States' parties, in light of the right to health.

A point of departure for the definition of the States' obligations is the notion of "progressive realization" in Article 2(1) ICESCR. The term "progressive realization" potentially leaves States with a wide margin of appreciation.<sup>26</sup> However, if we take the language from Article 2(1) ICESCR, General Comment 3, and General Comment 14 together, there are some clear limitations to the State's opportunity to realize the rights progressively. States should do so by<sup>27</sup>:

- using the maximum of their available resources;<sup>28</sup>
- moving as expeditiously and effectively as possible towards the full realization of the right to health;<sup>29</sup>
- taking deliberate, concrete and targeted steps towards the full realization of the right to health;<sup>30</sup> and
- guaranteeing the principle of non-discrimination immediately.<sup>31</sup>

In connection with this, the possibility for States to take "retrogressive measures" should be addressed. Along the lines of General Comment 14, the FCGH could discourage the taking of retrogressive measures and it could stipulate that, where they are taken, the burden of proof is on the State to demonstrate that they have been introduced:

"(...) after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources."<sup>32</sup>

Furthermore, should the state use “resource constraints” as an explanation for retrogressive steps, they could be considered in light of:

- the country’s level of development;
- the severity of the alleged breach;
- the country’s economic situation;
- the existing of other serious claims on the state’s budget (e.g. natural disasters);
- whether the country had identified low-cost options; and
- whether the state had sought cooperation and assistance.<sup>33</sup>

To clarify the legal state obligations resulting from the FCGH further, the drafters of the FCGH could explore whether it is possible to identify a set of minimum health services that States have to guarantee at the very least, generally called “minimum core obligations.”<sup>34</sup> While the concept of minimum core obligations is controversial and has been rejected explicitly by several courts,<sup>35</sup> the idea that there is a minimum level of services below which no government should fall is worth exploring further for the envisaged FCGH.<sup>36</sup> The question arises of just how specific the FCGH should be in defining minimum core obligations, or whether it could refer to existing minimum levels of health services that have been adopted, for example, in a regional context. It would also be important to bring the notion of minimum core obligations in connection with the concept of progressive realization, so as to avoid that states stop taking steps towards the realization of the right to health once they have realized the core.

Furthermore, minimum core obligations could play a role in identifying the obligations imposed on States during armed conflicts and other emergencies.<sup>37</sup> This could also help with the identification of minimum health services that have to be delivered to uninsured persons and/or undocumented migrants.<sup>38</sup>

With reference to the definition of the minimum core obligations, the FCGH could stress the duty imposed on states to guarantee a right to basic health services for everyone residing on their territory. When it comes to armed conflicts more specifically, there is a duty to respect the undisturbed delivery of medical services, as also stressed by international humanitarian law.<sup>39</sup> According to the ICRC, it is a rule of customary international law that “[m]edical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. [...]”<sup>40</sup>

In connection with the identification of the minimum core obligations, the instrument could identify three types of legal state obligations: obligations to respect, protect and fulfill, obligations which potentially also go beyond the minimum core.<sup>41</sup> This identification helps to identify the type of commitment that a state is required to undertake. While obligations to respect are negative obligations, requiring States to refrain from undertaking action (e.g. refraining from harming the health of individuals), obligations to protect and fulfill are positive undertakings, requiring States to take a certain action. Obligations to respect may, therefore, be relatively easy to identify and to delineate and are,

potentially, easier to adjudicate before judicial bodies. As will be clarified further below, the obligation to protect can play a key role in making the obligation of states' parties to regulate the private industry in the health field more explicit.

There is still a great deal of confusion with respect to the interpretation and implications of the concepts elaborated on above, and with regard to how they are inter-connected. For example, are "minimum core obligations" of immediate effect, like the principle of non-discrimination and the obligation to take steps?; how do minimum core obligations relate to the limitation clauses under Article 2(1) and 4 ICESCR?; and how does the so-called "AAAQ" relate to the definition of state obligations? More research is needed in order to understand how these tools interconnect and how they can best be implemented in the FCGH.

### *Extraterritorial obligations under the right to health*

In addition to identifying the State's obligations to realize the right on its territory, the FCGH should identify a set of extraterritorial obligations for States that are in a position to assist other States. Article 2(1) ICESCR mentions the duty of such States to provide "international assistance and cooperation, especially economic and technical."<sup>42</sup> The precise nature of such extraterritorial obligations is not further spelled out, and constitutes a huge challenge on the part of the drafters of the FCGH.<sup>43</sup> Ooms and Hammonds propose an interesting model in which rich countries agree on how much they should contribute to assisting poor countries in their realization of the core content of the right to health.<sup>44</sup> They propose that the FCGH should detail the extent of this global responsibility, and that a Global Fund for Health should be established to pool and to redistribute contributions.<sup>45</sup>

When it comes to emergency situations more specifically, it is increasingly accepted that States have an obligation to provide aid when they are in a position to do so.<sup>46</sup> General Comment 14 stresses that States have both a joint and an individual responsibility "to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons." It stresses that "each State should contribute to this task to the maximum of its capacities" and that "(...) economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard."<sup>47</sup> This language clearly identifies the obligation of States' parties to provide disaster relief and humanitarian assistance during emergencies.

### *The state's "obligation to protect"*

Under the "obligation to protect" the right to health, the state party has duties to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties.<sup>48</sup> This includes the duty to "control the marketing of medical equipment and medicines by third parties" and to ensure that "medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct."<sup>49</sup> In other

words, States' parties to the FCGH should be placed under a legal duty to regulate all the actors in the health sector, including healthcare providers, health insurers, and the pharmaceutical industry. However, this duty could also be phrased in such a way that it goes beyond the health sector, to the extent that the State also has to regulate the food and beverage industry.

Intrinsically linked to the State's obligation to protect is the issue of healthcare privatization. When healthcare is privatized, there is a shift from the state fulfilling the right to health, to the State having the obligation to protect the now private actors in the health sector.<sup>50</sup> As healthcare privatization is an ongoing global trend affecting most countries in the world, it would be worth identifying it as a concern in the FCGH, in light of the State's obligation to protect. While human rights law is, in principle, neutral on the issue of privatization (States are free to choose the health system they prefer, whether public or private or mixed),<sup>51</sup> the FCGH could suggest that privatization, or healthcare commercialization more generally, potentially create a tension with the duty of States to guarantee the AAAQ.<sup>52</sup> Like in General Comment 14, reference could be made to the State's duty to protect by stressing that States should "(...) ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services."<sup>53</sup> States could be encouraged to adopt strong and effective monitoring mechanisms overseeing all the public and private actors in the health sector, ensuring that they respect the health and human rights standards.

#### *Non-state actors under the FCGH*

While the FCGH could frame the state obligation to protect individuals vis à vis non-state actors, it could also allude to the responsibilities of non-state actors. General Comment 14 states the following:

“While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society—individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector—have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.”<sup>54</sup>

While, in principle, non-state actors cannot be bound through an international treaty adopted by States' parties only, this type of wording could have an important moral and symbolic effect and it would, therefore, be worth embedding in the FCGH.

As the envisaged FCGH will inevitably deal with the role and functioning of health systems, it has specific relevance to medical personnel or health workers, as a special group of non-state actors who play a key role in this field.<sup>55</sup> Often they are the first to detect a violation of the right to health or of other



health-related rights.<sup>56</sup> To protect health workers, the FCGH could stress the neutral and independent position of health workers and it could oblige states and other parties to respect and to protect the medical neutrality of health workers. Simultaneously, the FCGH could identify the special role that health workers can play with respect to the promotion and protection of the (right to) health and it could identify a number of commitments or principles for health workers, including the duty to report human rights violations in the health sector once they occur. A third possibility would be that the FCGH directly addresses situations where health workers become complicit in human rights violations, e.g. in settings where detained persons are being submitted to torture or inhuman and degrading treatment.

### INDIVIDUAL RIGHTS VS. COLLECTIVE CONCERNS

Hoffman and Røttingen have expressed concern over the individual nature of human rights, in the sense that it could “unintentionally prioritise individual rights over population-wide wellbeing.”<sup>57</sup> Human rights are indeed, by their very nature, rights of the individual versus the State. Yet the question arises whether the right to health, as an individual human right, may also reflect collective claims to health *vis-à-vis* governments, either on behalf of a specific population group, or on behalf of the public at large. In other words, for the benefit of the FCGH it would be important that the right to health has the potential to require governments to protect larger interests in health, or to enhance the health of the public at large. Meier and Mori, in their paper of 2005, have argued in favor of a collective right to public health, “[r]ather than relying solely upon an individual right to medical care, envisioning a collective right to public health-employing the language of human rights at the societal level- would alleviate many of the injurious health inequities of globalization.”<sup>58</sup>

While this is a very valid claim indeed, from a conceptual human rights perspective it is problematic. Human rights are framed as individual rights and it will not be so easy to change the existing mechanisms and our understanding of them. This does not mean that our existing individual rights cannot lead to collective claims, however. Based on the individual human right to health, governments have to adjust their laws and policies, which should benefit society at large or certain targeted population groups. Subsequently, when it comes to judicial accountability, it seems possible to capture the interests of an affected group in the form of a “bundle” or “cluster” of individual rights. As asserted by Galenkamp, we could perceive the right as “materially conferred on individual members of a group, but procedurally looked after by the collectivity.”<sup>59</sup> This is clearly evidenced by the case law of the European Committee of Social Rights, the treaty-monitoring body of the European Social Charter, which provides for a collective complaints procedure.<sup>60</sup>

This being said, there is also a danger in interpreting the right to health as a right to collective governmental action in the field of health. There can be a tension between this presumed public health component of the right to health and the civil and political rights of individuals, including their rights to physical integrity and privacy. This means that caution should be exercised if the right to

health is used to justify certain types of governmental health measures.<sup>61</sup> The FCGH should make it clear, somehow, that while the state has an obligation to protect health on the basis of the right to health, it cannot take such measures to the extent that said measures violate the (individual) rights of others. General Comment 14 states this as follows in para 28:

“Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. (...) Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.”<sup>62</sup>

This paragraph, which is very similar to the wording in the limitation clauses under civil and political rights, and has a close connection to the limitation clause under Article 4 ICESCR, provides valuable inspiration for the envisaged FCGH.

All in all, while the right to health is by its very nature an individual right, the envisaged FCGH could perceive the right to health as a bundle of individual rights leading to collective claims to public health. To avoid an excessive exercising of this collective right to health, it would be very important to clearly specify and delineate the possible grounds for limiting other rights, including the rights to privacy and physical integrity.<sup>63</sup>

#### **INSTITUTIONS AND MECHANISMS FOR IMPLEMENTATION: ACCOUNTABILITY**

In terms of institutional structures provided for by the FCGH itself, Gostin suggests that the FCGH should provide for a collaboration between the existing WHO secretariat and a number of new mechanisms, modeled roughly after the Framework Convention on Climate Change:<sup>64</sup> a “Conference of Parties”<sup>65</sup> (which should implement the FCGH duties and draft the protocols), an “intergovernmental panel on global health” (concerned with scientific research on innovative solutions), and a “high-level intersectoral consortium on global health” (which should lobby for health in multiple sectors).<sup>66</sup> Concern has been expressed about the potential role of the Conference of Parties. Given that it deals with topics that go to the core of the WHO’s Constitution, some have suggested that the COP’s role may overlap with the World Health Assembly.<sup>67</sup>

As to the nature of the accountability mechanisms provided for by the FCGH, the options should be considered very carefully and some creativity and ingenuity are required. It is increasingly recognized that creating accountability for human rights violations is a multi-faceted process, which should not rely on (quasi-) judicial accountability mechanisms only, but also on a wide range of non-judicial tools, including political, professional, social, financial and administrative accountability mechanisms.<sup>68</sup> In this process it would be important for the FCGH to facilitate the participation of a wide range of different actors in the implementation process of the FCGH, including civil society groups, the media, national parliaments, and professional societies.

One possibility would be for the FCGH to provide for a reporting mechanism along the lines of the FCTC. Article 21 FCTC provides that States parties shall submit to the COP periodic reports on the implementation of the

Convention. However, the potential clashes with existing human rights mechanisms are a potential concern. Should the FCGH provide for a reporting procedure, then this would create duplication with existing State reporting commitments under the human rights treaties, which equally require States parties to report on the progress made with regard to the realization of the right to health. Similar overlap would exist when the FCGH would provide for an individual complaint mechanism, which also exists under the human rights mechanisms.<sup>69</sup> A collective complaint mechanism, along the lines of the mechanism provided under the (Revised) European Social Charter (ESC) could have potential, as this type of mechanism does not exist in relation to the human rights treaties adopted at the UN level. It could facilitate collective complaints to public health, thus reinforcing the above-mentioned collective dimension of the right to health.

A further important matter concerns the possible accountability of non-state actors, including multinational corporations, for violations of the right to health under the FCGH. It would be very difficult to hold such actors to account directly, as they are unlikely to become parties to the FCGH. Some potential lies in a clear definition in the FCGH of the “obligation to protect” of States parties, which would imply a duty to regulate private actors and to hold them to account when they violate domestic law reflecting human rights standards.<sup>70</sup> However, and this goes back to the general scope of the envisaged FCGH, the question arises *what* exactly it is that States parties should regulate, and *how*. Given the general scope of the FCGH it may not be possible to regulate specific issues. However, there could be some benefit in stipulating a general duty on the part of States parties to regulate all actors involved with the protection of health so as to ensure that they act in compliance with the right to health. This general legal obligation could be specified further in specific protocols to be adopted under the FCGH.

The above illustrates that there are considerable hurdles when it comes to providing for suitable accountability mechanisms under the envisaged FCGH. Yet while these hurdles and all the possible options need to be assessed very carefully, the model so presented potentially adds another layer to the enforcement of the right to health, which is very necessary.

### **THE FCGH: A TOOTHLESS BULLY OR A LIONESS IN WAITING?**

To understand the feasibility of the envisaged FCGH, it is important to evaluate and to analyze past experiences. The overall positive experiences gained through existing framework conventions in the field of environmental law and tobacco control seem to indicate that this is a suitable tool for addressing global health inequities. Framework conventions are very suitable for stating broad commitments to parties. However, there is still the danger that the document becomes a broad, all-encompassing and, therefore, a merely aspirational and inapplicable instrument. The overall scope of the treaty should, therefore, be considered very carefully. It might be a good idea to find a more specific focus, possibly with an emphasis on global and domestic health inequalities.

Secondly, the tools available for implementing the instrument should be considered very carefully. As was illustrated in this contribution, General Comment 14 on the Right to Health contains useful language, much of which is directly transplantable to the FCGH. In addition, the FCGH provides an opportunity for updating some elements of General Comment 14, which was adopted more than fifteen years ago. More efforts should go into making its language more concrete and enforceable, for example by specifying the precise commitments imposed on States and other actors. It would be important that a concept such as “minimum core” does not remain a hollow phrase but is complemented with very concrete and enforceable commitments. Specific concepts that should be developed further include the social determinants of health, health sector corruption, and health sector accountability, issues that are not covered by General Comment 14.

All in all, if called into action with the utmost prudence and care, the envisaged FCGH may ultimately become a powerful lioness.

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<sup>1</sup> WHO, “10 facts on the state of global health”, Available at: [http://www.who.int/features/factfiles/global\\_burden/en/](http://www.who.int/features/factfiles/global_burden/en/).

<sup>2</sup> WHO, “2008-2013 Action plan for the global strategy for the prevention and control of non-communicable diseases.” Accessed April 27, 2015. <http://www.who.int/nmh/publications/9789241597418/en/>. See also Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice,” *Yale Journal of Health Policy, Law, and Ethics*, XIII: 1 (2013): 1- 75, at 4.

<sup>3</sup> World Health Organization/Commission on the Social Determinants of Health (chaired by Sir Michael Marmot), “Closing the gap in a generation, Health equity through action on the social determinants of health, WHO 2008”. Available at: [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html).

<sup>4</sup> JALI Health, *Joint Action and Learning Initiative on National and Global Responsibilities for Health*. Accessed April 27, 2015. <http://www.jalihealth.org/>. See also *JALI/FCGH Research Questions*, January 2014 update. Accessed 27 April, 2015. <http://www.jalihealth.org/research/docs/JALI%20Research%20Questions.pdf>.

<sup>5</sup> Steven J. Hoffman and John-Anne Røttingen, “Dark sides of the proposed Framework Convention on Global Health’s many virtues: A systematic review and critical analysis,” *Health and Human Rights*, 15(2013) 1, June 2013, 117-134, at 134.

<sup>6</sup> For an overview of constitutional provisions on the right to health see S. Katrina Perehudoff, “Health, Essential Medicines, Human Rights & Essential Medicines”, July 31, 2008. Available at: [http://www.who.int/medicines/areas/human\\_rights/Perehudoff\\_report\\_constitutions\\_2008.pdf?ua=1](http://www.who.int/medicines/areas/human_rights/Perehudoff_report_constitutions_2008.pdf?ua=1).

<sup>7</sup> E.g. Article 47 para 2 of the Convention on the Stepping up of Cross-border Cooperation particularly in Combating Terrorism, Cross-border Crime and Illegal Migration, 7 July 2005. See

also Nele Matz-Lück, “Framework Conventions as a Regulatory Tool”, *Goettingen Journal of International Law* 1(2009) 3, 439-458, at 455.

<sup>8</sup> Framework Convention on Climate Change, 20 June 1992, 31 I.L.M. 849; Vienna Convention for the Protection of the Ozone Layer, 22 March 1985, 26 I.L.M. 1516; and Convention on Biological Diversity, 5 June 1992, 31 I.L.M. 818. See also Matz Lück, 2009, at 440.

<sup>9</sup> European Framework Convention for the Protection of National Minorities, 1 February 1995, 34 I.L.M. 351.

<sup>10</sup> Framework Convention on Tobacco Control, 21 May 2003, 42 I.L.M. 518.

<sup>11</sup> Matz-Lück, 2009, at 451.

<sup>12</sup> Matz-Lück, 2009, at 451.

<sup>13</sup> Matz-Lück, 2009, at 440.

<sup>14</sup> Daniel Bodanski, “The United Nations Framework Convention on Climate Change: A Commentary”, *Yale Journal of International Law*, 18(1993)451, at 494.

<sup>15</sup> Bodanski, 1993, at 493.

<sup>16</sup> Bodanski, 1993, at 495.

<sup>17</sup> Matz-Lück, 2009, at 449.

<sup>18</sup> General Comment 14, para 11.

<sup>19</sup> Paul Hunt, UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. A/60/348, 12 September 2005, para. 7. World Health Organization/Commission on the Social Determinants of Health (chaired by Sir Michael Marmot), *Closing the gap in a generation*, Health equity through action on the social determinants of health, WHO 2008. Accessed April 27, 2015.

[http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html).

<sup>20</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), August 11, 2000, UN Doc. E/C.12/2000/4. Accessed April 27, 2015, paragraph 12. Available at: <http://www.un.org/en/rights/>.

<sup>21</sup> Transparency International, *Global Corruption Report 2006, Special Focus – Corruption and Health*, London: Pluto Press, 2006. Accessed April 27, 2015. Available at:

<http://www.transparency.org> (in particular William Savedoff and Karen Hussmann, “Why are health systems so prone to corruption?”, at 4-13). See also Brigit Toebes, “Human Rights, Health Sector Abuse and Corruption”, *Human Rights & Human Welfare*, working paper No. 26, posted 1 April 2011. Accessed April 27, 2015, 2015. Available at: <http://www.du.edu/korbel/hrhw/workingpapers/2011/64-toebes-2011.pdf>.

<sup>22</sup> Martine Boersma and Hans Nelen (eds.), *Corruption & Human Rights: Interdisciplinary Perspectives*, (Antwerp: Intersentia, 2010).

<sup>23</sup> See also below, the remark on health sector corruption.

<sup>24</sup> General Comment 14, 2000.

<sup>25</sup> As also firmly stated by Lawrence O. Gostin, “A Framework Convention on Global Health: Health for All, Justice for All”, 307 *JAMA* (2012): 2087-2092, at 2088.

<sup>26</sup> See, generally, Ben Saul, David Kinley and Jacqueline Mowbray (eds.), *The International Covenant on Economic, Social and Cultural Rights*, Oxford: Oxford University Press, 2014, at 133-172.

<sup>27</sup> General Comment 14, 2000, para 31 (see also para 30). CESCR, General Comment No. 3, *The Nature of States Parties Obligations*, UN Doc. E/1991/23, 14 December 1990, paras 1 and 2.

<sup>28</sup> Article 2(1) ICESCR

<sup>29</sup> General Comment 3, 1990, para 9.

<sup>30</sup> General Comment 14, 2000, para 30.

<sup>31</sup> General Comment 14, 2000, para 30.

<sup>32</sup> General Comment 14, 2000, para 32.

<sup>33</sup> Committee on Economic, Social and Cultural Rights, *An evaluation of the obligation to take steps to the “maximum of available resources” under an optional protocol to the Covenant*, UN Doc, E/C.12/2007/1, 10 May 2007, paragraph 10.

<sup>34</sup> See also Lance Gable and Benjamin Mason Meier, “Global Health Rights: Employing Human Rights to Develop and Implement the Framework Convention on Global Health,” *Health and Human Rights*, Volume 15 (2013) 1, 17-31, at 22.

<sup>35</sup> *Inter alia*, Karin Lehmann, “In Defense of the Constitutional Court: Litigating Socio-Economic Rights and the Myth of the Minimum Core”, *American University International Law Review*, 22(2006)1, 163-197; Constitutional Court of South Africa, *Minister of Health v Treatment Action Campaign* (TAC) (2002) 5SA721 (CC).

<sup>36</sup> See, generally, also Amrei Müller, *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law*, Leiden – Boston: Martinus Nijhoff Publishers, 2013, at 74-102.

<sup>37</sup> Brigit Toebes, “Healthcare on the battlefield: in search of a legal and ethical framework”, *Journal of International Humanitarian Legal Studies* 4(2014): 195-217, at 214.

<sup>38</sup> Dan Biswas, Brigit Toebes, Anders Hjern, Henry Ascher and Marie Nørredam, “Access to healthcare for undocumented migrants from a human rights perspective”, *Health and Human Rights* (Harvard), 11 (2012) at 49-60.

<sup>39</sup> Toebes, 2014, at 213.

<sup>40</sup> See also Rules 28 and 29 on the protection of medical units and transports respectively. J-M. Henckaerts and L. Doswald-Beck, *Customary International Humanitarian Law* (Volume I) (2005), at 78-86 (Rule 25).

<sup>41</sup> General Comment 14, 2000, paras 34-37.

<sup>42</sup> Article 2 para 1 ICESCR.

<sup>43</sup> See also ETO Consortium, Maastricht Principles on the Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, Heidelberg, January 2013, in particular the ‘obligations to fulfil’ (principles 28-35). Available at: [http://www.etoconsortium.org/nc/en/library/maastricht-principles/?tx\\_drblob\\_pi1\[downloadUid\]=23](http://www.etoconsortium.org/nc/en/library/maastricht-principles/?tx_drblob_pi1[downloadUid]=23) and **Mark Gibney and Sigrun Skogly (eds.)** *Universal Human Rights and Extraterritorial Obligations*. Philadelphia: University of Pennsylvania Press, 2010, in particular chapter 5.

<sup>44</sup> Gorik Ooms and Rachel Hammonds, “Taking up Daniels’ challenge: the case for global health justice”, *Health and Human Rights*, 12(2010) 1, 29-46, at 41.

<sup>45</sup> *Ibid.*

<sup>46</sup> See MME Hesselman, “Establishing a Full ‘Cycle of Protection’ for Disaster Victims: Preparedness, Response and Recovery according to Regional and International Human Rights Supervisory Bodies”, *Tilburg Law Review*, 18(2) 2013, 106-132, at 125-126.

<sup>47</sup> General Comment 14, 2000, para 40.

<sup>48</sup> General Comment 14, 2000, para 35.

<sup>49</sup> General Comment 14, 2000, para 35.

<sup>50</sup> Felipe Gómez Isa, “Globalisation, Privatisation and Human Rights”, in Koen De Feyter and Felipe Gómez Isa (eds.), *Privatisation and Human Rights in the Age of Globalisation*, Antwerp/Oxford: Intersentia, 2005, 9-31, at 21.

<sup>51</sup> Implicit in para 12 General Comment 14 (under ‘economic accessibility’). See also Gómez Isa, 2005, at 16.

<sup>52</sup> Brigit Toebes, “Taking a human rights approach to health care commercialisation”, in Patricia Cholewka and Mitra M. Motlagh (eds.), *Health Capital and Sustainable Socioeconomic Development*, Boca Raton/London/New York: Taylor and Francis, 2008, at 441-458

<sup>53</sup> General Comment 14, 2000, para 35. See also the judgment of the Inter-American Court of Human Rights, *Case of Ximenes-Lopes v. Brazil*, Judgment of 4 July, 2006, IACtHR, Series C No. 149, para 85. See also Antenor Hallo de Wolf, *Reconciling Privatization with Human Rights*, Antwerp: Intersentia, 2011.

<sup>54</sup> General Comment 14, 2000, para 42.

<sup>55</sup> If a doctor or nurse is employed by a state-run hospital, it could be argued that he or she is not a non-state actor but a state official, thus bearing direct responsibilities for human rights.

<sup>56</sup> For example, when detecting the inhuman and degrading treatment of persons in a mental institution or of prisoners, when confronted with a scarcity of resources in a healthcare institution, or when forced to turn away uninsured persons or undocumented migrants.

<sup>57</sup> Hoffman and Røttingen, 2013, at 122.

<sup>58</sup> Meier and Mori, 2005, at 102.

<sup>59</sup> Marlies Galenkamp, "Collective Rights", in *SIM Special No. 16*, Netherlands Institute of Human Rights, Utrecht, 1995, 53-102, at 70-71.

<sup>60</sup> European Committee of Social Rights, the treaty-monitoring body of the (Revised) European Social Charter (ESC). Its collective complaint mechanism has enabled several international NGOs to defend the health-related interests of population groups. See for example, ECSR, *ECCR v. Bulgaria* (complaint no. 46/2007), paragraph 49. For an overview of all the decisions see the website of the European Committee of Social Rights, see [www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints\\_en.asp](http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp).

<sup>61</sup> For more on this issue see also Brigit Toebes, "Human rights and public health: towards a balanced relationship", forthcoming in the *international Journal of Human Rights* and currently available at: [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2448860](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2448860).

<sup>62</sup> General Comment 14, 2000, para 28.

<sup>63</sup> See also Toebes, 2015.

<sup>64</sup> Articles 8 and 2(1) (Secretariat), 7 (Conference of Parties), 9 (Subsidiary Body for Scientific and Technological Advice), 10 (Subsidiary Body for Implementation), and 11 and 21(3) (Financial Mechanism) of the Framework Convention on Climate Change. See also Bodanski, 1993, at 532-543.

<sup>65</sup> Article 23 Framework Convention on Tobacco Control. On the 'COPs' in the Framework Convention on Climate Change see Bodanski, 1993, at 533/534.

<sup>66</sup> Gostin, 2012, at 2088.

<sup>67</sup> Hoffman and Røttingen, 2013, at 134; referring to J. Edge and C. Liu, "Chapter 10: Framework Convention on Global Health", in S.J. Hoffman (ed), *Student voices 2: Assessing proposals for global health governance reform* (Hamilton, Canada: McMaster Health Forum, 2001).

<sup>68</sup> Mark Bovens "Two Concepts of Accountability: Accountability as a Virtue and as a Mechanism". *West European Politics*, 33(5), 2010, 946-967, Helen Potts, *Participation and the Right to the Highest Attainable Standard of Health*, University of Essex Human Rights Centre/Open Society Institute. Accessed April 27, 2015. <http://repository.essex.ac.uk/9714/1/participation-right-highest-attainable-standard-health.pdf>. See also University of Groningen Seminar Series on Human Rights in Essential public Services Provision. Available at: <http://www.rug.nl/rechten/congressen/archief/2014/human-rights-seminar-series/>.

<sup>69</sup> In particular, the complaint mechanisms adopted with regard to the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

<sup>70</sup> *Inter alia*, Articles 9-11, 13 (regulation) and 15 (liability) FCTC.

# **Normative Considerations Underlying Global Health Financing: Lessons for the Framework Convention on Global Health**

Sharifah Rahma Sekalala

*The proposed Framework Convention on Global Health envisages the imposition of a binding obligation on developed countries to assist developing countries in their quest to achieve the right to health for all their citizens. Looking at the current state of global health governance, this paper examines the normative human rights considerations that ought to be imbued within any such proposed extra-territorial obligation. It argues that the extra-territorial obligation instituted by the proposed treaty should be underpinned by three fundamental human rights considerations: i) an explicit recognition of the right to health, ii) a focus on long-term funding, as opposed to short-term strategic interventions, and iii) more representative and participatory funding mechanisms at the national and global level in order to ensure accountability. The article also highlights possible normative problems presented by an extra-territorial obligation to finance health projects.*

## **THE PROPOSED FRAMEWORK CONVENTION ON GLOBAL HEALTH (FCGH)**

The past two decades have seen an increase in momentum in trying to address global health challenges. Instances of health inequity—like the denial of access to essential medicines for HIV/AIDS due to cost in the developing world—highlight these problems. Health related issues have also been pushed onto international agendas in the Security Council where HIV/AIDS, avian flu and the Ebola pandemic have been discussed as global security threats. The international community and philanthropists have also come together to increase research on neglected diseases that primarily affect the developing world. Their efforts have led to the development of new funding initiatives to solve global health problems, i.e., UNITAID. Furthermore, international efforts to address global health challenges have led to the development of institutions that focus on specific health related issues such as the Global Fund on Vaccines and Immunizations (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), PEPFAR, Roll back Malaria, Roll back Tuberculosis etc.<sup>1</sup>

Despite the increased focus, these initiatives underline the fact that there is a need for fundamental changes in global health governance. One of the major solutions to this problem that has gained traction is the proposal for a new treaty on health, called the Framework Convention on Global Health (FCGH). The proposed FCGH presents an opportunity to move towards legally binding international global health standards, which would address the post-2015 global Sustainable Development Goals agenda.<sup>2</sup> Grounded in a human right to health framework, the proposed Convention aims to introduce new global health financing standards by creating a redistributive mechanism that legally requires developed countries to help finance health initiatives in developing countries.<sup>3</sup>

The FCGH proposal constitutes a bottom-up approach to global health governance in the form of a treaty exhibiting four principal objectives: i) developing a core package of essential health services and goods; ii) improving States' responsibilities to govern well and to responsibly allocate health resources; iii)



increasing wealthy countries' responsibilities towards the world's poor and finally, iv) designing a global architecture that improves health and reduces disparities between rich and poor countries.<sup>4</sup>

A legally-binding obligation to provide extra-territorial financing is essential for the FCGH in order to make the right to health affordable for developing countries. Strong financing mechanisms would ensure sustainability of health programmes and enable developing countries to realize the right to health. Adequate financing of the right to health would also remove existing pressure on norm-setting bodies, like the World Health Organization, that are constantly losing their authority to newer financial actors that set the global health agenda, like the Gates Foundation.<sup>5</sup> This obligation to 'assist' is not new. Normative documents like General Comment No 14 to the International Covenant on Economic, Social and Cultural Rights (ICESCR) have long argued for its existence. However, in practice, the implementation of a binding obligation on health financing that is subject to human rights standards has always been contentious.

Global health commentators have welcomed the FCGH approach, citing a lack of clarity regarding domestic and international health financing responsibilities under existing international human rights laws.<sup>6</sup> The FCGH, it is argued, "could re-engage collaboration for health-related rights across the global community, creating a framework to develop and implement human rights as a basis for global health governance."<sup>7</sup> The development of this framework represents a bold and innovative move within the international human rights treaty regime. The question this paper poses is what human rights obligations ought to underpin the obligation of international financing under the proposed treaty.

It is important to consider what norms would underline a proposed duty to assist, as "normative components...confer substance to human rights, influencing the content and context of rights [by] determining to whom rights apply and under what circumstances."<sup>8</sup> Norms are especially important in the development and articulation of rights regimes. From a normative point of view, there are several measures already in place that make it easy to argue for such a right. However, there are also some dangerous implications of creating a duty exclusively for the right to health, including promoting a hierarchy that prioritizes health rights at the expense of other socio-economic rights.

This paper draws on lessons from current global health governance in order to highlight how normative documents could help the FCGH set out practical standards for global health in three major areas; i) the explicit recognition of a right to health, ii) the necessity of long-term funding as opposed to short term interventionist funding and iii) ensuring that international financing includes broad participation of civil society and individuals who are affected in financing decisions as part of their legally-binding obligations to the FCGH. The paper then proceeds to identify the major normative problems of the proposed FCGH. Whilst there is some existing literature critiquing the proposed treaty,<sup>9</sup> there are two particular problems with these analyses—both of which present normative considerations for the human rights regime—that have been largely neglected thus far. The first argument is that, in order to be successful, the FCGH must ensure that it does not create a blanket recognition of the duty to assist. This concern derives from the 'unstructured plurality'<sup>10</sup> of global health financing, which is deluged by a myriad of private actors and bodies. The risk is that the imposition of an unpopular and comprehensive obligation to assist would entail a conflation of duties between public bodies and private actors. The extra-territorial obligation could become very weak in practice or totally ineffective under public international law. Secondly, and perhaps more importantly, there is a real

danger that the financing mechanism proposed by the FCGH ignores one of the fundamental normative values of the right to health: its interdependence on other socio-economic rights. In funding the right to health over other, equally essential rights, there is a risk that we weaken the system of socio-economic rights as a whole.

### **COMPLEXITIES SURROUNDING THE CURRENT INTERNATIONAL HEALTH FINANCING REGIME**

The 2013 Report from the Institute for Health Metrics and Evaluation paints a complex picture on how global health is financed. Even amidst the financial crisis, financial assistance for global health managed to rise to US\$31.3 billion in 2013.<sup>11</sup> The major donors were countries—with the USA as the highest contributor—bilateral aid agencies, NGOs<sup>12</sup> and public and private organisations,<sup>13</sup> most notably the Global Alliance on Vaccines and Immunisations (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). The 2013 report, like other reports on global health financing, continues to emphasise the role of private actors in health funding, which, as we will see later, frames an extra-obligation for developed States.

Even with this increased funding, there are still huge discrepancies in health expenditure between developed and developing countries.<sup>14</sup> Some projections estimate that these global health inequalities account for nearly 20 million deaths annually.<sup>15</sup> The Committee on Economic, Social and Cultural Rights (CESCR)—a body of 18 independent experts that monitors State parties' implementation of the ICESCR—has previously warned that it is unrealistic to think many of the poorest developing countries can achieve the right to health without international assistance.<sup>16</sup>

A major problem with the FCGH proposal is that there are no guarantees about the sustainability of funding. The global economic down-turn in 2008-2009 led to serious deficits in many of the world's developed countries, negatively impacting overseas spending. In 2011, many poor countries felt the direct implications of developed countries' financial challenges when official development assistance fell for the first time since 1997.<sup>17</sup> The GF—which constitutes one of the largest funders for health programmes in the developing world—also suspended its funding round in the same year.<sup>18</sup>

The current system of funding has also faced criticism for inadequate co-ordination amongst different actors. As a result, there has been 'fragmentation' and 'duplication' of health outcomes, a lack of transparency from donors and developing countries, increasing bias towards certain diseases at the expense of neglected diseases and vital research and development,<sup>19</sup> and a perceived bias towards certain geo-political areas with a concomitant disregard for areas exhibiting the greatest need. Against this myriad of problems, the proposed Framework Convention on Global Health as part of the post-2015 global Sustainable Development Goals agenda is a welcome call.<sup>20</sup>

### **NORMATIVE RESPONSIBILITIES OF FUNDERS**

Even the most stringent advocates of the right to health acknowledge that the parameters of international assistance and cooperation in economic, social and cultural rights are far from settled.<sup>21</sup> However, there are four key documents that can furnish some clarification and encourage progress of international financing under the right to health.<sup>22</sup> The first is the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 2, which tentatively imposes an obligation for

inter-State cooperation, mandating that States take advantage of international cooperation in order to achieve the right to health:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The second is General Comment No. 14, which draws upon the preceding guidance issued by General Comment No. 3, and attempts to clarify the obligations of States to cooperate and assist. General Comment No. 14 provides normative guidance on the obligations of States under the treaty to give financial assistance. States are urged to focus on assistance for essential health services when providing aid and to ensure that they prevent third parties from violating the right to health in other countries. They are also implored to ensure that the right is central to legal agreements and accounted for within their representation of international institutions.<sup>23</sup>

The Committee in General Comment No. 14 argues for a negative duty by which donor countries must ensure that they do not diminish the socio-economic circumstances of the developing countries that they assist.<sup>24</sup> Scholars like Tobin have suggested that a duty to provide financing for health should be tripartite, compelling donor States to refrain from doing harm, to protect against violations and to fulfil the right.<sup>25</sup>

The third document is the 2011 Maastricht Principles on Extra-territorial Obligations (Maastricht Principles), which drew from several human rights agreements and treaties “in order to clarify on the content of extraterritorial State obligations to realize economic, social and cultural rights with a view to advancing and giving full effect to the object of the charter of the United Nations and international human rights.”<sup>26</sup> The Maastricht Principles afford guidance in relation to the extra-territorial obligation under Principles 3, 4 and 9. In particular, Principle 9(b) States that, “extraterritorial obligations also arise on the basis of obligations of international cooperation set out in international law.” Thus, a proposed treaty would both capitalize on existing human rights obligations and create new binding regulations that would underlie such a duty.

The fourth document is the 2012 report of the Special Rapporteur on the right to health, which sought to elucidate the issue of health funders’ human rights obligations: ‘The Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Standard of Physical and Mental Health’ to the General Assembly (hereinafter known as the Special Rapporteur’s report).<sup>27</sup> The Special Rapporteur’s report presents an account of the duties imposed upon domestic and international funders to ensure that their financial assistance enables developing countries to achieve the right to health through global health initiatives.<sup>28</sup>

The Special Rapporteur’s report points to the effect of the current financial crisis in reducing the amount of international funding before envisioning how funding could satisfy the right to health.<sup>29</sup> The report argues that international funding should be redistributive in nature so that the most developed countries offer funding to those less able to meet their health funding needs. The most efficient way to achieve this, he argues, would be to create an international treaty that will ensure a binding obligation, which in effect institutes a compulsory duty to assist. In order to

ensure adequate resources without wasteful duplication of funding, the Special Rapporteur's report urges developing countries to pool funds internationally from compulsory contributions by developed States based on their ability to pay. This approach is in harmony with the proposed FCGH in its quest to create a redistributive mechanism for extra-territorial funding.

Next, this paper considers the normative aspirations this proposed treaty obligation should espouse in order to promote the highest standards of physical and mental health. There are three key areas on which this extra-territorial duty would need to rely:

### 1) *Explicit Recognition of a Right to Health*

The proposed FCGH must espouse an international assistance obligation that explicitly recognises a right to health. This would be of normative value as it would create a distinction between this kind of assistance and other general foreign aid/humanitarian assistance. The Special Rapporteur's report maintains that a right to health should be a fundamental component of health financing initiatives in order to avoid conditionalities, like Structural Adjustment Programmes, which foster detrimental right to health outcomes by making funding an economic matter.<sup>30</sup>

Jonathan Mann, the head of the first World Health Organisation's (WHO) specific agency for AIDS, strongly pushed for a human rights approach to dealing with global disease in virtue of what he and others felt was a symbiotic relationship between health and human rights; i.e. without good health many people would be incapable of fighting for their human rights and strong enforcement of human rights led to better realization of the right to health.<sup>31</sup> This understanding is essential to funding programmes as it subjects them to human rights scrutiny on issues like discrimination and equality, the core of a right to health ethos. This scrutiny is important because the competing interests in providing health outcomes can sometimes inadvertently cause harm to the most vulnerable people.

Previous institutional experience has shown that the explicit recognition of human rights is fundamental. Take the case of the GF which, in its conception document, is referred to as 'a financing instrument' founded to commit huge sums of money to support large-scale prevention, treatment and care of the three major diseases.<sup>32</sup> Although the conception document explicitly refers to the Millennium Development Goals (MDGs), it is clear that the founders saw the GF purely as a financial agency for health services rather than for human rights.<sup>33</sup> In 2010, the Executive Director of the GF acknowledged that there was a tension between the agency's institutional approach—which allowed country ownership of grants—and the need to ensure that human rights were not violated as part of the grant allocation process.<sup>34</sup>

In 2011, the GF changed its grant model in order to include an explicit commitment to human rights.<sup>35</sup> As a result, the GF now aims to i) integrate human rights considerations through the grant cycle, ii) increase investments in programs that address human rights-related barriers to access, and iii) ensure that the GF does not support programmes that infringe upon human rights.<sup>36</sup> Thus in order to be successful, applicant countries must demonstrate that their grant will enable them to achieve better right to health outcomes. A proposed FCGH can draw on these experiences to ensure that any proposed international financing component includes explicit obligations *vis-a-vis* the right to health. This can extend to ensuring that countries making decisions on health financing projects take their right to health responsibilities seriously as part of the legally-binding obligations of the FCGH.

This commitment to the right to health is in line with General Comment No. 14, which called for an environment conducive to enabling people to achieve the right to health. The Committee urged States to ensure that the right to health was protected in international agreements and within international organizations such as the IMF and the World Bank. Article 42, in particular, recognises that there are other non-State entities that also have responsibilities with regard to the right to health, such as the civil sector, NGOs and the business sector.<sup>37</sup> Principle 15 of the Maastricht Guidelines reiterates this in relation to States' representation within international organisations.

Principle 13 of the Maastricht Guidelines imposes a duty on States to ensure that they avoid risking human rights with their conduct: "A state attracts its international responsibility where the resulting impairment of human rights is a 'foreseeable' result of that State's conduct."<sup>38</sup> The Commentary on the Maastricht Guidelines points out that steps must be taken in order to obtain knowledge necessary to minimize human rights risks. Thus, for any proposed obligation on international financing, an explicit recognition of a right to health would entail that developed States offering international assistance would have to ensure that they have taken reasonable steps to think about broader right to health implications as part of their financing obligation under the proposed FCGH.

There are increasing attempts to use human rights impact assessments as a way of ensuring that human rights considerations are taken into account at the beginning of projects.<sup>39</sup> Ensuring that a funding obligation contains an explicit recognition of the right to health under the proposed FCGH, as discussed earlier in this paper, would emphasise the necessity of appending a right to health into human rights impact assessment procedures as part of the international health financing obligation. This would serve to ensure not only short-term health protection but also a more holistic long-term protection of the right to health as envisaged by General Comment No. 14.

## *2) Long-term Health as Opposed to Short-term Fragmented Programmes*

The FCGH should also ensure that funding for international assistance is long-term, as opposed to short-term strategic funding that customarily targets specific health outcomes. Gostin clearly conceives of a proposed FCGH fulfilling this requirement as he believes that the treaty would build country capacity for enduring and effective health systems through developing resources, infrastructure and new organisational structures.<sup>40</sup> He believes that it is essential for developed countries to subscribe to a long-term commitment to funding, in contradistinction to the prevailing top-down mode of funding, which distorts health systems and often makes it difficult for developing countries to plan health outcomes in the long run.<sup>41</sup>

Many AIDS funding programmes focus on short-term interventionist initiatives<sup>42</sup>. The problem is that a large portion of this funding is disjointed and often duplicated by other funding agencies, leading to multiple funding streams for the same outcomes and, therefore, a great deal of wasted resources.<sup>43</sup>

The issue of short term funding and duplication of resources is not only specific to the AIDS pandemic. Empirical evidence in global health governance demonstrates that funders within international health are concentrating on funding the same outcomes, resulting in fragmentation of the international health architecture and consequential duplication and wastage of resources. Furthermore, this system leads to a dearth of research in certain neglected areas of medicine, which projects a massive burden upon some of the poorest areas of the world.<sup>44</sup>

Ensuring that a proposed FCGH obligation is of a long-term nature would encompass the full meaning of the right to health under General Comment No. 14. This requirement embraces a broad conception of a right to health, incorporating social determinants such as water, housing, food and sanitation.<sup>45</sup> The Special Rapporteur's report makes the same point.

A case for long-term health-system strengthening could also be drawn from current health governance where many programmes starting off with a single focus are now broadening out into health-system strengthening as they are unable to fulfil their objectives with narrow remits.<sup>46</sup> For instance, many ARV programmes in African countries at the height of the AIDS response soon realised that, although they could successfully deliver the drugs to countries, there were insufficient supply mechanisms to reach patients, severely reducing the effectiveness of the programmes. The solution was to consider more long-term programmes such as health-system strengthening and personnel training in order to ameliorate the efficiency of these programmes.<sup>47</sup> For example, when Malawi received its first grant from the GF in 2004, the World Bank advised that, due to the weakness of the government procurement and supply chain, an alternative system by UNICEF should be used. However, the new system became unsustainable, causing the GF to commit strengthening the in-country system through a grant for health system strengthening.<sup>48</sup> The UN has also tried to aid the process of procurement through its Pledge Guarantee for Health that underwrites countries' letters of credit in order to speed up the procurement process.<sup>49</sup> Although all these mechanisms have been developed in response to AIDS, they serve a wider purpose of strengthening domestic health systems. This is in line with the Paris Declaration on Aid Effectiveness in 2005, in which international donors committed to aligning development assistance with country priorities so as to strengthen in-country health systems.

The GF and PEPFAR have also diverged from their original funding mandate of dealing primarily with HIV/AIDS to broader education and health-strengthening programmes. In April 2007, the board of the GF agreed to consider comprehensive country health for financing which would deal with wider health infrastructure. The new International Health Partnership Plus launched in September 2007 with the aim of helping low-income countries to develop such programmes. As a result, they are now concerned with long-term projects targeting health-system strengthening as opposed to short-term initiatives that deal solely with access to ARVs. These include expansion of service delivery and health facilities, training of health workers, focusing on associated diseases, and auxiliary needs such as nutrition and care.<sup>50</sup>

### *3) Broad Participation of Civil Society Stakeholders in International Financing Mechanisms*

The proposed FCGH should ensure that there is broad representation of all stakeholders at the national and international level in any obligation on international health financing. This is in line with several existing human rights obligations, such as Principle 7 of the Maastricht Guidelines, which creates an obligation for States to ensure that everyone has the ability to participate in decisions that affect their human rights. States are therefore urged to consult widely with various stakeholders—including parliaments and civil society—in order to design and implement policies and measures that are relevant to a broad cross-section of the population.<sup>51</sup>

General Comment No. 14 requires that various vulnerable groups, such as women, children, disabled people and indigenous people, must be consulted as a

condition of respecting, protecting, and fulfilling the right to health. The Special Rapporteur's report recognises that rights can only be exercised through mutual recognition. This mutuality presupposes the need to understand the requirements of the most vulnerable in society; i.e., paying attention to health as it is experienced by communities. Different stakeholders within these communities need to play a part in framing what the right to health means to them. This transformative approach ensures that groups that are normally excluded from the political structures of global political economy are given a voice in the decision-making process. In this regard, Tobin argues that:

The aim is to contribute a dialogue with the interpretive community whereby an understanding as to the practical implementation of the right to health will be developed through consultation and negotiation.<sup>52</sup>

The Special Rapporteur's report specifically calls for participation of civil society and affected populations within community health governance structures in order to ensure responsiveness and sustainability. Better participatory procedures recognise that, at their core, health programmes belong to the communities and not to donors. Therefore, communities ought to be at the centre of creating responses to their health needs. In many instances, many of the people in these communities have lacked the capacity to participate in their health governance. The GF encourages applicants to address this disconnect.

The involvement of civil society in the participatory process can serve three major functions. First, it can attempt to address the democratic deficit within structures of global health governance that were previously mainly State-oriented. This can be both at the domestic and local level where civil society can counter government power by giving a voice to more vulnerable members of society. Secondly, civil society could offer a comparative advantage over the government in delivering services, in view of its outreach and presence within the target communities. Thirdly, it offers a revalidation of the public interest amidst often-privatized health care systems by creating greater accountability.

Accountability by civil society can be exercised through naming and shaming of high costing ARVs, which historically led to the establishment of institutions dedicated to ARV financing. Civil society and affected communities can also participate by coming together to help people seek redress at the domestic level. This may be through judicial review processes if international funders violate fundamental elements of due process but, in some instances, redress may also be sought through compelling the government to take advantage of international funding, as happened with the Treatment Action Campaign (TAC) case.<sup>53</sup> Here, the civil society organisations challenged the government's policies relating to the prevention of mother-to-child transmissions. The government had refused to supply nevirapine (an ARV) to mothers who were HIV-positive. The drug had been provided free by a pharmaceutical company but the government of South Africa opted to test it using two pilot projects, which meant that only ten percent of the estimated 70,000 affected births were covered. TAC claimed that the government program violated the right to health and asked the court to issue an order for the distribution of nevirapine. The court ruled that the government had a duty to provide nevirapine to all expectant mothers. In this case, the court took into account the fact that the government had acted unreasonably because they had not set up an implementation plan that included all the relevant sections of society. This ruling highlights the role of civil society in creating health outcomes.

However, civil society involvement may not always be effective, especially if top-down pressures seek to impose the kind of civil society to which countries should aspire. For example, the GF has been criticised for favouring certain kinds of civil engagement to the detriment of others that may be better suited in some community settings. Moreover, a representative approach may in some instances create a confluence of interests between human rights and private entities. We have seen this with the debate on generic medicines, where the interests of private pharmaceutical companies seemed to trump any right to health, resulting in challenges for developing countries that wanted to create generic medicines for diseases such as AIDS.<sup>54</sup> An explicit recognition of a right to health in an international health financing obligation would weed out participation that was not compliant with health outcomes.

At the international level, lessons can be drawn from the creation of new international funding organizations that have sought to create more representation with different stakeholders, including developing countries and civil society organizations. The GF, UNAIDS, UNITAID and GAVI all have a mix of donor and developing countries on their boards at the international level. Furthermore, they also provide for civil society representation in decision-making at the international level.<sup>55</sup> Decisions at the domestic level ought to include a broad mix of representatives, extending not only to government officials, but also to civil society organizations and community participants.

## **NORMATIVE CHALLENGES TO THE PROPOSED FCGH**

The second part of this article will consider more problematic normative areas in trying to create an international obligation to assist. Three such areas will be explored. The first pertains to the practical problems of hardening human rights obligations. The second is the difficulty of accommodating an increased role for private actors who are traditionally not part of the human rights treaty regime system. Finally, there is the danger that, in focusing on an individual socio-economic right such as the right to health, we run the risk of fundamentally weakening other important socio-economic rights, creating further fragmentation within international law.

### *Hardening human rights obligations within treaties*

The voluntary nature of funding makes it extremely hard to predict with any certainty how much international funding developing countries will receive. For example, in 2011, as a result of the global financial crisis, the GF resorted to suspending a funding round due to inadequate pledges from its donors. Thus, creating a hard law obligation to create predictable funding may seem like an ideal solution. The Special Rapporteur's report on health financing points out that, even with pooling of resources, international funding is susceptible to the problems of sustainability due to its voluntary nature. The Special Rapporteur's report therefore urges countries to aim towards a compulsory treaty-based system that would ensure that rich States have a continuous legal obligation to contribute to efforts to promote the right to health in less developed countries. The proposed treaty would oblige countries to pay a percentage of their GDP in order to create an "obligatory treaty based regime based on global solidarity."

Literature on the proposed FCGH suggests that funding could be provided directly or through a common funding mechanism through exclusive funding by



richer countries or through a pro rata contribution by all States parties. Another option would entail the generation of funds through a taxation system, such as by taxing unhealthy foods.<sup>56</sup>

However, there are problems with hardening human rights obligations within a binding treaty. The right to health approach traditionally recognised the essential role that international assistance plays in ensuring that adequate funds and resources are available for health globally, particularly in developing countries. States have always been urged to cooperate internationally in order to ensure the availability of sustainable international funding for health. This includes an obligation to pool funds internationally from compulsory contributions by States, predicated upon their ability to pay, and a corresponding duty to allocate funds to States based upon their need. However, these responsibilities have gained very little traction from developed countries, who have always argued that financial pooling and needs-based allocation ought to constitute manifestations of moral—and not legal—exigency.<sup>57</sup>

The current legal obligation for health financing in the WHO has proved problematic in practice. Even where there is a clear institutional obligation within the WHO to finance global health, States have often ignored their obligations, leading to massive shortfalls. The WHO is financed by the assessed contributions of its members, known as Extra Budgetary Funds (EBFs). However, some major donors—like the United States—have been adept at refusing to pay their fair share, resulting in a paralysis of WHO activities. From 1996 to 1999, the United States owed the WHO US\$35 million in arrears. In May 2001, it managed to get a reduction in its budgetary contributions of about US\$25 million before it agreed to pay, leaving many developing countries feeling aggrieved at what they saw as coercion by richer countries to pick up the tab.

A number of soft law initiatives have led to a growing consensus that a duty to assist is essential if developing countries are to achieve key human rights goals. The OECD Guidelines stipulate that country members should contribute 0.7 per cent of their GDP (shown in terms of ODA/GNI ratios to reflect the replacement of gross national product with gross national income in 1993) for international development. MDG No. 8 also encourages partnerships for development, including aid for developing countries that are unlikely to meet any of the targets without international assistance. Furthermore, new international health financing institutions, such as the GF, GAVI and UNITAID, have all been set up and run primarily with contributions from international donors.

However, attempts to harden these obligations into any sort of binding obligation have so far been met with widespread resistance. The two cases in which the international community tried to create binding obligations on developed States using a treaty process through a human rights framework were met with difficulty. In 2001, the WTO, to much critical acclaim, recognized that human rights—especially the right to health—should be taken into consideration in making decisions in response to public health emergencies.<sup>58</sup> After the non-binding Doha Declaration on Health was passed, it took another two years to arrive at a proposed amendment to the TRIPS Agreement. To this date, the requisite two thirds of countries have not ratified the amendment in order to put it into effect. This is largely due to the fact that, in order to reach consensus, many of the gains of the Doha Declaration were watered down, leaving a solution that many developing countries consider unusable in practice.<sup>59</sup>

In the drafting of the Optional Protocol to the ICESCR, many States reiterated earlier objections to creating a legal duty to assist.<sup>60</sup> The final language of the

Optional Protocol has been sharply criticised for its weak wording, creating a procedure that is unlikely to be enforced as States are unwilling to reach consensus on more effective remedies. Only 45 countries have signed and 15 have ratified the Optional Protocol.<sup>61</sup>

*Private actors as parties to treaties within global health*

Any serious obligation on international health financing would have to take into consideration the increased role of private funding on the international global health landscape. Increasingly, funding comes from a small group of private actors who, together, now account for about a quarter of all development aid for health. This funding trend raises more fundamental questions about the obligations of those actors under international law.<sup>62</sup> Some of these foundations include the Gates Foundation and the Clinton Foundation, private pharmaceutical companies, and more often, private finance companies. Furthermore, there is an increase in the number of public-private partnerships in global health, which make it increasingly difficult to delineate responsibilities in practice.<sup>63</sup>

The Gates Foundation is by far the largest private funder and also the largest single funder in global health, disbursing approximately US\$800 million per annum. According to McCoy et al., from 2000 to 2007, the Gates Foundation provided a quarter of all funding for GAVI. Indeed, when the Global Fund ran out of money at the height of the financial crisis, it was the Gates Foundation that came to the rescue with a promissory note of US\$750 million.

While General Comment No. 14 recognises influences by non-traditional actors, it still puts the focus of enforcement on State parties:

While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society—individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector—have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.<sup>64</sup>

The report of the previous Special Rapporteur on the Right to Health, Paul Hunt, set a precedent on the role of this positive duty in the form of pharmaceutical guidelines that stated that, due to the public nature of the functions carried out by pharmaceutical companies, they had ‘additional responsibilities’ to fulfil the right to health. This potentially saddles developing countries with the unrealistic duty of policing actors who are potentially much more powerful than themselves.

With regard to corporations, the Guiding Principles on Business and Human Rights endorsed by the Human Rights Council in June 2011 provide a normative framework under which corporations can protect human rights in developing countries.<sup>65</sup> However, they have been criticised by scholars who argue that, apart from their non-binding nature, they rely primarily on due diligence that is supposedly an ineffectual method of ensuring human rights compliance; companies are able to report on their human rights obligations.<sup>66</sup> These guidelines also do not address the problem created by foundations that have been accused of ‘philanthrocapitalism’, by which they favour private interests over the health-related interests of the people whose needs they fund.<sup>67</sup>

The Maastricht Guidelines go a bit further, with Article 18 endeavouring to place the responsibility upon the developed country State in which the private entity is domiciled. However, this remains a soft obligation and expanding the responsibilities of State entities to include private entity actions—especially in instances where these entities are domiciled in tiny States for the purposes of tax avoidance—remains a challenging proposition.

### *The right to health vis-a-vis the socio-economic rights*

General Comment No. 14 states that:

the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.<sup>68</sup>

Financing the various social determinants that underlie the right to health would be a tall order. This would create two fundamental problems in practice from a normative point of view. The first is a danger that financing a meaningful right to health would always be unachievable given its wide scope. The second is that, in choosing a treaty that concentrates on a right to health as opposed to all socio-economic rights under the treaty, we risk prioritizing one right over all other equally-essential rights like those pertaining to water, housing or sanitation. In realizing a treaty for this right, we could end up with a bid to have more treaties for each of these rights, which could cause further fragmentation of the human rights treaty system. Thus, there is a danger that, if we succeed in creating a financing obligation for a right to health over other human rights, we will weaken human rights considerations. In turn, we would risk the establishment of a hierarchy of second-tier rights that lack the perceived moral weight requisite to gain funding.

### CONCLUSION

If it is to work, the proposed Framework Convention on Global Health must impose binding obligations on developed countries to assist developing countries in their quest to achieve the right to health for all their citizens. This should include an explicit recognition of the right to health and a focus on long-term funding, as opposed to short-term strategic intervention. The treaty should also promote more representative and participatory funding mechanisms at the national and global level in order to ensure accountability.

It is questionable whether this can be achieved. In particular, three areas are especially problematic. The first involves the practical problems of hardening human rights obligations when soft approaches are likely to be more effective in the long term. The second is the difficulty of accommodating an increased role for private actors who are traditionally not part of the human rights treaty regime system. Finally, there is the danger that, in focusing on an individual socio-economic right such as the right to health, we run the risk of fundamentally weakening other important socio-economic rights, creating further fragmentation within international law. Given these difficulties, it may be inadvisable for the Framework Convention on

Global Health to impose binding obligations. The discussion in this paper illustrated the paradox of the proposed FCGH. On the one hand, it needs a binding obligation for international financing in order to ensure that developed countries can provide ample assistance to their less developed counterparts, but on the other there are serious normative questions to consider. Perhaps the solution is to adopt the incremental approach that Gostin suggested that starts off with non-binding obligations that harden over time. Most importantly, the international community must reconsider a treaty for health and develop a framework for socio-economic rights as a whole. However, more importantly perhaps we need to reconsider a treaty for health and think of a framework for socio-economic rights as a whole.

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<sup>1</sup> John Liden, *The Grand Decade for Global Health: 1998-2008*, Chatham House: Centre for Global Health Security (2013)

<sup>2</sup> The 2015 goals will replace the Millennium Development goals but will apply to developed and developing countries alike. This however creates a unique opportunity for global negotiations on contentious issues like global health financing.

<sup>3</sup> Lawrence Gostin, *Global Health Law*, Harvard University Press pp 437. Also see Lawrence O Gostin, Eric A Friedman, 'Towards a Framework Convention on Global Health: A transformative agenda for Global Health Justice,' 13 *Yale J Health Policy and Ethics* 1-75 (2013).

<sup>4</sup> Lawrence O. Gostin, "Transforming Global Health Through Broadly Imagined Global Health Governance," *McGill Journal of Law and Health* 4 (2010-2011): 5.

<sup>5</sup> This paper takes as a starting point that the proposed FCGH ought to have a duty to assist and does not deal with normative discussions of why such a duty is necessary. For more discussion of a duty to assist under international law, see Sakiko Fukuda-Parr, "Millennium Development Goal 8: Indicators for International Human Rights Obligations?" *Human Rights Quarterly* 28, no. 4 (2006): 967-977, and Lawrence O. Gostin and Eric A. Friedman, "Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice," *Yale Journal of Health Policy, Law and Ethics* 13 (2013).

<sup>6</sup> Gorik Ooms *et al.*, "Great Expectations for the World Health Organisation: a Framework Convention on Global Health to Achieve Universal Health Coverage," *Public Health* 128 (2014).

<sup>7</sup> Benjamin M. Meier and William Onzivu, "The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights through Global Health Governance," *Public Health* 128 (2014): 185.

<sup>8</sup> Lance Gable, "The Proliferation of Human Rights in Global Health Governance," *Journal of Law, Medicine & Ethics* 35, no. 4 (2007).

<sup>9</sup> Steven J. Hoffman and John-Arne Røttingen, "Dark Sides of the Proposed Framework Convention on Global Health's Many Virtues: A Systematic Review and Critical Analysis," (2013) *Health and Human Rights* 15, no. 1 (2013).

<sup>10</sup> Roger S. Magnusson, "Rethinking Global Health Challenges: Towards a 'Global Compact' for Reducing the Burden of Chronic Disease," *Public Health* 123 (2009).

<sup>11</sup> Institute for Health Metrics and Evaluation, *Financing Global Health 2013: Transition in an Age of Austerity* (Seattle: IHME, 2014), <http://www.healthdata.org/policy-report/financing-global-health-2013-transition-age-austerity>.

<sup>12</sup> The definition of NGO used here is that of Brown and Covey, who divide NGOs into four categories, one of which is developmental organisations at the international level: See L. David Brown and Jane Covey, "Development Organisations and Organisation Development: Toward an Expanded Paradigm for Organisation Development," in *Research in Organisational Change and Development, Volume 1*, ed. Richard W. Woodman and William A. Pasmore, (Greenwich, CT: JAI Press, 1987), 59-78.

<sup>13</sup> Public-Private Partnerships are 'voluntary and collaborative relationships between various parties, both public and non-public, in which all participants agree to work together to achieve a common

purpose or undertake a specific task and, as mutually agreed, to share risks and responsibilities, resources and benefits.' See United Nations General Assembly, "Towards Global Partnerships," A/C.2/60/L.38/Rev. 1 (2005), <http://daccess-dds-ny.un.org/doc/UNDOC/LTD/No5/642/74/PDF/No564274.pdf?OpenElement>, para. 2.

<sup>14</sup> See World Health Organisation, *World Health Statistics 2012* (France: World Health Organisation 2012), 38-40 (Figure 10 of which, providing total health expenditure (US\$) per capita for 2009, utilises a logarithmic scale to assimilate the data, the need for which arises in virtue of the enormous variation in State health expenditure).

<sup>15</sup> Gostin and Friedman, "Towards a Framework Convention," 1.

<sup>16</sup> This is implicit in para. 45 of General Comment No. 14

<sup>17</sup> OECD, "Development: Aid to Developing Countries Falls because of Global Recession," accessed August 23, 2014, <http://www.oecd.org/newsroom/developmentaidtodevelopingcountriesfallsbecauseofglobalrecession.htm>.

<sup>18</sup> Peter Moszynski, "Global Fund Suspends New Projects until 2014 because of Lack of Funding," *British Medical Journal* 343 (2011), doi: 10.1136/bmj.d7755.

<sup>19</sup> Gostin and Friedman, "Towards a Framework Convention," 25-29.

<sup>20</sup> The 2015 goals will replace the Millennium Development goals, but will apply to developed and developing countries alike. This, however, creates a unique opportunity for global negotiations on contentious issues like global health financing.

<sup>21</sup> Judith Bueno de Mesquita, Paul Hunt and Rajat Khosla, "The Human Rights Responsibility of International Assistance and Cooperation in Health," in *Universal Human Rights and Extraterritorial Obligations*, ed. Mark Gibney and Sigrun Skogly, (Philadelphia: University of Pennsylvania Press, 2010).

<sup>22</sup> Of course, there are other normative obligations – rendered in various institutional documents, such as other Special Rapporteur's reports, treaties and international agreements, and the MDGs – on which this paper will draw to strengthen the analysis.

<sup>23</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), "General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)," E/C.12/2000/4 (2000), [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=E%2FC.12%2F2000%2F4&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2FC.12%2F2000%2F4&Lang=en), paras. 38-39.

<sup>24</sup> General Comment No. 14 states that:

To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. *Ibid* para. 39.

<sup>25</sup> For more on the typology to respect, prevent and remedy with the right to health, see John Tobin, *The right to Health in International Law*, (Oxford: Oxford University Press, 2013), 331.

<sup>26</sup> Olivier De Schutter *et al.*, "Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights," *Human Rights Quarterly* 34, no. 4 (2012).

<sup>27</sup> United Nations General Assembly, "The Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,"

A/67/302 (2012), <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N12/461/01/PDF/N1246101.pdf?OpenElement>.

<sup>28</sup> Although General Comment No. 14 and the Maastricht Guidelines deal with health financing, the current report presents the most detailed analysis of the issue. Previous Special Rapporteur's, such as Paul Hunt, had dealt with financing only incrementally through the access to medicines issue.

<sup>29</sup> United Nations General Assembly, "The Interim Report," para. 2.

<sup>30</sup> *Ibid*, para. 24. (most likely para. 24, although nowhere in the report is it provided that a right to health ought to be incorporated into health financing initiatives *in order to avoid* conditionalities; rather, the Special Rapporteur appears to maintain that conditionalities ought to be avoided in virtue of the fact that their exploitative use constitutes a violation of the right to health. The implementation of the right precedes the obligation to avoid conditionalities, but it is not suggested that the right is instituted as a direct and specific response to conditionalities).

<sup>31</sup> See, for instance, Jonathan M. Mann, "Health and Human Rights," *British Medical Journal* 312 (1996) and Jonathan M. Mann *et al.*, "Health and Human Rights," *Health and Human Rights* 1 (1994).

<sup>32</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria, "The Framework Document," (2001), [http://www.theglobalfund.org/documents/core/framework/Core\\_GlobalFund\\_Framework\\_en/](http://www.theglobalfund.org/documents/core/framework/Core_GlobalFund_Framework_en/), 91.

- <sup>33</sup> UNAIDS, "The First 10 Years," UNAIDS/07.20E/JC1262E (2008), [http://data.unaids.org/pub/report/2008/jc1579\\_first\\_10\\_years\\_en.pdf](http://data.unaids.org/pub/report/2008/jc1579_first_10_years_en.pdf), particularly Chapter 5.
- <sup>34</sup> Michel Kazatchkine, "Redoubling Global Efforts to Support HIV/AIDS and Human Rights," *HIV/AIDS Policy & Law Review* 15, no. 1 (2010): 71.
- <sup>35</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria, "The Global Fund Strategy 2012-2016: Investing for Impact," [http://www.theglobalfund.org/documents/core/strategies/Core\\_GlobalFund\\_Strategy\\_en/](http://www.theglobalfund.org/documents/core/strategies/Core_GlobalFund_Strategy_en/). See also Johanna Hanefeld and Anuj Kapilshrami, "The Global Fund's New Funding Model - Missed Opportunities for Human Rights?" *Health and Human Rights Journal* (2013), <http://www.hhrjournal.org/2013/07/18/the-global-funds-new-funding-model-missed-opportunities-for-human-rights/>.
- <sup>36</sup> *Ibid.*
- <sup>37</sup> CESCR, "General Comment No. 14," paras. 39-42.
- <sup>38</sup> De Schutter *et al.*, "Commentary to the Maastricht Principles," 1113.
- <sup>39</sup> Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 1997, Principle 14. See also United Nations General Assembly Human Rights Council, "Report of the Special Rapporteur on the Right to Food, Olivier De Schutter: Guiding Principles on Human Rights Impact Assessments of Trade and Investment Agreements," A/HRC/19/59/Add.5 (2011), [http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-59-Add5\\_en.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-59-Add5_en.pdf).
- <sup>40</sup> Gostin, "Transforming Global Health."
- <sup>41</sup> *Ibid.*
- <sup>42</sup> Laurie Garrett, "The Challenge of Global Health," *Foreign Affairs* 86, no.1 (2007): 22- 23.
- <sup>43</sup> *Ibid* 23, in his discussion of Haiti's AIDS situation.
- <sup>44</sup> Gostin and Friedman, "Towards a Framework Convention."
- <sup>45</sup> CESCR, "General Comment No. 14."
- <sup>46</sup> Dongbao Yu *et al.*, "Investment in HIV/AIDS Programs: Does it Help Strengthen Health Systems in Developing Countries?" *Globalisation and Health* 4, no. 8 (2008), doi: 10.1186/1744-8603-4-8.
- <sup>47</sup> In Uganda, a study found that a weak health system was constraining the absorption of funding, leading to only 26 percent of a Global Fund grant being spent after twenty months. In one instance some drugs actually expired in the stores without ever being delivered. See Ruairi Brugha, "Global Fund Tracking Study: a Cross-country Comparative Analysis," (Discussion Paper, Geneva: The Global Fund, 2005), [http://www.theglobalfund.org/documents/library/Library\\_IE13\\_Report\\_en/](http://www.theglobalfund.org/documents/library/Library_IE13_Report_en/), and Michael Bernstein and Myra Sessions, *A Trickle of a Flood: Commitments and Disbursement for HIV/AIDS from the Global Fund, PEPFAR, and World Bank's Multi-Country AIDS Program (MAP)*, (Washington D.C.: Centre for Global Development, 2007).
- <sup>48</sup> Erik J. Schouten *et al.*, "Antiretroviral Drug Supply Challenges in the Era of Scaling Up ART in Malawi," *Journal of the International AIDS Society* 14, no. S4 (2011).
- <sup>49</sup> United Nations Foundation, "What We Do: Pledge Guarantee for Health," accessed August 23, 2014, <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/pledge-guarantee-for-health/>.
- <sup>50</sup> For more on this project, see generally <http://www.internationalhealthpartnership.net/en/> and Yu *et al.*, "Investment in HIV/AIDS programs."
- <sup>51</sup> Gostin and Friedman, "Towards a Framework Convention," particularly 59, 71-72.
- <sup>52</sup> John Tobin, *The right to Health in International Law*, (Oxford: Oxford University Press, 2013), 98.
- <sup>53</sup> Ministry of Health v Treatment Action Campaign (TAC) (2002) 5 SA 72 (CC)
- <sup>54</sup> Sharifah Sekalala, 'Third world access to essential medicines and the WTO General Council Decision of 2003' *Kings College Law Journal* 21 (1), (2010)
- <sup>55</sup> Thomas Hale and David Held, 'Handbook of Transnational Governance, Institutions and Innovations' 161-166
- <sup>56</sup> Gostin and Friedman, "Towards a Framework Convention."
- <sup>57</sup> Sigrun Skogly, *Behind National Borders: States' Human Rights Obligations in International Cooperation* (Antwerpen-Oxford: Intersentia, 2006), 138.
- <sup>58</sup> See Meier and Onzivu, "The Evolution of Human Rights," 182 and Sofia Gruskin, "Is There a Government in the Cockpit: a Passenger's Perspective or Global Public Health: the Role of Human Rights," *Temple Law Review* 77 (2004).
- <sup>59</sup> Sharifah Sekalala, 'Third world access to essential medicines and the WTO General Council Decision of 2003'
- <sup>60</sup> UNHCR, "Report of the Open-Ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights on its Second Session," E/CN.4/2005/52 (2005): para. 76.

<sup>61</sup>The Optional Protocol came into force on 5th May 2013 after achieving the requisite ten signatures for ratification. See [https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-3a&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3a&chapter=4&lang=en).

<sup>62</sup>David E. Bloom, "Governing Global Health," *Finance and Development* 44, no.4 (2007): 31-35.

<sup>63</sup>Whilst the ICESCR does not have an explicit provision on states, General Comment No. 14 contains general obligations for states to progressively realise the right to health. In this regard, the ICJ has also held that the ICESCR guarantees essentially-territorial rights in the case of the Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory (Advisory Opinion 2004) ICJ Rep 136, 112.

<sup>64</sup>CESCR, "General Comment No. 14," paras. 42.

<sup>65</sup>OHCHR, *Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework* (New York and Geneva, United Nations, 2011).

<sup>66</sup>James Harrison, "Establishing a Meaningful Human Rights Due Diligence Process for Corporations: Learning Lessons from Experience of Human Rights Impact Assessment," *Impact Assessment and Project Appraisal* 31, no. 2 (2013).

<sup>67</sup>David McCoy and Linsey McGoe, "Philanthropic Foundations," in *Partnerships and Foundations in Global Health Governance*, ed. Simon Rushton and Owain D. Williams, (Basingstoke: Palgrave Macmillan, 2011).

<sup>68</sup>CESCR, "General Comment No. 14," para. 3.

# Health for the Common Good

Jalil Safaei

*Improving health and reducing health inequities is a chronic yet urgent global issue. In addition to appeals to humanity, social responsibility, distributive justice and human rights as powerful normative perspectives that unite and guide efforts for achieving global health equity, this paper argues that providing effective healthcare for all and addressing the underlying political, socioeconomic and environmental determinants of health are justified by viewing healthcare and health as a common good. As well, we argue that a sustainable and equitable funding mechanism for achieving global health equity would be helped by a global welfare fund. The paper outlines some of the structural barriers to achieving health equity and view the Framework Convention for Global Health as a timely effort for mobilizing global resources towards achieving health equity.*

*There exists an intrinsic connection between the common good on the one hand and the structure and function of public authority on the other. The moral order, which needs public authority in order to promote the common good in human society, requires also that the authority be effective in attaining that end.<sup>1</sup>*

Pope John XXIII

## INTRODUCTION

The health and wellbeing of nations is a paramount goal towards which all countries, developing and developed, are striving. Some countries are focusing on economic growth and prosperity as the pathway to individual and social wellbeing.<sup>2</sup> Others have made commitments to protecting and promoting population health both as an end in itself and as a prerequisite to economic development and prosperity.<sup>3</sup> The experience of various countries over the past several decades is one of overall improvement in population health and wellbeing in terms of reduced mortality or increased life expectancy as documented by medical historians. Such improvement has been attributed to factors like better nutrition due to economic development<sup>4</sup>, large-scale investments in sanitation and other public health measures and public health education, along with improvements in controlling infectious diseases before the advent of clinical medicine.<sup>5</sup> However, despite significant improvement in populations' health all around the world, major inequities persist and continue to grow in many jurisdictions. Health inequities are not randomly distributed. A vast body of literature indicates that the poor, the unprivileged and those in lower social classes receive the brunt of ill health, morbidity and mortality.<sup>6</sup> There is a systematic health disadvantage among low-income people ubiquitously; from the very poor countries of the "South" to the very rich countries of the "North". As a result, vulnerable populations are predestined to poorer health outcomes, which could perpetuate well into the future affecting the lives of their children and future generations.



Having good health is viewed as commensurate with access to healthcare. The medical community and healthcare professionals play a significant role in reinforcing this narrow *biomedical* approach to health. Similarly, politicians and policy makers generally feel more comfortable with this approach. Consequently, within this view, better health means better healthcare, and health inequities are attributed to differential access to health care. This has led many advocates of health equity to call on their governments to either provide healthcare to everyone directly as in the case of National Health Services in United Kingdom<sup>7</sup>, publicly fund health insurance through general taxes such as Medicare in Canada,<sup>8</sup> or subsidize employment-based health insurance systems such as Sickness Funds in Germany and other countries<sup>9</sup>.

Ensuring access to healthcare has been variously justified over time. Appeal to humanity and the virtue of taking care of the sick among us is perhaps as old as human history. Long before the emergence of governments, charities and religious institutions would provide whatever healthcare available to the sick and destitute. Even today, many charities, non-governmental organizations and community groups are playing a part in providing healthcare or assisting access to healthcare for the poor and vulnerable populations.

More recently, equal access to healthcare is justified on human rights grounds. According to the United Nations Universal Declaration of Human Rights, every human being is entitled to “a right to a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing and medical care ...” (Article 25).<sup>10</sup> Subsequent covenants of the United Nations such as the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights have endorsed the right to health for all individuals.<sup>11</sup> Appeals for good health and wellbeing for all and equal access to healthcare has been echoed subsequently in many of the World Health Organization (WHO)’s declarations and communications. The Preamble to the WHO Constitution states, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”<sup>12</sup> The Alma Ata Declaration,<sup>13</sup> the Ottawa Charter<sup>14</sup> and more recently, the WHO Commission on Social Determinants of Health<sup>15</sup> recognize the right to health and its underlying socioeconomic determinants. Despite such clear articulation by the international organizations and endorsements by the vast majority of their member countries, the actual translation into action by countries so far is mixed and more needs to be done. For example, only 56 of the 194 countries that have ratified ICESCR have legally recognized the right to health.<sup>16</sup>

Equitable access to healthcare remains an enduring issue in health policy debates. Alternative theoretic, ethical and philosophical frameworks have been proposed to ground the right to healthcare and health by reference to some conception of justice or equality of rights. For instance, Jennifer Ruger proposes the *health capability paradigm*. Inspired by the Aristotelian notion of *human flourishing* as elucidated by Nussbaum<sup>17</sup> and Irwin,<sup>18</sup> and the idea of capability and its relationship with freedom as articulated by Sen,<sup>19</sup> Ruger appeals to society’s obligation - based on the ethical principle of human flourishing - to maintain and improve health capabilities and reduce “shortfall inequalities” for all.<sup>20</sup> Similarly, Norman Daniels draws on Rawls<sup>21</sup> notion of *equality of opportunity* to advocate for the right to healthcare<sup>22</sup> and the right to health.<sup>23</sup> His basic argument is that healthcare protects or restores *normal*

*functioning* of individuals ensuring fair for everyone, which according to Rawls' view of justice is a core commitment of liberal democratic societies. He argues "...If we have obligations of social justice to provide equality of opportunity, as in Rawls's robust notion of fair equality of opportunity, then we have social obligations to promote normal functioning and to distribute it equitably in society by designing our institutions properly."<sup>24</sup>

Daniels' view of the right to healthcare has been challenged by several critics. Drawing on Kass,<sup>25</sup> Merrill and Miller<sup>26</sup> argue that "assertions of a right to health or health care project an inappropriate view of personal and collective responsibility."<sup>27</sup> They consider the state of health and the healing process as the dynamic outcome of exceedingly complex interactions between our native dispositions and our environments, a process in which personal responsibility is centrally important. They are also concerned that the right to healthcare, and by extension a right to health, entails an expansive view of justice and creates a level of obligation that cannot be met, and will give the government an almost unlimited reach.<sup>28</sup>

Daniels' expansive view of rights is similarly questioned by Kenneth Cust<sup>29</sup> who argues that in Daniels' account of fair equality of opportunity the scope of opportunity is much broader than that of Rawls's. Cust argues "The promotion of equality in more areas of life is problematic, for, if it cannot be constrained, society may find itself attempting to meet all health-care needs in the name of fair equality of opportunity. Any such attempt would place us on the edge of a "bottomless pit" that has the potential to consume not only our health-care budget but all of society's resources."<sup>30</sup> Cust advocates for a *universal right to a just minimum of healthcare*,<sup>31</sup> based on David Gauthier's idea of society as a "cooperative venture for mutual advantage among persons conceived as not taking an interest in one another's interests," and his principle of distributive justice – *minimum relative concession*.<sup>32</sup>

The right to health is also promoted by those who are concerned with health equity at the global level. For instance, Lawrence Gostin draws upon global health law and other international legal regimes to make a strong case for *global solidarity* to achieve an equitable distribution of health worldwide.<sup>33</sup>

Undoubtedly, the right to health is much more involved and has vastly greater implications for creating equal opportunity than the more limited notion of the right to healthcare. And as expected, it is even more resisted than the right to healthcare by those who do not believe in absolute rights, or have different conceptions of social justice and moral obligations.

To avoid normative implications of rights-based approaches to health and healthcare and overcome the difficulties of arriving at some level of social consensus with regard to the importance of ensuring equal access to healthcare and promoting health for all, health and healthcare is often distinguished as a *public good*, or more broadly, as a *common good*. The next section discusses the distinguishing features of public goods and how they apply to healthcare, making parallels between healthcare and basic education, which is widely and equally provided and enjoys almost unanimous societal support. After that, health as a common good is discussed, where the 'common good' is interpreted more broadly as the 'good or wellbeing of the society'. The following section discusses achieving health equity at the national level by focusing on social policy as government's response for reducing socioeconomic and health inequities and protection and promotion of health for all. This discussion is extended to achieving

health equity at the global level in a subsequent section where it calls for *global social policy* as a policy framework for sustainable global governance for health. The next two sections outline some of the barriers to achieving global health equity in the current environment of global tensions, insecurity and mistrust resulting in part from the impotency of the existing global governance structures, and consider the Framework Convention on Global Health as a way forward, respectively. The last section closes the paper with some concluding remarks.

## HEALTHCARE AS A COMMON GOOD

Certain goods and services by virtue of their unique nature have been distinguished from other goods and services. Such goods are known as *public* goods or common goods. The key distinguishing features of common goods are 1) inability or difficulty of excluding others from using it once it is produced; 2) the absence of rivalry or competition among consumers of such goods in the sense that consumption by one does not take away consumption by another consumer.<sup>34</sup> Since the markets are ill-equipped to handle common goods or produce them at an optimal rate, the governments are usually the providers or funders of common goods, hence the *public* good attribution. The categorization of private, provided by the market, versus public or common goods is not absolute. It is best to think of the array of the goods along a spectrum that extends from *purely private* goods on one end to *purely public* goods on the other. This relative ordering suggests that some goods are in between and possess dual private and public features. National defense is often given as an example of a pure common good. Most common goods are not pure, however. Take the example of basic education, which is almost universally provided by the governments as a public good. However, there are private schools where cost is based on market principles; thus education can be a private good. However, the common good features are dominant, which explains why governments all around the world, regardless of their ideological and political persuasions, are providing basic education, and in many cases even higher education, as a public good.

Even if it is possible to exclude people from educational services by way of a price barrier, it is not usually desirable to do so. A society that commits to educating its young members either as a basic human right, or as a means to cultivate its values, norms and experiences in current and future generations, finds it necessary and desirable to provide free education as a common good. From a social justice perspective that is concerned with fair equal opportunity, basic education appears to be the most effective way of equalizing opportunity and increasing social mobility, essential for reducing social and economic inequalities. There are still additional grounds for providing education as a common good. Economic progress and prosperity is now more than ever dependent on an educated workforce that is trained in all areas of science, technology, arts and humanities. It is unimaginable to have a highly educated and trained workforce without providing primary and secondary education on a mass scale. The beneficiaries of education are first and foremost individuals (and their families) who obtain the education. However, educational benefits spill over to other parties who have not participated in its provision. The business community is availed with a trained labor force, which is so vital to its existence and success. More broadly, a society with educated citizenry is more likely to be more respectful of its members, be more tolerant

of diversity and difference among its members, be more cohesive and capable of social innovation for the betterment of society, be less prone to social conflict, social malaise and criminal activity, and more pertinent to the point of this paper, to be leading a healthier life style. The latter are all positive externalities that spill over to the society as a result of providing education.

Healthcare or more broadly health promotion, very much like education, qualifies as a common good. It shares many features of education as a common good. It benefits everybody to have a healthy population, much like having an educated population. In the same way that education empowers individuals and increases their productivity, promoting health is fundamental to human functioning and effective participation in social life. The business community has much to gain from a healthy workforce as it does from an educated workforce. Health education and promotion perpetuates healthy living and a healthy environment that would sustain good health and healthy behavior in future generations.

In addition to the shared features with education, healthcare and health, there are unique characteristics that make their provision and promotion even more justified. First, they cater to the basic need for being healthy, which is fundamental to human beings. The more urgent and critical the need, the more crucial the provision of healthcare or promotion of health would be. As ill health undermines our capacity to learn, to work, and to enjoy life, it is critical to make sure our health can be maintained and restored when it is compromised. No other good or service features this sense of urgency. Second, ill health to a great extent is unpredictable, and despite our best efforts, cannot be controlled or planned. It is potentially very expensive for serious illnesses and thus, beyond average people's financial capacity, making it a *catastrophic* expense. Both the uncertainty of ill health and its financial burden explain the widespread health insurance that modern societies have instituted to protect individuals against ill health. And herein lies the logic of public healthcare insurance; to provide *access* to necessary healthcare as a common good, even if the actual healthcare service may be provided by non-profit organizations or private practices. Third, in the same way health benefits (arising from healthcare, or more broadly from the up-stream determinants of health) spill over to others as external benefits in providing a healthy and productive workforce and a healthier society, health hazards are *negative* externalities that also spill over to others who are not often compensated or cannot be compensated for the cost imposed. An obvious example is epidemics of infectious disease. We are all concerned about the spread of AIDS, MERS and highly pathogenic influenza viruses, or more recently Ebola viruses that threaten our health and wellbeing. However, we are not as alert to less extreme negative externalities such as polluted air, water and soil, to which we are exposed all the time, even though they have significant cumulative adverse impacts on our health.

So, as environmental hazards and pollutants negatively affect our health, we need to have public health measures in place to protect us against such negative spillovers by way of preventative measures, regulations and remedial activities. Understandably, we need to broaden the range of healthcare services to include public health services along with healthcare that is provided to us as individuals. Lastly, we tend to care more about the health of our fellow human beings than their level of education, employment, income or other social entitlements. In other words, we tend to be more receptive of the idea of being healthy and having access to healthcare as a human right than we are with

respect to other human rights. The additional features of healthcare and health along with those shared by education make an even stronger case for equitable promotion of health and provision of healthcare as a common good.

## HEALTH FOR THE COMMON GOOD

The ultimate objective of a society presumably is to maintain and promote the *health* and wellbeing of its members. The need for healthcare and the desire for ensuring equitable access to healthcare is premised on the popular understanding that healthcare is central to both individual and population health. However, as previously stated, many factors bear on our health in a much more fundamental and persistent manner than healthcare. These factors, generally referred to as the *upstream* factors, predispose us, some even before being born, to a life trajectory that to a large extent determines our health and our experiences of morbidity, disability and death. Early childhood development, housing and living conditions, education, employment and job experiences, income and wealth, social relations, socioeconomic position, civil and human rights are some of the key social determinants of health that define and shape our health as we go through our life cycles. The overwhelming evidence that locates ill health predominantly among the poor and the marginalized and identifies a *social gradient* in health even among the relatively well-off,<sup>35</sup> underscores the significance of the upstream determinants of health. Thus, if we really care about impacting health outcomes, it is imperative to address the social determinants of health by making sure that resources of all kind are equitably distributed, fair opportunities are provided for everyone, and people are empowered to take charge of their own life and health. Such provisions are not only socially justified in their own right, they also support preventing ill health, disability and mortality that burden society with immeasurable loss and significant cost otherwise.

Most countries around the world are concerned about the ballooning rise in their healthcare costs. This issue is even more serious in the United States where roughly every sixth dollar of total national income is spent on healthcare, although recent healthcare reforms under the Obama administration appear to be curbing the growth of healthcare costs. There is an ongoing debate over the sources of such “cost explosion”. As a matter of cost control policy it is very important to identify the factors that are contributing to the rise in healthcare costs. In the final analysis, it does not matter who the culprit is: whether it is the pharmaceutical industry, the payment system of healthcare providers, the cost of healthcare administration bureaucracy, the greediness of private healthcare organizations or the wasteful practices of public healthcare systems. What matters is the fact that a heavy, if not sole, emphasis on *curative* healthcare misses the point that a *preventative* healthcare system that addresses the roots of ill health—the causes of the causes—has a much greater chance of success with a much smaller cost. Ever rising healthcare costs is not just a threat to the healthcare system itself, it also undermines the society’s financial capacity to address other equally important social programs, be it early childhood development and care, education, youth employment, pension plans, long term care and so on. The experience of countries that have addressed the underlying determinants of health by way of a relatively fair distribution of income in combination with generous social security

measures to obtain the highest population health outcomes speaks very loudly in this regard.<sup>36</sup>

Understandably, health policy and more broadly, governance for health that is anchored in the social determinants of health paradigm is a major sociopolitical undertaking that would be fiercely resisted by the establishments that benefit from the status quo and the prevailing paradigm.<sup>37</sup> Therefore, it will take tremendous effort and persistent and effective advocacy to educate the public, motivate the policy makers, and convince the influential entities—who may perceive the social determinants approach as too radical—that ensuring the health and wellbeing of everyone in the society is good for society as whole.

### ACHIEVING HEALTH EQUITY AT THE NATIONAL LEVEL

An ideal approach for working towards reducing health inequities and ensuring an equitable distribution of health would entail a fair *primary* distribution of income and other resources through market allocations and public provisions. Such distribution would focus on wage equity, healthy work environment, job security and publicly provided or funded education and healthcare services to maximize the prospect of fair opportunity and equal footing in the society. It is hard, if not impossible, to imagine that a society can achieve health equity without achieving social justice in its broadest sense. Short of achieving an equitable primary distribution of resources and opportunities, social policy in the form of the welfare state has been able to rectify some of the injustices of the prevailing primary distributions through *secondary* distribution or redistribution.<sup>38</sup> Child welfare, family assistance, food stipends, and other social security measures are *remedial* measures to address some of the deprivation and inequities that are endemic in almost any society. The extent and depth of such remedial measures, or the generosity of the welfare states, varies significantly from country to country to the extent alternative welfare state *regimes* or models have been identified for quite some time.<sup>39</sup> It is now widely known that the so-called Nordic model of the Scandinavian countries are most generous in providing comprehensive social security services. It is not surprising that these countries have achieved some of the highest rankings in population health outcomes over many years.<sup>40</sup>

Welfare state provisions or social security expenditures are affected by variations in the fiscal viability of the governments. Some of the variations are due to cyclical fluctuations in the economy that affect the tax revenues, as during the recessions. The recent Great Recession that followed the global financial crisis of 2008-2010 posed significant threat to the viability of the welfare systems especially in southern Europe where countries such as Greece, Spain and Italy were pushed to the brink of insolvency and had to go through very painful fiscal and welfare state restructuring.<sup>41</sup> Welfare state programs are also vulnerable to the political ideology of the governments in office. More specifically, governments with a conservative or neoliberal political view who perceive welfare programs as symptoms of “fat governments” have made deliberate efforts to reduce government’s capacity in delivering social services. They do so by reducing taxes for the high-income earners and corporations, thereby reducing government revenues and fiscal capacity. On the expenditure side, they tighten up the rules and requirements for recipients of welfare and limit the programs to certain target groups by various means-tested approaches.<sup>42</sup> These efforts in the name of balancing the budgets are often

accompanied by media campaigns that appeal to individual sense of responsibility and border on stigmatizing welfare recipients. Although fiscal shortfalls due to market variations are more or less unavoidable, those driven by political ideology are contrived and can be avoided.

### ACHIEVING HEALTH EQUITY AT THE GLOBAL LEVEL

Arguably, achieving health equity at the global level is a much more daunting task than doing so within a country. It is much easier to achieve a sense of community or solidarity among the citizens of a nation as common historical heritage, cultural affinities, geographical vicinity, and shared social, economic and political experiences bind the nationals of a country together. Therefore, committing to some level of social justice and caring for other fellow citizens are more likely to happen as the experiences in many countries show. All the aforementioned factors that bind the citizens of a country to a cohesive society are absent at the global level. Different histories, cultural differences, distant geographies, and widely varied social, economic and political experiences—not to mention histories of warfare and colonial domination—conflate to undermine achieving a sense of *global solidarity* anywhere near what has been achieved in terms of national solidarity.

Moreover, the absence of an effective and respected global governance regime that could organize and mobilize the global society towards achieving a common goal or caring for each other remains a significant barrier for achieving global justice and moving in the direction of health equity. The current global governance structure has sadly proved to be ineffective in achieving even the most basic goals such as global peace and security, environmental stewardship and fair trade among the developed and developing nations. Without achieving these basic goals, moving towards global justice and health equity appears too optimistic.

Although it is difficult to escape the pervasive sense of pessimism one feels by seeing the many challenges around the globe, we need to press forward for progressive changes at the global level as the only way out of this unfortunate situation. Recognizing the arduous task of achieving social justice at the global level—a task that has proven difficult even at the country level—we could more realistically hope to move in the direction of setting up what might be called *global welfare governance*, a concept similar to the national welfare states prevailing in most advanced countries. That is, we need to call for a global social policy that undertakes to redistribute the riches and resources from the affluent to the poor and deprived nations. A systematic global social policy would replace the ad hoc and fragmented efforts of current international agencies in transferring resources from donating nations to the aid recipients often during emergencies. It would be established by setting up a fund—like a “Global Welfare Fund” (henceforth the Fund)—to which the affluent nations contribute on a regular basis in proportion to their economic affluence (e.g. identified by Gross Domestic Product per capita or some other macroeconomic measure). The poor and less affluent countries would be entitled to transfers from that Fund in proportion to their needs. The specifics of the contributions and transfer payments in cash or kind would have to be worked out on the basis of a reasonably reliable estimate of the extent and the nature of the need as well as the capacity of the contributing nations.

Several key issues in setting up the Fund and running it are worth pointing out. First, the Fund should be governed or monitored by an assembly of global representatives from all the participating nations consisting of community leaders or civil society activists along with government officials *with equal voting privileges*. This is to ensure a globally inclusive supervision. Second, in the interest of transparency and accountability, the needs for transfers have to be properly documented and registered, as should be the delivery and expenditure of resources transferred by periodic reporting and auditing that are made available to the international community. Third, the resources available to the Fund should be prioritized towards basic needs such as food and shelter, education and healthcare and so on to achieve the highest outcomes possible. Fourth, there needs to be a mechanism in place in order to reassess the country needs and report on the impact achieved over time, which would help in revising the global distribution of transfers, if need be. Fifth, for greater democratic representation and accountability, the country representatives to the assembly have to be on limited terms and accountable to any judiciary body the Fund may see fit. The intention here is not to provide a blueprint for the Fund; it is, rather, to highlight some of critical aspects of organizing and administering such a Fund if it is ever going to be an effective and promising initiative.

Once properly organized and committed to by the participating nations, the Global Welfare Fund would have several advantages over the current situation of international aid and relief activities. Most importantly, the receiving nations would consider themselves to be entitled to such global transfers as a right that is upheld by the obligation of the contributing countries. Our planet is the broadest *common good* we all share as human beings. So, by virtue of being born on this planet we are all entitled to some share of its vast resources. As such, we can avoid the stigma that is so often associated with unilateral donations by specific countries or organizations when helping some populations or countries out of a sense of charity and presumptuous generosity. Equally important would be the fact that countries could rely on a secure and consistent pattern of assistance for as long as their needs persist, and not be left at the mercy of the sporadic benevolence of some donor countries. In addition, a well functioning and transparent Global Welfare Fund would make sure that the resources transferred would be received by the rightful recipients in need, and not squandered by the corruption of the bureaucracies in receiving countries. Fortunately, there are some existing global bodies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund)—established in 2002—and the President's Emergency Plan for AIDS Relief (PEPFAR)—established in 2003—that mobilize resources from various voluntary donations from private and public sectors to assist many developing countries—mostly in Africa—with funds and technical assistance to eradicate AIDS and other infectious diseases. The successful record, organizational capacity, technical knowhow and field experiences of those bodies are valuable assets that could be incorporated into the establishment of the proposed Global Welfare Fund. More importantly, the emphasis on country ownership of the programs and the involvement of civil society in those global initiatives resonate well with the spirit of an equitable and transparent model of global governance.

The underlying philosophy of a well-functioning global welfare system is not to create a culture of dependency and perpetuity in need, but to enable and empower the unprivileged to develop their own capacity and be able to fully participate in the society.



As such, a desirable Global Welfare Fund would direct resources to the receiving countries with a view to develop the productive capacities in their domestic economies and put in place institutions for economic, social and political progress that would allow them to play their respective roles in the international community. The mere transfer of resources without any constructive direction or a purposeful plan of action would not go so far in enabling and freeing the poverty stricken people from the vicious cycle of poverty and dependency. Therefore, what is expected from the well-off countries is not just monetary resources but also contributions in kind, such as technical knowhow, institutional experience and knowledge, organizing and mobilizing skills and so forth. Such support will be absolutely critical during the transitional period of building social and economic infrastructures, institutions, rules and policies for accountable and responsible governance in receiving countries. By the time the transitional period is over, the governments in the worse-off countries are expected to be absolutely responsible for a fair and effective distribution of transfers to priority areas and those with the most need in a transparent and cooperative manner. No global governance can succeed without successful national governance, which in turn, relies on good and effective local governance.

### **BARRIERS TO ACHIEVING GLOBAL HEALTH EQUITY**

The aspiration towards global health equity must identify and understand the existing as well as potential barriers, if it is going to be realized. In what follows we sketch some of these barriers.

#### *Different Political Philosophies and Views of Governance*

As touched upon earlier, coming to a sense of caring for others rests on shared values and common interests that people within a distinct society and geography develop over time. Some nations have been able to come together, help each other and put in place institutions that facilitate a more or less socially acceptable distribution of resources. Others have failed in this regard allowing chronic deprivation, injustice and discrimination. The sentiments of solidarity and social protection that were particularly strong right after the Second World War provided the moral and political support for the creation of welfare states around the western world. In the heydays of the *golden age* of capitalism following the War, a social consensus emerged that we can all prosper and share our prosperity with the less fortunate leading to the rise of significant middle class in western societies. This shared prosperity and social cohesion began to disappear in the 1970s and early 1980s. A discussion of why it happened is beyond the scope of this paper. What is evident is the rise of the conservative political philosophy and governance as manifested for example by the so-called reign of “Thatcherism”<sup>43</sup> in United Kingdom or “Reaganomics” in the United States.<sup>44</sup> At the risk of oversimplification, this political philosophy, which had its roots in classical economics, opted for a *minimal government* and emphasized *individual responsibility*. It placed market allocation at the center of social distribution and began to dismantle the welfare states with varying success in different countries. The outcome of such views and policies has been the unprecedented growth in income and wealth inequality, rising poverty and the polarization of the societies into *haves* and *have-nots* with the shrinking

middle class in between.<sup>45</sup> The implications of such developments for social justice and health equity are enormous. Rising poverty in the face of affluence, increased job insecurity and low wages, deteriorating public infrastructure, ever declining social protection, increased social tension and so on. The impact of the latter on health and health equity is well documented.

At the global level, there have been mixed developments. With the opening of China to the West in late 70s and early 80s, a vast number of people have seen their life prospects rise. Also, the collapse of communism in former Soviet Union and East and Central Europe circa 1990, created renewed hope that the old animosities and political antagonism would go away, giving way to a new era of international cooperation and global solidarity with consequent prosperity for the people of that region.

With continued economic prosperity in India and other emerging economies around the world as a result of opening their economies and adopting market mechanisms, it appeared that the world was converging towards a shared system of values and institutions driven mostly by market forces. Some even were led to believe that history had come to an end.<sup>46</sup> There is no doubt that significant economic progress has been made in China, Russia, India and other emerging economies in East Asia and Latin America, leading to rising average incomes in many countries around the world.

However, the rising tide of global economic prosperity has not lifted all boats. Many countries in Sub-Saharan Africa, South America and South East Asia are still grappling with massive poverty and deprivation. Moreover, even within the countries that have benefited from the new world order and rapid globalization, the distribution of resources and riches has not been equitable. The sudden opportunities and the fast pace of economic growth have advantaged a minority at the top at the cost of deprivation for the majority at the bottom. This has led to increased inequity and greater gaps between the rich and the poor in those countries.<sup>47</sup> Political development has lagged behind economic growth and development, hindering the emerging society's capacity for developing governance institutions and structures for a fair and systematic distribution of economic windfalls.

More disappointing is the fact that a great portion of the newly found economic fortune has been diverted to building up military capacity for future aspirations that are not so well intentioned. With the turn of the century, and more so in recent years, global political tensions are once again on the rise with the disturbing prospects of a renewed arms race and probable military confrontation as is happening in the Middle East and Ukraine.

With widely divergent views on global governance, the chronic divide between the global North and South, significant regional differences in opportunities and challenges and renewed nationalistic interests, the prospect for consensus on a global governance directed at social justice and health equity appears unreachable.

### *Outdated Global Governance Structure*

Much of the current global governance structure was put in place after the Second World War. This structure, for all purposes and intentions, has proven effective in bringing about peace and security for much of the past sixty years or so. It has set up mechanisms for conflict resolution, attracted significant funds for assisting the poor and developing nations, helped bring financial stability and urgent financial assistance to

avoid global financial crises, set up rules and regulation for expanding trade among nations, and more importantly for our purposes here, it has established an organization (the World Health Organization (WHO)) charged with monitoring, managing, assisting and advocating for health around the world.

Since its inception, the WHO has been a progressive voice in defining health and advocating for inclusive approaches to achieve health for all. Much of its efforts in the past reflected the dominant biomedical view of health and have been focused on controlling infectious diseases, securing drugs for poor countries or providing medical relief during natural disasters. More recently, however, WHO has been a global champion for promoting the social determinants of health paradigm and calling for a multi-sectoral approach to health.<sup>48</sup> Nonetheless, WHO like other UN agencies and organizations, is limited in its capacity to garner, mobilize and allocate resources and capabilities for affecting the social determinants of health and improving health equity on a global basis.

We have inherited an outdated global governance structure that has failed to renew itself in view of the massive sociopolitical and economic changes that have occurred around the world. Persistent attempts at reforming the UN Security Council—which is undemocratic and gives veto powers to a select number of countries—have remained frustrated so far.<sup>49</sup> The United States has contributed 22% of the United Nations budget in 2010 and 2011 by way of assessed and voluntary payments, followed by Japan, Germany, United Kingdom, France and Italy who contributed 12.5%, 8%, 6.6%, 6.1% and 5%, respectively.<sup>50</sup> The voluntary funding is not secure and is often subject to the political expediencies of the time. In addition, it comes with the expectation that the funds are used in ways that further the interests of the funding countries. This has led to unfortunate but expected outcome that many global objectives such as Millennium Development Goals (MDG) remain under-achieved.<sup>51</sup> Inadequate funding, mismanagement of the funds and lack of a proper global governance and control are among the reasons for underachievement. Many of the goals listed in the MDGs, if achieved, would have been a tremendous help in furthering the cause of social justice and health equity.

Finally, a potential barrier to forming a globally representative body of people from various countries to perform as guardians of the Global Welfare Fund is the likely possibility of having representatives from individual (mostly developing) countries that may not be true representatives of their countries, especially when appointed by undemocratic countries. The latter once again underscores the necessity of good national governance for good global governance.

## **A WAY FORWARD**

Constructive social change is incremental by nature, as it takes time to register support and commitment, plan ahead, mobilize resources and implement the plan into action. A key initiative for constructive change, advocated by a global coalition of civil society and academics—the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)—is calling for a Framework Convention on Global Health (FCGH). This global initiative, which originates from the normative standpoint that the right to health is a human right, draws upon international law to establish a legal framework for global commitment to improve health and reduce health

inequities.<sup>52</sup> The FCGH is seizing the opportunity of the upcoming planning for the post-2015 MDG by the United Nations (UN) and is offering a number of modalities that are considered to improve health and reduce health inequities. The suggested modalities include 1) defining national responsibilities for the population's health; 2) defining international responsibilities for reliable, sustainable funding; 3) setting global health priorities; 4) coordinating fragmented activities; 5) reshaping global governance for health; and 6) providing strong health leadership through the WHO.<sup>53</sup> The proposed modalities center around governments' responsibility, transparency and accountability in a cooperative environment with the key normative objective of recognizing the right to health for all and doing all that is possible to reduce health inequities. The FCGH is said to be similar in approach to the UN Framework Convention on Climate Change or WHO Framework Convention on Tobacco Control, which is flexible enough to "allow states to agree to politically feasible obligations, saving contentious issues to later protocols."<sup>54</sup>

Although improving global health and reducing health inequities needs to be a multi-prong global undertaking by the entire global governance structure, the advocates of FCGH consider the WHO as the most effective conduit for this global initiative. In Burris and Anderson's words, "WHO's record in influencing international and national policy and practice compares very favorably with that of a wide array of human rights and development bodies charged with promoting social justice under the UN system."<sup>55</sup> The WHO through the powers granted to it by the WHA [World Health Assembly] and supported by the array of global, national, and local health institutions, has the legitimacy and authority to create 'constitutional' instruments in the broadest sense of the term.<sup>56</sup>

The FCGH initiative can be considered as a stepping-stone towards a global health governance model that appeals to human rights and international law for promoting health and reducing health inequity worldwide. It recognizes the difficulties of cooperation at the international level and appears to settle for a minimum of feasible international solidarity to garner a degree of legally binding commitment to global health and health for all. However, it runs the risk of becoming yet another "Convention" to which certain countries do not feel obliged and seek exceptions from its terms. Also, its limited focus on health (as an outcome) may detract attention from the underlying determinants of health that are imbedded in the unjust social and economic circumstances of many countries around the world. To address the underlying determinants of health, we need to redistribute international and national resources to achieve a fair distribution that is so critical for health and health equity. The proposed Global Welfare Fund, recognizes this fundamental need for redistribution, and as such, is a more comprehensive and bolder suggestion than the FCGH.

## CONCLUDING REMARKS

Improving health and reducing health inequities is a chronic but urgent global issue that deserves the attention of all nations and all people concerned with a better life for all human beings. Therefore, appeals to humanity, social responsibility, distributive justice and human rights are powerful normative perspectives that unite and guide efforts for achieving health equity at local, national and global levels.

This paper argues that providing effective healthcare for all and addressing the underlying political, socioeconomic and environmental determinants of health are additionally justified by viewing health and healthcare as a common good, both in its narrower sense of an important *public good*, as well as its broader notion of *something that is good for all*. People, in general, happen to be more alarmed by the imminent threat of a new flu virus out of fear of contagion. Unfortunately, they are often oblivious to the much more profound risk of social inequity and its far-reaching implications for health inequity, sociopolitical tensions, global insecurity and environmental unsustainability.

The legacy of welfare states in various countries indicates that societies that take care of each other through a redistributive fiscal mechanism enjoy better health and less health inequity. We argue that adopting a similar mechanism (e.g. through a global welfare fund) for a sustainable and equitable financing of global health issues would be a desirable step forward in promoting global health and health equity.

As a matter of political feasibility, mobilizing societal resources, both public and private, for putting health and its inequitable distribution on the global agenda, and demanding practical commitment on the part of all nations and governments for improving the health of their populations and reducing health inequities—like the FCGH initiative seeks to achieve—is a welcome effort for the common good. And yet, we seem to have a long road ahead of us to attain the global governance that has the *moral authority* for the common good and is *effective* in delivering health for all in a fair and equitable manner.

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<sup>1</sup> Cited in H. S. Harvey, B. Dahlby, R. S. Smith and P. Boothe, *Public Finance in Canada*, (Toronto: McGraw-Hill Ryerson, 2003).

<sup>2</sup> Typical among such countries are those with an Anglo-Saxon liberal tradition like US, Canada, Australia and UK.

<sup>3</sup> These are typically countries with a social democratic political tradition such as Scandinavian countries in Northern Europe and to a lesser extent those with a Bismarckian welfare tradition.

<sup>4</sup> See for example, T. McKeown, *The modern rise of population*, (New York: Academic Press, 1976); T. McKeown, *The role of medicine: Dream, mirage, or nemesis?* (Oxford: Basil Blackwell, 1979); R. Fogel, New findings on secular trends in nutrition and mortality: Some implications for population theory, in *Handbook of population and family economics*, M. Rosenzweig and O. Stark (eds.), (Amsterdam: Elsevier Science B. V. 433-81, 1997).

<sup>5</sup> See for instance, S. Szreter. "The importance of social intervention in Britain's mortality decline c. 1859-1940," *Social History of Medicine*, 1, no.1, (1988): 1-37; D. Cutler, A. Deaton and A. Lleras-Muney, "The determinants of mortality," *Journal of Economic Perspectives*, 20, no. 3, (2006): 97-120; D. Cutler and G. Miller. "The role of public health improvements in health advances: The 20<sup>th</sup> century United States," *Demography*, 42, no. 1, (2005): 1-22.

<sup>6</sup> Among the pioneering work, those of E. M. Kitagawa and P. M. Hauser. *Differential Mortality in the United States: A Study in Socio-economic Epidemiology*, (Cambridge, MA: Harvard University Press, 1973); A. Antonovsky. "Social class, life expectancy and overall mortality," *Milbank Memorial Fund Quarterly*, 45, (1976): 37-73; D. Black. *Inequalities in Health, The Black Report*, (London: DHSS, 1980); G. Rose. "Sick Individuals and Sick Populations," *International Journal of Epidemiology*, 14, no. 1, (1985): 32-38; M. G. Marmot et al. "Health Inequalities among British Civil servants: The Whitehall II

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<sup>13</sup> WHO (1978), *Declaration of Alma-Ata*, International Conference on Primary Health Care, (Alma-Ata, USSR: WHO), available at [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf), accessed June 2014.

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<sup>18</sup> T. Irwin, *Aristotle: Nicomachean ethics*, (Indianapolis: Hackett Publishing, 1999).

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<sup>20</sup> J. P. Ruger, *Health and Social Justice*, (New York: Oxford University Press, 2010).

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<sup>24</sup> Ibid. at p.3.

<sup>25</sup> L. R. Kass, *Toward a More Natural Science*, (New York: Free Press, 1985).

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<sup>28</sup> Ibid. p. 13.

<sup>29</sup> K. F. T. Cust, "Justice and Rights to Health Care," *Reason Papers*, 18, (1993): 153-168.

<sup>30</sup> Ibid. p. 155.

<sup>31</sup> Ibid. p. 157.

<sup>32</sup> D. Gauthier, *Morals by Agreement*, (Oxford: Clarendon, 1986), p.10.

<sup>33</sup> L. Gostin, *Global Health Law*, (Cambridge: Harvard University Press, 2014).

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# **Global prescriptions and neglect of the “local”: What lessons for global health governance has the Framework Convention on Global Health learned?**

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*The Framework Convention on Global Health comes amid wider recognition of health inequalities and several recent calls for greater democratization of the world order. The framework suggests wider consensus on principles of human rights, equity and justice in addressing global health. In this paper, we draw on our empirical research and wider literature to discuss the lessons learned from the application of global “ideas” and “innovations” and reveal institutional and political processes and structural constraints that affect their implementation. We present our approach on the basis of two key arguments. First, gross inequalities and unequal distributional effects of the current global political and economic environment do not offer a level playing field for nation states to translate principles enshrined in the framework into practice. Second, such a “view from above” undermines processes of empowering communities to create responsive health systems. Through a case vignette of the People’s Health Movement, we then discuss substantive ways to facilitate local ideas and action.*

## **INTRODUCTION**

Several calls for a global movement and “planetary action” for health equity have been issued in the recent past.<sup>1</sup> These respond to an on-going crisis in global health, which is characterized by growing social and health inequities within and among nations, increasing trans-border threats of disease outbreaks, and dominance of perverse market forces,<sup>2</sup> making public health incidental to trade and economic growth.<sup>3</sup>

Concerned with persistent indefensible differences in life chances of a child born in Sub-Saharan Africa and another in North America, the global health community is drawn into discussions on what might a post-2015 development agenda look like. As debate on the much touted ‘Sustainable Development Goals’ gathers heat, global health actors are unified in their desire to explore solutions to contemporary challenges in global health. One such proposal, the Framework Convention for Global Health, would create a global health treaty advanced by a coalition of academics and civil society members, namely the Joint Action and Learning Initiative. The framework responds to concerns about fragmentation of the global health system and the weakening of the World Health Organization and other institutions charged with global governance.<sup>4</sup> Endorsed by the UN Secretary-General, the framework purports to “reimagine global governance for health” as structured around human rights, equity and justice, and legally bind governments to standards that catalyze accountability and guarantee inclusive participation. It establishes clear goals in response to seven “grand challenges in global health” identified as struggling leadership, inadequate and volatile funding, poor coordination, neglected priorities, reduced accountability, and insufficient intersectoral influence<sup>5</sup>. These goals include increasing government health spending for domestic and external needs, re-setting global governance arrangements for

health through incremental protocol negotiations, and realizing the human right to health by clarifying the necessity of universal health coverage. The proposal has garnered wider support on national and global responsibilities for health, due to its transformative intent in reforming global health governance. The framework is not without its critics. Several concerns have been articulated, not least about the ‘unintended’ consequences likely to result from its implementation. Critics draw attention to direct and opportunity costs of such international law, mainly reducing possibilities of political dialogue, imposing foreign values and externally defined goals on less powerful nations, prioritizing individual rights over issues that merit population-wide responses, and offering sub-optimal solutions for challenges to global health.<sup>6</sup> In addition, these scholars argue that framework proposals, through development of new protocols, structures and obligations, duplicate efforts and undermine existing human rights treaties. Of significance are conflicting mandates of the regime likely to implement the framework and the functions and mandate of the World Health Assemblies. Such tension is likely to contribute to weakening the WHO although the proposal recognizes its centrality to the Framework’s governance architecture.

The unparalleled interest received by this proposal brings to the forefront historic debates on universalist vs relativist paradigms for development. There are important questions to be asked about how such rights-based frameworks in global health can be operationalized given the conceptual ambiguity around what constitutes ‘global health’<sup>7</sup> and its varied use, both descriptive and prescriptive.<sup>8</sup> Also, what are the limits in its application in a non level-playing field marked by significant geo-political, economic and historical differences? Lastly, these debates must facilitate critical reflections on why historic milestones in global health such as the promises of Alma Ata and other conventions /declarations did not bear fruit. In this paper, we ask some of these fundamental questions by drawing on our empirical research on international health systems and policy to reflect on what we stand to gain and lose from applying universal prescriptions to improve ‘global health’. We first present a brief account of the global health governance landscape, and the scholarship defining it, in order to illustrate the unprecedented growth in the quest for normative frameworks for good governance. Through two case vignettes we then explicate the contestations and implications of applying ideas without critical reflection on their normative underpinnings, the processes through which institutional arrangements are mediated, and their underlying structural and contextual determinants. These, we argue, are important lessons to be learned from history with implications for the application of the Framework Convention on Global Health.

## **GLOBAL HEALTH GOVERNANCE AND ITS QUEST FOR NORMS, IDEAS AND VALUES**

Global Health Governance is a rapidly expanding field of scholarship. The term, coined by Dodgson and colleagues,<sup>9</sup> emerged amid growing recognition of the impact of globalization on health determinants and outcomes and the arguable limits of nation-states in determining matters transcending national frontiers.<sup>10</sup>

For the purpose of this paper, we restrict the study to describing key characteristics of the concept and discussing its normative dimension. We adopt the conception of Global Health Governance as a complex open adaptive system,<sup>11</sup> but also as a “process of contestation”<sup>12</sup> between a variety of different ideas and discourses, each of which takes a particular approach to health and generates certain policy responses. Global health governance can thus be defined in terms of its key

constituents, namely i) architecture and organization (or the lack thereof) with multiple actors, their transient relationships, and complex networks they are embedded in; ii) core functions; and iii) normative ideas and frameworks that create paradigms for investments in health.

*Governance ‘architecture’* is the “overarching system of public and private institutions, principles, norms, regulations, decision making procedures and organizations that are valid or active in a given issue area of world politics”.<sup>13</sup> The contemporary governance architecture is characterized by an ‘unstructured plurality’,<sup>14</sup> whereby new actors emerge/ are created (for example, 120+ global health initiatives that provide a substantial portion of funding and products) while pre-existing actors (e.g. World Bank, private foundations, NGOs) re-define or carve out new roles for themselves in health. This has re-configured the political space for global health; first, the focus of decision-making is shifting as power is getting dispersed from G8 concentration to growing economies and regional powers represented by the G20 (especially emerging economies), and the recently founded G7+1.<sup>15</sup> While this shift challenges the broader political/institutional relationship of power (and strengthens southern nation-states,<sup>16</sup> including those perceived as ‘fragile’), in itself it does not trigger equity in health. Rather, as some have argued, health priorities are becoming secondary to finance, trade and security objectives.<sup>17</sup> Second, greater engagement with non-state actors has undermined legitimacy of the state, across several functions of governance including agenda setting, enabling dispersion of power and decision making among multi-lateral institutions. Global health governance literature is deficient in examining state sovereignty and growing legitimacy of non-state actors vis-à-vis the roles and functions of governance. Peter Haas purports that “effective governance rests on the performance of multiple governance functions”,<sup>18</sup> formally or indirectly performed. He outlines 12 core functions of governance, from agenda setting and issue linkage to monitoring and capacity building (through technology and skill transfer), and maps these across diverse actors while evaluating their performance. The Framework Convention does not offer insights into how either the international community or nation-states (constituencies cited) will perform these different functions, and how a human rights framing can affect such division of task.

### *Normative ideas and frameworks towards ‘good’ governance*

Several proposals have been put forward to correct deficiencies inherent in the existing global health governance system and the vagaries of international development assistance in health. Some call for transformative changes to redress the “unconscionable health gap”<sup>19</sup> (e.g., Global Plan for Justice); others propose strengthening of existing institutions, for example, through formation of Committee C of the World Health Assembly<sup>20</sup> or the creation of new entities (e.g., a Global Fund for Health). Proposals seek to either address cross-cutting challenges facing the global health community (e.g., UN Global Health Panel) or target specific policy areas and constituencies to ensure equitable drug development and distribution (e.g., Health Impact Fund for incentivizing pharmaceuticals) and achieve sustainable and ethical economies (UN Global Compact for businesses). Notably, the latter

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<sup>1</sup> The G7+ established a new foundation for collaboration between 20 fragile states, donor nations and other global governance structures focused on state building and peacebuilding, based on the principles of the Paris Declaration on Aid Effectiveness.

agreements are premised predominantly on mutual advantage and cooperation strategies.

This persistent quest for innovations in institutional arrangements and approaches to managing the externalities arising from intensive cross-border flows have come to define the global health governance system and produced a *complex mosaic of institutions*,<sup>21</sup> often with overlapping norms and constituencies. These innovations take a variety of forms: i) regulatory “trans-border-agreements” to protect health, for example formal instruments such as the Framework Convention on Tobacco Control (FCTC), International Health Regulations (IHR); ii) technical interventions and technological silver bullet solutions to global health problems<sup>22</sup> that are often determined by institutions (such as the Gates Foundation) largely with representations from HICs; iii) new funding mechanisms and incentives to correct resource scarcities and low prioritization of specific health problems, which have given rise to a number of disease-specific and product development partnerships that are perceived to enhance ‘country ownership’;<sup>23</sup> and iv) application of unifying international principles for achievement of ‘good’ global governance. While there is no consensus on conceptions of ‘good’ governance and therefore principles to attain it, the hegemonic ‘problem solving’ discourse tends to focus on creating structures to enhance administrative efficiency and management<sup>24</sup> to correct perceived governance failures defined primarily in terms of corruption, transparency and accountability problems in fund utilization and procurement /supply chains as well as those emerging from uncoordinated action.<sup>25</sup> These principles are embraced by mechanisms adopted by complex configurations of state and non-state actors and their assemblages into ‘public-private partnerships’ to steer achievement of public health goals.

There is a simultaneous resurgence of interest in equity, rights and social justice as the basis for health investments and programming, and more broadly in reshaping substantive ways in which ‘the system beyond governments’ be governed.<sup>26</sup> These notions of solidarity and justice are taken up by all, albeit with varying degrees of acceptance and incremental or piecemeal approaches.<sup>27</sup> These developments occurred in the context of wider support by donors and global actors, and in the last decade, to more integrative modalities of aid such as sector wide approaches, poverty reduction strategy papers (PRSP), and direct budgetary support, although these make greater use of economic frameworks in decision-making.<sup>28</sup>

Scholars offer a range of economic and political explanations for the failures of global health governance<sup>29</sup>. However, few address how these factors are maintained and reinforced by existing approaches. Critical scholarship, albeit limited, questions structural inequities, power imbalance and ethical foundations of global health governance calling for transformative shifts<sup>30</sup>. As well as material power, popular policy ‘innovations’ are shaped by deeply entrenched ideas or *frameworks of thought*,<sup>31</sup> both of which must be examined for a careful assessment of the contemporary field of global health governance.<sup>32</sup> One such hegemonic idea structuring this field is that of *neoliberalism*, which has evolved over a period marked by economic, political and financial crisis and shrinks any alternative policy space and sites of resistance.<sup>33</sup>

Neoliberalism serves as the overarching logic for several contemporary paradigms and framings of the global health and public policy agenda. Rushton and William<sup>34</sup> articulate three ways in which neoliberalism shapes global health policy: first, through the roll back of the state, thus dispersing power across a wider range of both public and private actors, and second by promoting the uptake of a series of policy preferences by powerful actors, notably the international finance institutions

who apply these across countries through a variety of mechanisms. These policy preferences underscore liberalized and privatized health care systems and economies, and explain current policy trends. Neoliberalism shapes global health policy in a third way by colonizing many global health paradigms and concealing the macro-economic, political, and social determinants of health. Initiatives and conventions designed to enable coherence (such as IHP+, Health 8, Paris declaration) have gained traction. However, these remain focused on vertical program delivery in countries, with limited attention paid to upstream drivers of health concerning changes in agriculture, trade, and other policy sectors.

We illustrate these pathways through specific examples of reform attempts within the global health system; through principles of participation and human rights; and the policy approach of health systems strengthening. We present two case vignettes that demonstrate contingencies of practice and the extent to which the hidden transcript of policy innovation and its underpinning principles depart from the public transcript. A third case study then illustrates a case of organic bottom-up reforms that have both normative and substantive impact in health governance.

### **CASE VIGNETTE: GLOBAL HEALTH INITIATIVES’ TRYST WITH RIGHTS AND EQUITY**

Global health initiatives (GHIs) have assumed dominance within global health policy networks<sup>35</sup> and are regarded as the backbone of the global response to HIV.<sup>36</sup> In particular, the Global Fund, PEPFAR, and GAVI Alliance, together with new philanthropies, namely the Gates Foundation, are credited for leveraging unprecedented amounts of financial resources for the roll-out of large scale treatment programs, especially ARV and other life-saving therapies, and associated with a significant reduction in rates of new infections and associated mortality.<sup>37</sup> Notwithstanding these gains, GHIs came under severe criticism for their unintended consequences (fragmentation, competition, misalignment with national/ local priorities) implicating already weak health systems.<sup>38</sup> Responding, in part, to these criticisms as well as growing policy consensus on aid effectiveness, a number of more prominent GHIs have embraced the Health Systems Strengthening (HSS) agenda.<sup>39</sup> Such renewed commitment to health systems, and more recently human rights,<sup>40</sup> comes amid international debates on the trade-offs between vertical programs and integrated health care; short-term health goals (and provision of life-saving therapy) and building sustainable health systems. It is reflected in recent strategic frameworks of GHIs such as the Global Fund, GAVI Alliance and in program priorities endorsed by other global health actors. A recent assessment of the Global Fund’s Round 8 grants shows that 37% (US\$ 362 million) of funding in Round 8 was devoted to health system strengthening.<sup>41</sup>

Viewed as a positive development in the fractured global health system, GHIs embracing “the health system action agenda” (WHO 2006) has been argued to be “putting to rest the longstanding debate of vertical vs horizontal approaches”.<sup>42</sup> However, recent evidence reveals significant departure from the rhetoric supportive of holistic health systems. Storeng<sup>43</sup> illustrates how by adopting the above rhetoric, GHIs and the World Bank have captured the global debate about HSS in favor of their specific ethos and single-minded focus on vaccines or specific diseases. Through ethnography of GAVI, Storeng reveals how its support to HSS is partly conditional on a set of targets for immunization/ vaccination coverage. Although the HSS strategy espouses the principles of aid harmonization and country ownership, in practice, any proposals for mitigating negative health system effects arising from their grants (such as reducing reporting burden by adhering to country systems)

were dismissed. In effect, the systems approach was reduced to strengthening the components needed to achieve disease-specific goals; suggesting a significant departure from the comprehensive vision and legacy of the Declaration of Alma Ata. Globally, the power and political expediency enjoyed by global partnerships such as the GAVI Alliance and large philanthropies backing these have led to an “ideological convergence around the so-called ‘Gates approach’ to global health”,<sup>44</sup> whereby, as typical of the techno-managerial paradigm within global health, debates on health systems are re-cast as technical debates about healthcare and product delivery systems. These findings resonate with our country level research on the *governmentality* of the Global Fund and contracting experiences in health systems of fragile states.

A simultaneous resurgence of interest in the principles of *rights and social justice* as the basis for health investments and programming can be seen since 2009. Arising in part from recognition of the failure of neoliberal health reforms adopted in LMICs to reach the most poor and vulnerable,<sup>45</sup> these principles have made their way into public transcripts of several global health institutions. However, where principles of human rights and social justice have been included, they have been molded into existing approaches, as evidenced by the new funding strategy of the Global Fund, which incorporates human rights in a narrative structured around i) more rigorous performance based funding, ii) fiduciary risk management, whereby aid is granted on the basis of recipients’ rankings on international benchmarks of good governance; and iii) financial austerity emphasizing value for money.<sup>46</sup> Critical evidence on global health initiatives has emerged globally as well as in countries such as India, South Africa, Zambia, and Peru. This evidence is examined below to highlight how principles of partnership, participation, and human rights are translated at the national level and into local practices, and the extent to which these transform global governance.

The term partnership implies collaborative development and implementation of policy with community involvement, consistent with principles of good governance.<sup>47</sup> However, partnership is being effectively used, at the global level, by powerful commercial interests to gain a seat at the decision-making table, while marginalizing less powerful communities and voices. Global agencies unequivocally seek civil society representation and *participation* as a gateway to enhanced representation, transparency and accountability,<sup>48</sup> the three tenets of reforming and democratizing the global health system. However, decision making in their governing bodies continues to be skewed with the private sector ‘over represented’ despite their modest contributions, and the WHO and civil society constituency under represented.<sup>49</sup> The Global Fund has been at the forefront of this debate. At the country level, through its structures including country coordinating mechanisms, the Global Fund is credited for fostering country ownership and creating space for participation of sections of communities hitherto marginalized in the political process, such as men who have sex with men in China or people who use drugs.<sup>50</sup> However, detailed analysis and ethnography of the *governmentality* of the Global Fund in India revealed how grant disbursements and management structures steer the direction of program priorities, privilege donors, NGOs and national elite networks over grassroot initiatives in decision making forums,<sup>51</sup> reinforcing the democratic deficit characteristic of the contemporary global health governance landscape.

Evidence from other countries corroborates these findings and suggests that the pursuit of goals of participation and rights by global health actors has been tokenistic. Entry of the Global Fund and the authority of its protocol have

transformed HIV governance in various ways. Studies suggest that annual grant making calls resulted in a proliferation of consortia with sometimes overlapping objectives and activities competing for funding and legitimacy in country level policy and governance. While some local groups received greater visibility and leverage to influence national policies, they were simultaneously exposed to inflexible funding and associated conditionalities. Pressures for scale-up, demonstrating achievement of targets (such as improvements in adherence rates) through computerized information systems resulted in opportunism and manipulation at facility level, loss of social capital, and a shift from more critical and political to technical and managerial discourses.<sup>52</sup>

### **CASE VIGNETTE: OPERATIONALIZING THE POLICY INNOVATION OF CONTRACTING OUT IN CAMBODIA, A ‘FRAGILE’ STATE**

Greater attention to ‘fragile states’ began in the late 1990s with a concern that ‘good governance’ and aid effectiveness agendas had overlooked situations of conflict or weakly governed states.<sup>53</sup> Such states are considered to “lack the *functional authority* to provide basic security within their borders, the *institutional capacity* to provide basic social needs for their populations, and/or the *political legitimacy* to effectively represent their citizens at home or abroad.”<sup>54</sup> The fragile state concept, now normalised and applied to many diverse situations, was mainly “intended to guide the interactions and relationships between donor countries and recipient countries facing conflict and poverty”.<sup>55</sup> In these situations, the donors are in the driving seat, a predicament acknowledged by Akwetey,<sup>56</sup> who states: “fragility involves a heavy dependence on external assistance in the spheres of political, economic and social governance.” The policy of ‘contracting out’ as a mechanism for the delivery of public health services has been widely applied in fragile states such as Afghanistan, Cambodia, the Democratic Republic of Congo, Rwanda and South Sudan.<sup>57</sup>

In Cambodia, the institutional, technical, and management capacity of the health system, at the end of the war in 1991, had deteriorated significantly, particularly with the dramatic loss of many professionals to the years of genocide and on-going war.<sup>58</sup> From a recent life history study with Cambodian people regarding episodes of illness, deaths and births of participants to the years of genocide and on-going war,<sup>59</sup> it was apparent that many had relied solely on self-medication and indigenous practitioners for much of the period up to 2000.<sup>60</sup> Given these constraints and the urgent need to re-establish a functioning health system, it appeared sensible—to the donors—to introduce contracting into the public health system in ‘partnership’ with the state, particularly where the contractors were well-known international NGOs with established track records in Cambodia and other fragile states.<sup>61</sup> Introduction of contracting in fragile contexts often allows states with limited institutional capacity to deliver health services within a relatively short period of time,<sup>62</sup> addressing health care needs of the local population. The trade-off is that state mechanisms may be bypassed by donors and contracting agencies, anxious to achieve relatively quick returns in terms of health coverage. This potentially undermines the much longer-term process of re-engaging citizens and the government through a ‘social contract’ with the public.<sup>63</sup>

In fragile states, posing the problem in terms of expanding health coverage alone presents tensions with the wider objectives of state-building and peacebuilding, considered by several<sup>64</sup> as core processes in re-establishing effective services. The tensions arise from different perspectives on what should be prioritised – universal health coverage delivered by non-state actors, or rebuilding the

legitimacy of the state. Fritz and Menochal<sup>65</sup> suggest that the legitimacy aimed for in fragile states is often normative, and does “not derive from its ability to produce outcomes (including economic growth and service delivery), but rather rests on a principled commitment to the democratic process.” Kruk et.al<sup>66</sup> suggest a more instrumental legitimacy calling for specific attention to the health system’s political, social and capacity-building functions when designing the strategy for its rehabilitation as it “may help national governments and international development partners to harness the potential gains in social cohesion and rebuilding of trust that are critical to state-building.”<sup>67</sup> The contracting model, introduced and implemented by external agencies and contractors, however, produces limited accountability to either the state or the population, and facilitates an ongoing “condition of aid dependence”<sup>68</sup> and donor surveillance.

Baird and Hammer<sup>69</sup> have documented how the policy on contracting-out was designed poorly for the circumstances of the remote North-East province of Ratanakiri in Cambodia. Ratanakiri was selected for inclusion in the second stage of contracting-out on the basis of its high levels of poverty and vulnerability. Following the health system strengthening policy introduced in 1996, operational districts were created across Cambodia, covering between 100,000 and 200,000 people; in the weaker operational districts, a policy of contracting-out to international NGOs was implemented to try to achieve wide coverage of the population with a ‘Minimum Package of Care’. An innovation in the Cambodian experience was the introduction of the Health Equity Fund (HEF), which aimed not only to offset the charging of user fees on the poor,<sup>70</sup> but to cover transport, food and related costs.<sup>71</sup> In Ratanakiri, the HEF component was under-financed as the contract designers had failed to recognize the higher proportion of the population that would qualify, and had to be suspended.<sup>72</sup> The project design also failed to recognize that the social relations of indigenous groups in Ratanakiri tended not to be mediated through cash transactions leaving user fees an extremely unpopular mechanism for health care funding. Equally excluding were the communication difficulties between Khmer speaking health staff and the population’s more prevalent indigenous languages. Narrow measures of program ‘success’ failed to capture the breadth of health sector activities; for example TB services were not incentivized, and consequently appeared to be neglected. Neither did the contractor fully engage in building the capacity of local state health actors, considered a central component of the stated model; for example, the health budget of the international contractors was not revealed to them, leaving a critical gap. Of particular concern, Baird and Hammer found no evidence of a sophisticated understanding of local realities when establishing the contracting arrangements; they describe lip service to the requirement for participatory planning mechanisms by which implementers might have developed useful learning, and document a lack of effort of the implementing NGO to build capacity in the operational district.

Couched under the systems strengthening agenda, the contracting experience of Cambodia has been widely viewed as successful innovation, premised on analyses of national household surveys, and experience in a few specific sites. On the basis of this evidence, there has been widespread enthusiasm for the rolling out and scaling up of a generic model. However, the evidence cited above suggests, there is insufficient recognition of the specifics of contexts into which global policy models have been rolled out and scaled up which is likely to be detrimental to the populations of regions distinctly different across diverse contexts. It is evident that health system interventions in fragile states often follow similar templates in



situations “qualitatively different from one another, with unique problems that often require novel policy responses.”<sup>73</sup>

### **THE (DIS)CONTENTS OF FCGH AND THE RISK OF SUBVERSION OF THE RIGHT TO HEALTH**

The two case vignettes presented above focus on distinct ideas of policy ‘innovations’ that are couched in progressive conceptions and normative goals of attempted health systems and governance reform in diverse social, economic and political realities. The first draws on emergent scholarship on critical ethnographies of GHIs (including the primary author’s research) that examine the contested social processes through which local effects of global policies are produced, and legitimized. This body of literature opposes the dominant view that “local” effects are “unintended consequences” of well-meaning global health actors, and challenges the perceived neutrality and desirability of such initiatives.<sup>74</sup> In the dominant view, any failures arising in countries are credited to inefficiencies in decision making, resulting from weak governance and ill-defined hosting arrangements at country level<sup>75</sup> and to the dynamics of “open source anarchy.”<sup>76</sup> Extending this argument, reform in global health governance is likely to be achieved through creation and/or endorsement of policy innovations towards a more centralized, harmonized regime (through aid effectiveness, systems strengthening, and principles of rights and justice), as also suggested by the Framework. Instead, we argue that these failures are inevitable outcomes of structures that are underpinned by the logic of competition and embedded in a neoliberal discourse. For example, studies examining the GHIs in India, Namibia, South Africa and Zambia illustrate how grant disbursement structures, and the push for rapid scale-up and performance- and target-based approaches foster competition. This serves to reproduce power asymmetries and differences between international and local, for-profit and non-profit entities, and affect the most disadvantaged. The latter is evident in the second case vignette, which examines how the wider health systems strengthening debate, and its specific proposal of “contracting out” to extend coverage, plays out in Cambodia, a context reflecting political, institutional and social fragility. In this context, adoption of health equity and participatory proposals within an externally developed and implemented program did little to prevent further weakening of a system hollowed out through decades of colonialism, political conflict, and macro-economic reforms. Nor did the presence of “global” implementers, who were aware of “constraints such as language, culture, poverty and access”<sup>77</sup> routinely faced by the indigenous population, alter their program in ways that would reduce their exclusion from services and guarantee their “right to health.” The potential to build capacity and local ownership, to re-engage with the public health system by both health workers and local population, was thus undermined.

Against this backdrop, despite its commitment to proposals with a redistributive intent, the proposed Framework is implicated in some fundamental flaws. We discuss these below.

#### *Rationale*

The Framework Convention on Global Health is premised on the success of two binding multilateral treaties: the IHR and the FCTC. These, arguably, demonstrate the “potential of hard law to improve health outcomes,” albeit with inconclusive evidence on how policy changes facilitated by the treaties affected health outcomes in

countries, nor the nature of civil society engagement these evoked. The proposal recognizes their singular focus and limitations in addressing key social determinants of health and establishes the insufficiency of ‘soft law’ (codes and declarations) for ensuring global health justice, making a compelling argument for a broader framework that allows a marriage of the two to achieve this.

While the Framework recognizes key governance challenges (for example, mis-aligned priorities, trade and economic regimes impacting health goals, fund volatility and differential capacities) and their country level effects, the structures and mechanisms producing these are treated as largely unproblematic, and therefore replicative. Global endeavors such as the Global Fund are described as “embodying several key principles of good global governance,” and failures attributed to the ‘voluntary nature of its funding scheme.’ As we demonstrate in the cases above, the key governance threat that GHIs such as the Global Fund present is not the depleting funding pledges but the additional burden their funding mechanisms, parallel systems, and conditionality generate. The cases also illustrate the need for re-orienting the debate on obligations in the multi-level global health system to highlight the responsibility of (and to hold to account) transnational elites. Not only do diseases cross borders and issues have a global genesis, global actors (commercial and non-commercial) influence policy response at the national and sub-national level by leveraging resources and mutually co-producing outcomes through ‘partnerships’ with national elites i.e. wealthy and influential actors who control and/or benefit from maintenance of power in the global health enterprise.

### *Gap between analysis and solutions*

Recommendations proposed for an effective global health governance architecture fall short of the robust analysis of governance challenges developed in the proposal. Onus is primarily put on nation-states in meeting the human-rights based targets, while the role of the international community is limited primarily to managing fiscal deficits. Furthermore, the Framework lays emphasis on a target/ indicator driven approach, which as country studies demonstrate, fosters competition, opportunism, narrow constructions of health system strengthening, and lack of accountability to local populations. Disproportionate attention is given to alternative financing innovations,<sup>78</sup> and channeling funding through the global fund for health is envisaged as the solution to simplify the complex and politically contested landscape of health actors. While the Framework strongly commits to refining priorities locally through participatory, equitable processes, it is not clear how such bottom-up, inclusive processes would operate; nor how this will be distinct from what earlier and ongoing endeavors, such as PRSP and the SDGs, aimed to achieve.

### *Why have transformative proposals and promises of Alma Ata not delivered?*

In their review of the Primary Health Care (PHC) strategy, De Maeseneer and colleagues<sup>79</sup> examine the factors underpinning the failure of Alma Ata. Some of those failures are attributed to the philosophical conflicts between selective and comprehensive primary health care and the presence of ideology over concrete, adaptable practice recommendations. PHC was perceived by many as not only a roadmap to achieving international health equity, but also an approach encompassing social and political reform.<sup>80</sup> In the period immediately following Alma Ata, the wider macro-economic environment propelled by the oil crisis, global recession, and the introduction by development banks of Structural Adjustment

Programmes, shifted national budgets away from social services, including health.<sup>81</sup> As Abhay Shukla<sup>82</sup> highlights in his powerful critique of the Alma Ata Declaration, “however noble the intentions..., these could not be converted into action if the forces blocking the way to ‘Health for all’ were not identified and challenged;” Thus for a reimagined global health governance, its structures and institutions must be fundamentally revamped. Binding nation states to human rights is not sufficient, and far from transformative for global health governance. While states continue to be “normatively and empirically the most appealing primary locus for social cooperation in health”<sup>83</sup> solutions to health problems that are rooted in political and commercial interests demand wider mechanisms for ensuring moral responsibility and remediating harm from actions of global actors (that produce conditions that hinder protection and promotion of individual and population health). It is unclear how the Framework proposes to address one of the key challenges for global health today, i.e. ensuring meaningful accountability, in particular holding corporations accountable beyond proposals for enforcing taxation policies. The Framework instead makes a more significant contribution to strengthening accountability of nation states (and systems) to their people. In the vignette below, we describe an alternative approach to attaining a similar objective.

### **STRENGTHENING HEALTH GOVERNANCE FROM BELOW: THE PEOPLE’S HEALTH MOVEMENT (PHM)**

The World Health Conference in Alma Ata (1978) ended with the promise of ‘Health for All by 2000’. Despite the failure to achieve HFA, the year 2000 marked an important year for advancing equity and social justice in health. At its onset, civil societies across the world mobilized under the umbrella of the PHM to commemorate the goal of HFA and propose an alternative vision and pathway to realize the right to health, resulting in a people’s health assembly (PHA) in Bangladesh in December 2000. As part of this movement, Indian civil society facilitated a country-wide process to examine progress towards HFA in India, which led to the establishment of *Jan Swasthya Abhiyan* (People’s Health Campaign). In the years since 2000, the JSA has emerged as a key policy advocate on health.

At the 25<sup>th</sup> anniversary of ‘Health for All’ in 2003, JSA launched a nationwide campaign on the ‘Right to Health Care’. In collaboration with the National Human Rights Commission (NHRC), JSA held a series of public hearings across India, where violations of health rights (including denial of care, sub-standard care, and failure to address wider determinants such as occupational health hazards) were heard and redressed by a panel. These further informed a national public consultation where over 250 JSA members from 16 states analyzed the content of the Right to Health Care and, jointly with NHRC, developed a campaign strategy to recognize it as a fundamental right, outlining constitutional obligations for the state. Cognizant of the outstanding need to strengthen weak and dysfunctional public health systems in rural India, JSA members became involved in shaping, critiquing, and monitoring the National Rural Health Mission, the country’s flagship health program launched in 2005. In particular, through its strong grassroots networks within states, JSA contributed to strengthening public health systems by empowering communities to be involved in the planning and utilization of these systems through a rights-based framework. Members shaped the community based monitoring (CBM) approach, a mechanism implemented within the mission that aims to strengthen the citizen-state relationship and ensure accountability of health systems. Although CBM continues to evolve as a methodology and in terms of coverage, emerging evidence reveals

tangible contributions to the strengthening of health services. Besides improvements in quality of care, recent independent external evaluations<sup>84</sup> emphasize its potential to empower communities to demand services, and to create positive pressure on the system to become more responsive and accountable. The CBM experience in Maharashtra<sup>85</sup> reported an increase of 18 percent (from 48% to 66%) in the community's rating of health services as 'good' and a decline in the percentage of services rated 'bad' (25% to 14%) over three subsequent cycles of monitoring. Improvements were also observed across specific indicators, for example, immunization services, supplementary nutrition, and use of untied funds by 21 (from 69% to 90%), 33 and 31 percentage points respectively; and PHC level services such as 24-hour delivery, in-patient services, laboratory, and ambulance services. More significantly, qualitative changes were reported in availability, attitudes and practices of health workers (elimination of unnecessary prescriptions and user charges for services) as well as health systems provision of safe drinking water and sanitation facilities,<sup>86</sup> indicating appropriate and “effective coverage” aspired to by the Framework. Further, growing acceptance among health officials of the significance of community-led action has transformative potential for health systems strengthening agendas. The CBM approach, though specific to health services, offers a pathway for extending commitments on universal health coverage to a broader set of social services. Concurrently, another mechanism adopted by the JSA involved successfully lobbying national political parties before the general elections to include the right to healthcare in their election manifestos and commit to an increase in health spending. The JSA continues to be one of the leading overseers of health policy implementation and campaigner for strengthened social accountability processes within health systems in India.

## DISCUSSION

The above vignette reinforces the notion that States have particular ethical obligations to their citizens, and, more importantly, this model of responsibility allocation and social accountability can be invoked through citizen-led action premised on principles of justice and agency. There is growing traction for normative approaches that incorporate voices from the ground and include concepts such as agency and capabilities central to flourishing human lives. For example, frameworks of shared health governance and provincial globalism<sup>87</sup> recognize the need for a consensus on the morality of health, not a top-down world government with coercive powers to compel compliance.

While our thesis departs from the premise of shared health governance, that all actors will aspire towards global health justice, and that chaos is an unintended consequence of their actions, we concur that creating conditions for global distributive justice (and ensuring functionality and morality of global health) requires a multi-level system of, as Ruger argues, “mutually reinforcing governments (nation states) and governance (both global and domestic) and a strong evaluative structure.”<sup>88</sup>

At the country level, citizen-led processes and principles embraced by such normative frameworks such as self-determination and individual and collective agency, hold promise. The Framework recognizes the value of this bottom-up approach but only so far as countering “the opportunist costs of an arduous treaty process”, carving a role for civil society in monitoring the compliance of nation-states to the Framework obligations, and in the process enhancing their access to governments and legitimizing their advocacy roles. This does not resonate with the

emancipatory objectives of bottom-up approaches described above. Moreover, at the global level, mere representation in policies and governing bodies of global health institutions, albeit promising, does not necessarily translate to exercising sovereignty and agency given the power and resource asymmetries. Thus, simultaneously realizing the systems of government and governance (at the global and domestic levels) requires different degrees and explicit instruments to establish harm, causality and evaluate public standards of accountability of state and non-state actors at the global and national levels. Notably, what is needed is an assessment of who is responsible, and thus accountable, for undermining health equity. This necessitates the development of mechanisms of effect and instruments established to shape the public norms (of accountability towards who the global health system is purported to serve) necessary for a normative structure of global health rooted in a theory of justice.

## CONCLUSION

Recently, the WHO Director General declared the West African Ebola crisis a “public health emergency of international concern” underscoring the urgency of coordinated action and the imperative of strengthening capacities and systems of low income states. Amit Sengupta argues that the analysis of factors responsible for concentration of the epidemic in West Africa must go beyond the focus on pathology of the disease to address “the pathology of our society and the global political and economic architecture.”<sup>89</sup> Decades of civil, political and economic unrest (triggered by colonial rule followed by neoliberal economic reforms) have systematically eroded capacities of health systems in low-income countries. Such weakened capacities have created conditions where outbreaks, such as Ebola, fester.

Amid this crisis, the Framework is timely and its call for a new law that binds nation states resonates with anxiety in many areas and constituencies of international relations for governance reform. However, the Framework needs clarity in its purpose. Nation-states are central to any guarantees of human rights to populations, but envisioning the grossest impacts of global capitalism to be solved through technical or legal instruments that hold states to account is misdirected not least because powerful instruments already exist. At the country level, people-led movements have immense potential to realize a rights-based approach to health, build local accountability and democratize power structures, especially decision-making related to how best financial resources be utilized. The task for such a Framework, therefore, must complement these processes by affecting structural and political power mediated by global and transnational elites by holding corporations and global institutions accountable.

The case studies reinforce how global mechanisms adapt poorly to local circumstances, especially in the most poverty stricken parts of the world. There is compelling evidence that global prescriptions of values such as participation, human rights, and accountability have tended to ignore local understandings and ways of ‘doing’ and served to reinforce power and structural inequities. Neoliberalism has increasingly come to frame such prescriptions in global health and is also deeply embedded in institutional behavior, political processes, and understanding of socio-economic ‘realities’. Hence, any alternative conceptions of governance must challenge the values that undermine organic processes of reform, address patterns of power that result from implementing global mechanisms, and contest processes that disadvantage countries and the “global health underclass”. A Framework must be cognizant of how structural and material reality is transformed so that application of

human rights principles do not become another tokenistic exercise, or impede the bargaining position of weaker states in the emerging global order. In contrast to the conceived forceful marriage of emancipatory rights and justice principles with global structures and norms, we conclude that guaranteeing health and social entitlements to people can be achieved through strong citizen-led movements.

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# **A Political Economy of International Health: Understanding Obstacles to Multilateral Action on Non-communicable Disease**

*Sebastian Taylor*

*A key issue for the proposed Framework Convention on Global Health (FCGH) is how to engage with the existing architecture of health governance.<sup>1</sup> Central within this architecture are the International Health Regulations (IHR). Most recently renegotiated in 2005, the IHR are a remarkable achievement of global cooperation; but they embody a vision of global health that is, in practice, unacceptably narrow. The roots of the current IHR lie in the lazaretti of 15<sup>th</sup> century Europe, emerging through the international sanitary conferences of the 19<sup>th</sup> century, and the League of Nations and United Nations (UN) in the 20<sup>th</sup>. As such—notwithstanding accession in 2005 to a wider set of unspecified ‘public health emergencies’—the regulations remain, fundamentally, oriented to the transnational control of infectious disease.*

*The IHR’s emphatic focus on disruptive infectious diseases—and resounding silence on non-communicable disease (NCD)—speaks of a foundational distinction within global health, framed by a neoliberal paradigm of social and economic management. On one hand, infectious disease is constituted as an assault on human society by an exogenous pathogenic nature—a battle in which the protective intervention of the state is not only warranted but mandated. On the other, NCDs are viewed primarily as endogenous to the individual (a combination of genetic and biological propensities manifested through behaviour, lifestyle and consumption choices). For the state to intervene in a similarly protective way would look worryingly like intervention between the individual and their sovereign right to choose how to live. In a world dominated by the discourses of liberal market democracy, such intervention is heavily proscribed.*

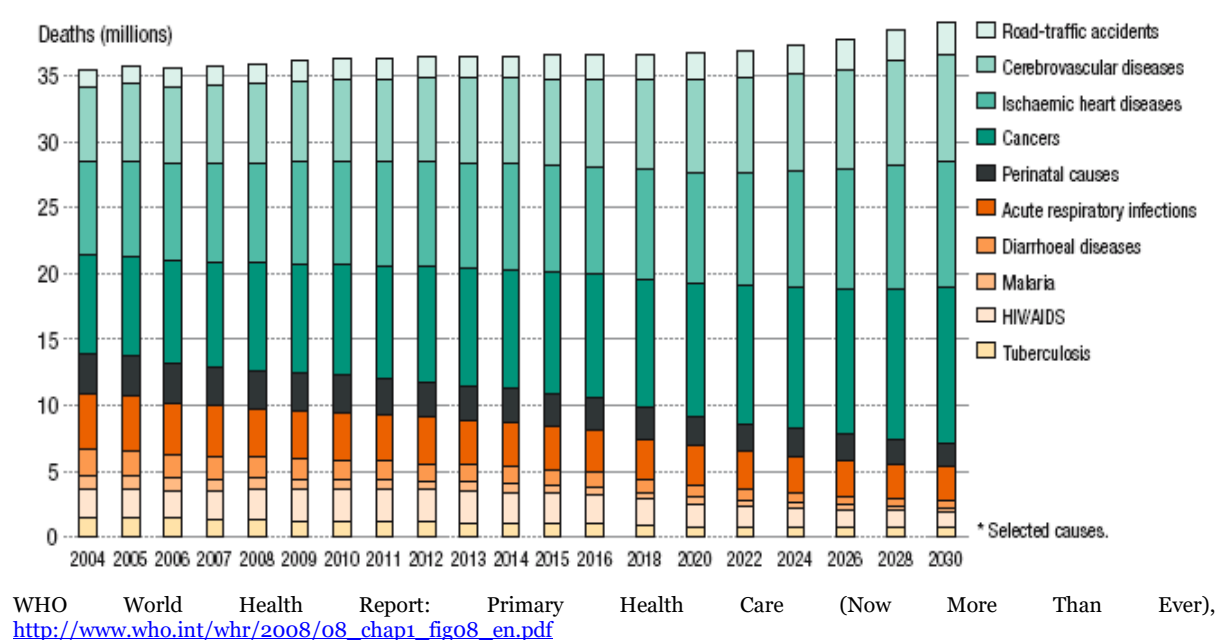
*The projected global epidemiological transition to NCDs, and the overwhelming evidence of the role of economic globalisation, trade, and shifting consumption patterns in this process, must surely now be accorded the status of ‘public health emergency of international concern’ (PHEIC). Commensurately, causally-linked economic and trade policies forged at the global level may be viewed as analogous to transnational pathogens, and subject therefore to an international regulatory framework for health. Such a framework would need to extend considerably beyond the existing IHR.*

## **INTRODUCTION**

The concept and practice of international health is generally construed to be a product of the modern period, forged roughly between the Spring of Nations and the start of World War II.<sup>2</sup> In reality, an inter-national dimension of health has been evolving, in formal terms, for at least five hundred years. But that evolutionary process has manifested and, I argue, continues to manifest an orientation to the idea of health in the transnational space that is interested primarily in infectious diseases, and much less in non-communicable illness.

For the first 450 years, this could be accounted for by the proportional contribution (or understood contribution) of infectious disorders to mortality across countries at all levels of economic and technological development, perhaps as well as by the extent to which scientific understanding and technologies of control and prevention for infectious pathogens far out-stripped knowledge of and capacity to intervene in chronic conditions. Within the last 50 or so years though, the burden of global disease has been shifting decisively in favour of NCDs, as the scale of infectious disease has been reduced in countries at the lower end of the wealth spectrum (Figure 1). In the same period, social and biomedical grasp of the drivers of NCDs from global to local level and corresponding capacity to intervene has escalated dramatically.<sup>3, 4, 5, 6, 7, 8, 9</sup>

Figure 1: The shifting burden of disease and mortality, 2004-2030



Mortality and morbidity associated with infectious diseases remain unacceptably high in many low- and middle-income countries. This is a matter of grave humanitarian urgency, and one that rightly merits the highest level of international attention. It would be unwise, moreover, to underestimate the threat of new or re-emerging pathogens, including in forms with increasing ability to survive current biomedical technologies of control. But it is the class of non-communicable diseases—primarily cancers, heart disease, chronic respiratory diseases, and diabetes, as well as the vast potential reservoir of diagnosed and undiagnosed mental illness—that now constitutes the burden by volume of worldwide ill-health and premature death.<sup>10, 11, 12, 13, 14</sup> Almost two-thirds of the 57 million deaths globally in 2008 were the result of non-communicable diseases—mainly cardiovascular diseases (48%), cancers (21%), chronic respiratory diseases (12%) and diabetes (3.5%).<sup>15</sup> Notwithstanding a tenacious misapprehension that chronic illness is the penalty of accrued wealth in advanced economies, 80% of this mortality occurred in low- and middle-income countries as they move through the stages of socioeconomic development.<sup>16</sup> NCDs are responsible for 60% of regional mortality in Southeast Asia;<sup>17</sup> and even in sub-Saharan Africa, where the concentration of infectious

diseases dominates, NCDs contribute about a third of the continent's burden of disability-adjusted life years (DALY).<sup>18</sup>

Unchecked, the rise of non-communicable diseases does not just threaten the world's wealthy. Nor is the threat confined to health sectors and systems, progressively flattened under an intolerable weight of aging, demand and cost. Epidemic NCDs spreading across low- and middle-income countries threaten to reverse wholesale the hard-won developmental gains made over the entire post-war period.<sup>19</sup> Yet, when one looks to the global level for leadership, one sees an institutional landscape that is curiously uneven. A fundamental etiological distinction—between communicable and non-communicable disease—has resulted, over time, in two quite different tracks of global health governance. One—focused on communicable diseases, and epitomised in the IHR—is relatively advanced though, as I will argue, shaped by the interests of a wider global political economy. The other—for NCDs—remains firmly in the shadows.<sup>20, 21, 22, 23, 24, 25, 26, 27</sup>

The emerging picture of future global disease suggests that there is a need now, as a matter of some urgency, to move beyond that, ultimately artificial, epidemiological balkanisation of health. There is a need to recognise the achievement of the IHR, but to build beyond it—to establish a framework agreement, with a much more significant level of enforcement, that addresses infectious and non-communicable diseases as manifestations of a single human ecosystem, and supports states to work together to identify, understand and address health risks now operating at a global level. To make that argument though, it is important to understand what lies behind the current global political economy of health.

## INTERNATIONAL HEALTH – THE LONG VIEW

The great surge in seafaring mercantilism from the 14<sup>th</sup> century onward brought people and pathogens into a closer proximity in ways that manifested epidemically with speed and devastating effect. The arrival of plague in mainland Europe, both from the south and west by sea and from the east by land, killed upwards of a third of countries' populations and closely followed the contours of transnational trade.<sup>28</sup> The *lazaretti* of the Venetian Republic, established as early as 1423, were designed to protect the citizenry from epidemic disease but, commensurately and arguably as importantly, to protect commerce from the disruptive problems such diseases presented to smooth economic interaction.<sup>29, 30</sup> From the *quarantina* (40-day) controls on the movement of commercial vessels into host harbours, to aggressive control of population movement in villages and towns on major overland trade routes into Russia, an articulation was explicitly forged between control of infectious disease and maintenance and protection of international trading activity.<sup>31, 32</sup>

The spread of cholera from the 'far east' through central Asia into Europe, following well-trodden trade routes and resulting in epidemic outbreaks between 1825 and 1854, was the inspiration behind the series of international sanitary conferences starting in 1851 in Paris that formalised subsequently as the International Sanitary Bureau (ISB). The conferences were led by the US and Europe, with the express purpose of protecting their core economies from the external threat of 'Asiatic diseases'.<sup>33, 34</sup> In spite of burgeoning scientific and policy capacity across Europe in the broader domain of public health science and management, the conferences targeted just three epidemic infectious diseases: plague, cholera and yellow fever – a trio which was to remain at the epicentre of international health over the following hundred years.

The International Sanitary Office of the American Republics (subsequently the Pan-American Sanitary Bureau (PASB)) was established in 1902 with a core mandate for regional malaria reduction and the transnational control of plague, cholera and yellow fever. Although participating states lobbied for attention to be paid to the wider continental conditions of poor maternal and child health, the PASB's agenda remained significantly shaped around the ISB's infectious trio. This may in significant part be attributed to the influence of US hegemonic interest in the region, controlling the diseases that most directly threatened its access to raw materials, as well as strategic interests in extending the infrastructure of intra- and inter-regional trade (intensifying after resumption of the Panama canal construction, closed down some years earlier in part due to loss of labour to yellow fever).<sup>35</sup>

The early years of the PASB demonstrate the emergence of contest over the meaning and practice of health in the international space which can be characterised as a struggle between the *narrow view* (health as an instrumental input to the super-ordinate goal of economic trade and growth); and the *broad view* (health as a comprehensive condition of social well-being, an intrinsic goal of national development). This paper does not argue that the narrow view has emerged whole and uncontested over this period. But it does argue that, where the two visions have confronted one another in and through international institutions, the narrow view has largely prevailed.

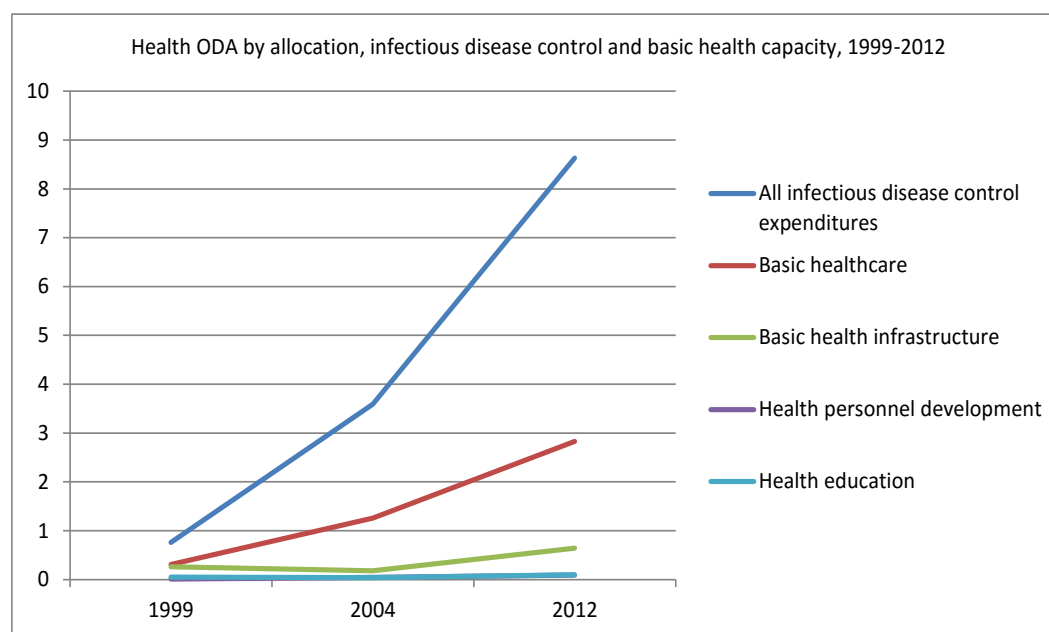
When the *Office International d'Hygiène Publique* (the International Office of Public Health) and the Health Organisation of the League of Nations (LNHO) clashed over the proper remit of international health in the first decades of the 20<sup>th</sup> century, it was the former's concentration on plague, cholera and yellow fever that emerged dominant. The League's aspiration to a wider international health function, including coordination of research into nutrition, cancer and heart disease, was effectively quashed, not least by the decision of the United States to withhold its endorsement.<sup>36</sup>

From its founding in 1948, the World Health Organisation (WHO) epitomises the tension between a narrow, technicist and a broad socio-political vision of health. Caught between the encompassing constitutional vision of global health as a complete state of well-being, and the political reality of Cold War warriors' preference for vertically-organized, and technically—rather than socially—constructed health interventions, WHO's first three decades were heavily shaped in favour of large-scale disease control initiatives.<sup>37, 38</sup>

The "Health for All" campaign launched in Alma Ata in 1978, may represent the most serious attempt in the post-War period to reconfigure health as a broad vision and intrinsic value in international policy. That this global initiative invoking a social model of health was submerged within two years under the weight of a global economic crisis may be a matter of historical coincidence.<sup>39</sup> But the multilateral response to that crisis—institutionalising a new paradigm of economic management based on "structural adjustment" invoking fiscal austerity, deregulation of state controls, and transfer of state functions to private actors and market dynamics—is suggestive, at least, of an opportunity seized by the neoliberal "counter-revolution" to discipline a global health community that had strayed into the territory of international economic policy.<sup>40, 41</sup> Whatever the interpretation, the net effect—squeezing national policy space for health spending, replacing comprehensive with selective primary health care, and shifting WHO funding in favor of extra-budgetary support for vertical disease control programmes—was a powerful reassertion of the narrow view of international health.

The last two decades in international health can be characterised by three ostensibly contradictory phenomena: on one hand, fragmentation of global health leadership; on the other, unprecedented agreement of global health goals (in the Millennium Development Goals (MDGs) and, from 2015, the Sustainable Development Goals (SDG)); and, a major increase in global health aid. There is no doubt that international health funding rose dramatically over much of the life of the MDGs from 1990 onwards. Donor commitments to health climbed to unprecedented levels in the 2000s, totalling USD \$21.8bn in 2007 and USD \$26.4bn in 2008.<sup>42, 43</sup> But in the absence of leadership towards a broad international health vision, donors' goals and money have gravitated towards the narrow view. Aid for infectious disease control towers over other areas of health assistance, as presented by Figure 2. Between 2002 and 2011, the proportion of health aid allocated to MDG 6 (targeting reductions in HIV/AIDS, TB and malaria often through vertically-organised finance and programming) rose from 30% to just under 60% of the global total. Assistance for “health policy and administrative management”—core support to build the capacity within countries to construct and manage their own health systems—fell from around 30% to under 10%. By 2012, spending on infectious diseases was triple the total budget allocation to “basic healthcare,” with fractional allocations to “basic health infrastructure” and “personnel development,” and virtually no spending on “medical research” and “health education”—arguably key elements in attacking the social and economic determinants of non-communicable disease risk.

Figure 2: Health aid by allocation, infectious disease control and basic health capacity, 1999-2012



In 2007, less than 3% of all development assistance for health was allocated to non-communicable diseases (around USD \$503m of USD \$22bn)—roughly USD \$0.78 per DALY for NCDs, compared with USD \$23.9 per DALY for HIV/AIDS, TB and malaria.<sup>44</sup> Financing for non-communicable diseases within global health aid is so marginal that it does not have a reporting category in the Organisation for Economic Co-operative Development's (OECD) aid data system. I argue that this is not an accidental omission. From the 15<sup>th</sup> century and the beginnings of an

association between health and trade, we find ourselves some five centuries later confronted with a vision of international health, defended and maintained with a curiously atavistic determination, in which control of infectious disease as an instrumental input to economic ends continues to dominate, apparently almost entirely ignoring the exponential growth in chronic disease.

I argue that there is a coherent political explanation for this ostensible mismatch in the orientation of international health policy. The explanation has to do with a fundamental distinction between infectious and non-communicable diseases based on how, respectively, they are conceived within contemporary paradigms of globalisation, trade and economic policy.

### **NCDs: GLOBAL GOVERNANCE VS INDIVIDUAL CHOICE**

Infectious diseases—diseases enacted, as it were, by pathogens operating in the environment, traversing the zoonotic barrier, or carried by parasites in food, water or air—can be constituted as an exogenous assault on the human body by a periodically hostile nature. In such instances, society—more particularly the “state” that purports to represent our collective interest—has a clear mandate to intervene to protect individuals and communities. Non-communicable diseases, by contrast, are constituted as the endogenous effects of “lifestyle”—effects, in the methodological individualism of a dominant liberal market paradigm, which must be viewed as the result of choices made by individuals manifesting their sovereign right to live and consume as they please. In these instances, the legitimacy and hence ability of the state to intervene is much more limited—constrained by an ideological imagination of the supremacy of undisturbed interaction between individuals operating in and through markets.

I suggest that the origins of the architecture of international health are rooted in the concern of economically dominant nations to protect their ability to access raw materials and maintain trade with one another, and that this association between health governance and trade persists into the current period, embodied in the framework of the IHR—the pre-eminent mechanism for enforceable global health governance. As such, I argue that the dominant contemporary discourse of international health is rendered meaningful insofar as, on one hand, it supports transnational commerce, and on the other, it excludes interference in individual choice and the lifestyle mediation of markets. In this perspective, the primary imperative of a global health system is to manage and control the diseases that pose a threat to trade—fast-moving epidemic infectious diseases; but, by the same token, to constrain action on non-communicable diseases where such action might challenge liberal economic development and consumption-as-choice.

Labonté et al. (2004) describe the resulting attitude of the multilateral system to the problem of non-communicable disease as a kind of ‘fatal indifference’.<sup>45, 46</sup> I would argue that the attitude is more purposive than that. It can be viewed as a conscious discursive attempt to shift the focus of NCD action away from the global center and its trade-privileging policy formulations—not least in the sense that the process of globalisation may be understood not, as it is sometimes somewhat disingenuously portrayed, as a natural process, but rather as the “strategic behavior of economic and political elites.”<sup>47, 48, 49, 50, 51, 52, 53, 54</sup>

It is now broadly understood that tobacco, alcohol, processed foods (especially those high in salt, fat, sugar and low in nutrient value), and changes to labor and physical activity are key factors in the rise of NCDs in countries across the wealth spectrum.<sup>55, 56, 57, 58</sup> Processes of globalization have expanded and accelerated



transnational trade and marketing, associated in their turn with increased production and distribution of health-damaging commodities and conditions, escalating fastest in low- and middle-income countries.<sup>59, 60, 61, 62, 63, 64</sup> Evidence confirms that NCD-related risk factors are not randomly assigned within and between societies, but rather patterned along the social gradient, such that poorer people with greater exposure to health bads and less access to health goods will suffer disproportionately.<sup>65, 66</sup>

Given the increasing concentration of global, multilateral power over policy choices driving the distribution of NCD risks among and within states, there is a growing public health consensus that it is this level of economic policy-making—shaping trade rules, market power and progressive state marginalisation—that now constitutes the pre-eminent upstream determinant of non-communicable disease.<sup>67, 68, 69</sup> Logic suggests that action to address NCDs—efficiently and equitably—implies regulatory intervention at this level. But herein lies a fundamental paradox. The historical evolution of states' commitment to take collective action on health for the purposes of trade and growth has nurtured a process of mercantile globalization, and a paradigm of globally-instituted economic liberalism, in which states are collectively incapable of taking action on trade and growth for the purposes of health.<sup>70, 71, 72</sup> Confronted with this paradox, I suggest that the multilateral system has responded by sponsoring a discursive construction of non-communicable disease in which, in three respects, its own presence and role is effectively effaced.

Firstly, primary responsibility for action on NCDs is assigned to the national level, and to individual governments, with the international community occupying an “assisting...complementary” role.<sup>73</sup> Official documentation on the global response to NCDs is imbued with vibrant rhetoric about “whole-of-government” and multisectoral approaches—as well as the ubiquitous and deeply problematic language of “partnership” in which the notion of a hierarchy of responsibility, with the state dominant, is collapsed. Yet the latitude for policy-making enjoyed by individual governments, especially in the domain of economic management and trade relations, is increasingly constrained by global and regional agreements.

Secondly, global negotiations on NCD management have consistently shied away from invoking statutory force, relying on voluntary compliance in the case of states and self-regulation in the case of transnational companies. The unwavering adherence to voluntarism—in marked contrast to multilateral action on infectious diseases, and counter to an increasing body of evidence about the relative effectiveness of regulatory controls for NCD prevention—must be viewed as states' collective abnegation of multilateral power in order to protect individual economic competitiveness.<sup>74, 75, 76, 77</sup>

But thirdly, and more fundamentally, individual behaviour—and hence risk freely acquired through lifestyle choices—has emerged as the dominant explanatory framing for the global problem of NCDs.<sup>78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89</sup> The utility of the behavioral narrative is clear, obviating the structural need to impose fundamental regulatory controls on the social determinants of NCDs, and hence trespass on the foundational premises of the international economic system. But it is a narrative that is both conceptually flawed and empirically weak.

The lifestyle discourse of NCD causation often posits “behavior” and “choice” as if they were interchangeable forms of language, or linked together in a kind of semiotic yoke—choice as the inviolable principle of the liberal market model; behavior as its modifiable form. The advantage of this conflation, of course, is to root the NCD problem (behavior) firmly in a market-oriented solution (choice). In reality, though, behavior and choice are axiomatically distinct—behavior as a sub-set of

choice, and choice, itself, as heavily circumscribed by the material and socio-political conditions in which individuals, households and communities live. It is at best disingenuous to attempt to separate out the knowledge and attitudes of individuals from the social, economic, cultural and political milieu in which they subsist, or their behaviors from the limits to choice imposed by the social, economic, cultural and political structures within which they navigate their daily lives.<sup>90</sup>

Rather, the relationship between markets and individuals (increasingly unconstrained by the intermediating protection of the state) should be understood as interanimating.<sup>91</sup> Increasing global consumption of ultra-processed food reflects a remarkably neat alignment of household perceptions of affordability, satisfaction, or status—all heavily shaped by poverty and inequality—and the profit-maximising model of a global food trade: consumer and market locked in a short-run economic logic with disastrous long-run health consequences.<sup>92, 93, 94, 95, 96</sup> Consumption patterns for alcohol and tobacco reflect not just individual preference and cultural practice, but the interaction of these drivers with the regulatory environment by which supply is enabled or restrained.<sup>97, 98, 99</sup> The exchange value of people's labor—and hence their exposure to exploitation—is shaped not only by the manner in which labour is protectively organized, but also by the degree to which such protection is permissible under a globalizing legislative framework increasingly dominated by the interests of capital—one of whose axiomatic aims is to drive down the cost of labor.<sup>100, 101, 102, 103, 104, 105, 106, 107</sup>

Changes in the distribution of power in each of these interanimations, largely in favor of the market, can be traced back to policies propagated through the liberal economic model: relaxation of capital controls, including foreign direct investment (FDI), reduction in trade barriers, harmonization of regulatory functions (mainly to the lowest common denominator). And all of them have consequences for non-communicable disease so eminently patterned and predictable that the underlying policy mechanisms should themselves be as much the target of modification as should the behavior of individuals. Yet the concept of causal hierarchy—in which economic and trade policy sits atop a cascade of effects, with individual behaviors as subsidiary outcomes rather than as co-causes—is, in the behavioral construction of NCDs, effectively collapsed.

Ultimately, the focus on lifestyle and behavior as the primary drivers of non-communicable disease may be viewed as a conscious strategy by dominant economic interests to mitigate alternative interpretations which threaten prohibitive intervention in the free flow of markets, and to resist regulatory intervention in the multilateral space.<sup>108, 109</sup> The denial of a hierarchy of causation, with global economic and trade policy at the apex, may be viewed as a purposive attempt to shift the focus of attention, when considering how to deal with NCD epidemics, away from the global centers of policy-making and power.

## SO WHAT NOW?

The International Health Regulations serve as arguably the most concise illustration of how, when adequately motivated, states acting collectively can manifest a coherent commitment to enforceable international health. But they also show how the focus of that commitment expresses a larger concern to protect economic and trade activity from human interference. The question is: can we learn from the achievements of the IHR, to build a new and genuinely global approach to health?

Established in 1969 as the inheritor of the international sanitary regulations, the IHR were, and remain the pre-eminent, legally-binding multilateral agreement in

the domain of health between nation states.<sup>110</sup> Originally designed to enforce coordinated inter-state action on “six quarantinable diseases,” the scope of the regulations was actually reduced between 1973 and 1981, limiting the number of mandated diseases to the by-now-familiar trio: plague, cholera, and yellow fever.<sup>111</sup> Faced with the emergence of potentially catastrophic epidemic pathogens at the start of the 21<sup>st</sup> century, however, the regulations were renegotiated in 2005, supplementing references to specific diseases with a more generalised concept of “public health emergencies of international concern” (PHEIC).<sup>112</sup> This change, at least in theory, opened up the possibility of mandatory state intervention in instances of non-communicable disease. As such, the 2005 amendment is hailed by some as a major advance in the fit between the IHR and a real-world epidemiology of global health.<sup>113, 114</sup>

There is no doubt that managing any kind of agreement among the diversity of UN member states on collective responsibility for health was and is an extraordinary achievement. But I argue that that the IHR, even in their most recent incarnation, continue to manifest a profound disinclination on the part of the global community to broaden their shared vision of international health beyond diseases that threaten transnational economic activity.

The core characteristics of diseases listed as notifiable in the 2005 IHR<sup>115</sup> are speed of transmission and ecological adaptability, capacity for explosive outbreak, and commensurate potential quickly to disrupt social and economic systems within and between countries. In spite of the prominent role they play in contemporary global health, HIV/AIDS, TB and malaria are omitted, or at least not explicitly present. Their threat in the transnational space is relatively limited. Geographically bounded by the ecological requirements of transmission, relatively slow-moving, and/or with long periods of latency, they make cross-border control either wholly impracticable or sufficiently unwieldy that traffic and trade would suffer. Non-communicable diseases, conceived of as rooted in the internal lifestyles of individuals and hence unthreatening to the public interactions on which commerce depends, are entirely absent.

The text of the 2005 IHR is one of “events,” “outbreaks” and “emergencies.” The provisions are for short-run responses in surveillance, management and intervention, often focusing on emergency or supplementary control functions at and around border crossings. As such, it is hard to see how such measures would be feasible or useful in the case of most chronic conditions. The language leads us ineluctably to fast-moving infectious diseases, with the capacity to manifest catastrophically in and through the public space of human social and economic interaction. The regulatory framing is organized around the demographic, geographic and temporal dimensions of disease, rather than underlying social, cultural, economic and political drivers of health—invoking control measures with the core objective of protecting “travel, trade and economies” through interventions that have minimal disruptive impact on “international traffic and trade.”<sup>116</sup>

While the 2005 IHR is in some respects a deeply flawed instrument, it must be viewed as the foundation of the next generation of global health. Two key elements need to be taken forward into that new generation. First, the inevitable political contests and protectionist instincts of individual states that are entailed in the policy confrontation between health and trade require an instrument that has a substantial degree of submission by states to the idea of collective enforcement. Action on supranational determinants of health necessitates a formal rather than a voluntarist model of international treaty.

Second, there is potential in the 2005 IHR to exploit the vagueness of the notion of “public health emergency of international concern.” Although gaps in data, understanding and scientific proof remain, there is surely now an adequate body of global knowledge regarding the health impacts of macroeconomic policy to justify a precautionary principle in the way global governance is applied. A framework convention on global health needs to leverage the power of PHEIC—specifically its normative power to convene enforceable global attention to collective health threats—using that body of knowledge and the increasingly vocal community of international health advocates to frame a strategy that engages states simultaneously at the levels of reason and self-interest.

Clearly, a traditional IHR formulation of PHEIC (imposing transboundary restrictions on population movement, for example) cannot apply in the case of non-communicable disease. Rather, a PHEIC organised around a collective response to NCDs would focus on enforcing multilateral control over the pathogenic effects of global economic policy. Ultimately, governments can wait until the NCD wave becomes a *tsunami* and behave in characteristically reactive and economically counterproductive fashion, or they can adopt a leadership role and get ahead of the curve.

## CONCLUSION

This paper argues that a multilateral conception of health in the international space has, over a long history, distinguished fundamentally between infectious diseases where enforceable multilateral action is mandated, and non-communicable diseases where such action is extremely hard to achieve. It argues that this is based on a differential construction of the two disease types: one external to the individual, damaging to transnational trade, and hence eligible for intervention; the other internal and generated by the individual’s life choices protected under the emerging dominance of a liberal market model.

The systematic patterning of non-communicable diseases globally exposes this construction, suggesting instead the superior hierarchical influence on NCD risks of structural factors external to the individual, themselves shaped by transnational and multilateral economic norms and policy influence. Within an increasingly interconnected set of policy systems, radiating outward from the commanding heights of globalisation, those policies themselves may be viewed as analogous to infectious disease pathogens, as in a very cogent sense “communicable,” and as such in need of enforceable control measures consistent with those embodied in the current International Health Regulations.<sup>117, 118, 119</sup>

The proposed Framework Convention on Global Health (FCGH) must build on, rather than supplanting or attenuating existing international and multilateral agreements on health. Such a convention should aim to amplify already-established norms and instruments, but it should aim to do so in ways that genuinely extend the reach of health and its status within the system of global governance. This paper suggests that the evident collective commitment of states to concrete, mandatory multilateral action on health where it threatens global trade and economic advancement—embodied in the IHR—should be used to leverage a parallel “will-to-intervene” in the global domain of economic and trade policy, where evidence increasingly clearly demonstrates systematic negative impact on the spread of NCD risks within countries and between them. That will-to-intervene should be based on three principles.

Firstly, the will to generate—and then follow—the evidence. Given the prospects for non-communicable disease globally, the need for systematic, comparable data for this class of disorders among states is fundamental.<sup>120</sup> The gaps in a robust global dataset on NCD causation undermine the ability of actors to agree on common methods to analyse causation and compare effectiveness of interventions. As such, they also enable obfuscation on an industrial scale, as scientists, politicians, lobbyists and firms contest with one another from incompatible or contradictory empirical, sectoral and ideological positions. The projection of NCD growth—and catastrophic cost models—should inspire states to adopt a precautionary principle: to instigate mandatory standards in NCD data collection, to enhance investment in independent research using multilaterally-endorsed methodologies, but equally to a collective mechanism for translating empirical analysis into differential strategies for level and target of intervention, determined by proportional contribution to the problem, and relative effectiveness of the solution.

The IHR already make provision for strengthening investment in surveillance systems at country level across member states.<sup>121</sup> Expanded and enhanced surveillance for non-communicable diseases have been shown to be viable in principle and, in some instances, in practice in high- and lower-income country settings, both nationally and sub-nationally.<sup>122, 123</sup> Generating better data is feasible. Analysing data at a sufficiently aggregate level—and documenting levels of health inequity—would enable more robust identification of the role of upstream factors, particularly in the domain of transnational (and ultimately global) policy. Transparent generation of such analysis would mitigate the obfuscatory effects of vested interests often generated by the unhealthy interbreeding of corporate capital with state governance. Greater transparency in processes of data collection and analysis could be achieved through the establishment of an independent global commission, mandated by the World Health Assembly and, perhaps, co-chaired by the World Health Organisation and the World Bank.

Secondly, the will to take action at—and on—the global policy level. Whilst it is entirely legitimate for states, individually or collectively, to support NCD interventions at all levels—from enhancing technologies of treatment, through behavior modification interventions, to control of individual commodities or specific determinants—it is not legitimate to do so in ways that disproportionately concentrate on the downstream, leaving upstream, structural drivers weakly attended.<sup>124, 125</sup> There is growing support for the view that taking action on the drivers of non-communicable disease is more efficient than taking action on outcomes;<sup>126</sup> that structural, population-level interventions are more effective than elective behavior and lifestyle modification programmes;<sup>127, 128, 129</sup> and that taking action on individual determinants is less efficient than taking action on the “meta-policy” level (principally the global organisation of economic management and trade) that shapes and distributes risk within different sectors. As globalization progressively concentrates meta-policy at the multilateral level, that level is, surely, a key target for collective regulatory and legislative intervention.<sup>130, 131, 132</sup>

The long, lethargic response of the multilateral system to the rising threat of NCDs may be attributed to a kind of “global lock” in which individual states are unable or unwilling to subordinate their economic and trade interests to the collective, super-ordinate goal of global health; or are sufficiently bullied by states manifesting dominant economic interests that they undertake, at best, an effectively neutral position in relevant multilateral negotiations. One strategic route around such a lock is for a group of states genuinely interested in the problem of NCDs (we

could call them the “*Friends of Global Health*”) to launch a process nominating, say, diabetes as a “public health emergency of international concern.” Diabetes has the advantage of invoking nutrition (implicating both under- and over-nutrition, thus of relevance to the widest possible number of affected countries), as well as being relatively robustly linked to obesity and to globalization-related changes in transnational patterns of food production and trade. In the face of inevitable multilateral resistance such a group, copying humanitarian arms control processes such as the Convention on Cluster Munitions, could organize outside the UN system until such time as, with enough states supporting, the UN itself was obliged to extend it formal recognition.<sup>133</sup>

Thirdly, the will to make action mandatory. The ostensible inability of the global community to respond adequately, rationally and proportionately to the rising risk of non-communicable disease is a political rather than a technical failure.<sup>134</sup> The preference for voluntary rather than binding multilateral agreements on NCDs reflects both the global dominance of a liberal economic paradigm and the inability of the multilateral system, under that paradigm, to regulate itself in ways that compromise economic and trade imperatives. That states individually show limited signs of voluntarily undermining their perceived competitiveness now, in the interests of NCD changes in the medium term, can be of little surprise. If the pre-eminent distal driver of non-communicable disease is, itself, the global market system, neither transnational corporations who increasingly dominate it, nor individual states increasingly subordinated under it, can be expected voluntarily to impose controls on their relation to it, in the absence of assurance that any resulting disadvantages will be evenly shared by their competitors.<sup>135</sup>

A multilateral mechanism to address NCDs at the global level, mirroring the IHR, must be statutory if it is to leverage coherent action across the community of states. Implying fundamental changes to economic relations and trading behavior, that statutory mechanism has to be strong enough to match not only the power of global economic and trade arrangements as they are embodied in the WTO, but also to influence the growing body of sub-global regional free trade agreements—such as the Transatlantic and Trans-Pacific agreements currently under negotiation—which can obviate or actively undermine the policy flexibilities built into existing global agreements.<sup>136, 137, 138, 139, 140</sup> There is now a substantial network of multilateral treaties, agreements, conventions and frameworks, from foundational rights conventions to control of at least one commodity for the purposes of health.<sup>141, 142, 143, 144</sup> At the centre of this network, the International Health Regulations provide insight both into the constraints on but also the possibilities of better, stronger collective global action framed to control and mitigate the foundational economic drivers of NCD risk—possibilities that should be strongly developed within or through the Framework Convention on Global Health.

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<sup>1</sup> More information about the Framework Convention is available here: <http://www.jalihealth.org/documents/Framework.pdf> and here: <http://www.jalihealth.org/research/>

<sup>2</sup> This paper uses the term ‘international’ rather than ‘global’ health primarily. It reflects the view that while states, including at multilateral level, have achieved a degree of concert on some universal principles regarding health, there are as yet still few examples of genuinely global health governance infrastructure, based on binding agreements which go beyond the plurilateral conventions of voluntary member state engagement.

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<sup>4</sup> Robert Beaglehole et al., “Priority Actions for the non-communicable Disease Crisis,” *The Lancet* 377, no. 9775 (2011): 1438–1447.

<sup>5</sup> Richard Sullivan and AD Purushotham, “Avoiding the Zero Sum Game in Global Cancer Policy: Beyond 2011 UN High Level Summit,” *European Journal of Cancer* 47, no. 16 (2011): 2375–2380.

<sup>6</sup> Peter Nsubuga et al., “Strengthening Public Health Surveillance and Response Using the Health Systems Strengthening Agenda in Developing Countries,” *BMC Public Health* 10 (2010), doi: 10.1186/1471-2458-10-S1-S5.

<sup>7</sup> Robert Geneau et al., “Raising the Priority of Preventing Chronic Diseases: A Political Process,” *The Lancet* 376, no. 9753 (2010): 1689 – 1698.

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[http://www.who.int/social\\_determinants/thecommission/finalreport/en/](http://www.who.int/social_determinants/thecommission/finalreport/en/)

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<sup>10</sup> World Health Organization, *Political Declaration of the High-level Meeting of the General Assembly on the Control and Prevention of Noncommunicable Diseases* (Geneva: WHO, 2013).

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<sup>11</sup> George Alleyne et al., “Embedding Non-communicable Diseases”.

<sup>12</sup> Shah Ebrahim et al., “Tackling Non-Communicable Diseases In Low- and Middle-Income Countries: Is the Evidence from High-Income Countries All We Need?” *PLoS Medicine* 10, no. 1 (2013), doi: 10.1371/journal.pmed.1001377.

<sup>13</sup> Robert Beaglehole et al., “UN High-Level Meeting on Non-Communicable Diseases: Addressing Four Questions,” *The Lancet* 378, no. 9789 (2011): 449–455.

<sup>14</sup> Rachel A. Nugent and Andrea B. Feigl, “Where Have All the Donors Gone? Scarce Donor Funding for Non-Communicable Diseases.” (Working Paper 228, Center for Global Development, 2007).

<sup>15</sup> World Health Organization, *Political Declaration of the High-level Meeting of the General Assembly*.

<sup>16</sup> Nugent and Feigl, “Where Have All the Donors Gone?”.

<sup>17</sup> Antonio Dans et al., “The Rise of Chronic Non-Communicable Diseases in Southeast Asia: Time for Action,” *The Lancet* 377, no. 9766 (2011): 680–689.

<sup>18</sup> Ebrahim et al., “Tackling Non-Communicable Diseases”.

<sup>19</sup> Sidney C. Smith et al., “Moving From Political Declaration to Action on Reducing the Global Burden of Cardiovascular Diseases: A Statement From the Global Cardiovascular Disease Taskforce,” *Journal of the American College of Cardiology* 62, no. 22 (2013), doi: 10.1016/j.jac.2013.08.722.

<sup>20</sup> Jonathan Liberman, “Making Effective Use of Law in the Global Governance of NCD Prevention,” in *Regulating Tobacco, Alcohol and Unhealthy Foods: The Legal Issues*, ed. Tania Voon, Andrew D. Mitchell and Jonathan Liberman. (London: Routledge, 2014).

<sup>21</sup> Kristina Jönsson, “Legitimation Challenges in Global Health Governance: The Case of Non-Communicable Diseases,” *Globalizations* 11, no. 3 (2014): 301–314.

<sup>22</sup> Ebrahim et al., “Tackling Non-Communicable Diseases”.

<sup>23</sup> Jeremy R. Youde, *Global Health Governance* (Cambridge: Polity Press, 2012).

<sup>24</sup> Beaglehole et al., “UN High-Level Meeting”.

<sup>25</sup> Eeva Ollila, “Global Health Priorities – Priorities of the Wealthy?,” *Globalization and Health* 1, no. 6 (2005), doi: 10.1186/1744-8603-1-6.

<sup>26</sup> Derek Yach et al., “The Global Burden of Chronic Diseases Overcoming Impediments to Prevention and Control,” *The Journal of the American Medical Association* 291, no. 21 (2004): 2616–2622.

<sup>27</sup> Robert Beaglehole and Derek Yach, “Globalisation and the Prevention and Control of Non-Communicable Disease: The Neglected Chronic Diseases of Adults,” *The Lancet* 362, no. 9387 (2003): 903–908. Theodore H. Tulchinsky and Elena A. Varavikova, *The New Public Health: An Introduction for the 21<sup>st</sup> Century* (London: Elsevier, 2014).

<sup>29</sup> The political and commercial value of quarantine should not be underestimated as an incentive for states to continue to invest heavily in such control measures. In March 2009, H1N1 influenza (‘swine flu’) was identified as the agent of an epidemic outbreak in Mexico and parts of the United States. In June of the same year, the US reported trade restrictions on its swine and pork products in 27

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<sup>32</sup> Ronald Labonté, Katia S. Mohindra and Raphael Lencucha, “Framing International Trade and Chronic Disease,” *Globalization and Health* 7, no. 20 (2011), doi: 10.1186/1744-8603-7-21.

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# **What a Wonderful World it Would Be: The Promise and Peril of Relying on International Law as a Mechanism for Promoting a Human Right to Health**

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*This article delineates the limitations of international human rights law—including ambivalent language, loopholes, ill-defined state obligations, and a lack of concrete enforcement mechanisms—that have limited the effectiveness of international human rights law as a mechanism for advancing the cause of global human rights. These limitations suggest that the costs from the establishment of a Framework Convention on Global Health (FCGH) may outweigh the benefits. Given that a human right to health is already codified in existing international human rights law, this article also suggests that the FCGH would be a duplicative treaty that would contribute to redundancies and bureaucratic inefficiencies in the existing international human rights regime. Further, it would divert scarce resources that might be more productively spent on other global health initiatives.*

## **INTRODUCTION**

In a 2013 perspectives paper published in the *Bulletin of the World Health Organization*, several prominent global health practitioners and academics urged the adoption of a Framework Convention on Global Health (FCGH) resting on the foundations of equity, a human right to health, and a focus on the barriers to optimal health faced by marginalized communities. According to the authors, the attainment of just global health outcomes requires “robust global governance,” and the adoption of a Framework Convention on Global Health would represent a concrete step towards that end.<sup>1</sup>

The authors of the perspectives paper envision a FCGH as an ambitious and effective tool for tackling the most significant barriers to equitable and just health outcomes for populations across the globe.<sup>2</sup> Their vision of the advantages of the proposed framework convention is worth stating below:

The overriding purpose of a framework convention on global health would be to dramatically reduce the health disadvantages experienced by the marginalized and the poor, both within countries and between them, while reducing health injustices across the socioeconomic gradient. Guided by principles underlying the right to health and mutual responsibility, a framework convention would universally ensure three conditions that are essential for a healthy life: a well-functioning health system providing quality health care; a full range of public health services, such as nutritious food, clean water, and a healthy environment; and broader economic and social conditions conducive to good health, such as employment, housing, income support and gender equality.<sup>3</sup>

This view of a universalistic legal framework for promoting global health articulates a laudable normative vision for a just and equitable world. If the authors are correct that the FGCH could universally ensure well-functioning health systems, universal access to comprehensive public health services, and optimal economic and social conditions, then the adoption of a framework convention would be one of the most important policy steps that states could take to promote human rights. Further, it should be identified as a global policy priority of the highest order.

However, the significant gap between the rhetoric of international human rights law and the reality of the attainment of human rights in practice in other issue areas suggests that the idealism of the proponents of the FCGH needs to be tempered by careful consideration of the political obstacles, legal challenges, and resource constraints inherent in efforts to use formal international law as a mechanism for leveraging critical changes to economic structures, political systems, and socio-economic barriers to optimal health for human populations. International human rights law is characterized by a range of deficits—including ambivalent language, loopholes, ill-defined state obligations, and a lack of concrete enforcement mechanisms—that limit its general effectiveness as a mechanism for advancing the cause of global human rights. Furthermore, because the human right to health is already codified in international human rights law, the FCGH risks the expenditure of significant resources for the establishment of a duplicative treaty that would contribute to redundancies and bureaucratic inefficiencies in the existing international human rights regime, without adding significant enhancements to this body of law.

Proponents of the FCGH contend that it represents a flexible and dynamic approach that will avoid the pitfalls of more traditional international human rights treaties. The proposed FCGH is intended to operate in ways that will engage not only states but also broad sectors of civil society integral to the success of global health initiatives. Proponents of the FCGH also envision a legal framework that will set specific standards with enforceable goals. Although this perspective is laudable, scant evidence exists that formal international legal frameworks—whatever the intentions that undergird them—consistently produce intended outcomes even when specific, focused standards are set.

The WHO Framework Convention on Tobacco Control (FCTC), a model for the FCGH, is instructive. In this case, a strong majority of member states comply with treaty reporting requirements and are taking steps to implement key provisions of the treaty, including the creation of education programs designed to raise public awareness about tobacco-related health risks and the adoption of prohibitions on the sale of tobacco to minors. However, few member states have adopted FCTC recommendations to ban advertising, establish smoke-free public spaces, or create economic alternatives for populations who rely on tobacco-related income.<sup>4</sup> Further, it is not clear that compliance with reporting requirements and the creation of educational programs—the most successful elements of the FCTC to date—have produced significant, concrete health improvements in targeted countries.

Moreover, it is important to note that a framework convention governing a narrow and specific health-related policy area—tobacco control—is significantly different from a framework convention intended to govern global health in general. In contrast, the FCGH is a governance arena that involves numerous bodies of domestic law and a range of public policies that are difficult to coordinate across states and civil society in diverse countries. In this regard, the question is not whether a FCGH might produce small improvements in the global governance of health; it likely would. Rather, the question is whether the costs associated with the creation of a FCGH and the associated bureaucracy are worthwhile investments, considering scarce global resources, when other international human rights treaties already guarantee a human right to health. Given that international law primarily functions as a political tool that can be used to advocate on behalf of specific causes and policy changes at the national level, a new FCGH would arguably create a redundant body of law and institutional machinery primarily for the purpose of advancing goals that can be served by existing legal mechanisms and at the risk of crowding out funding for other global health initiatives that might have greater capacity to produce concrete improvements in global health.

Ultimately, formal international law plays a secondary role in global efforts to advance global health. States are the primary actors with the capacity and resources for producing fundamental improvements to population health within their borders, and public health infrastructure and national health care systems are vital components of any effort to produce sustainable improvements in the health of populations across the globe. Necessary changes in national health care systems and public health policies are more likely to be generated by bottom-up domestic politics, rather than by abstract, distant legal frameworks intended to promote change from the top-down. Furthermore, global health initiatives that directly empower non-state actors with the capacity to improve health outcomes in specific issue areas are more likely to succeed in the realization of a human right to health, than the creation of another layer in the existing global health bureaucracy.

## THE INTERNATIONAL LEGAL FOUNDATIONS FOR A HUMAN RIGHT TO HEALTH

A human right to health is already well-established in the existing body of international human rights law. Most commonly, the human right to health is implicit in treaty provisions that, while not explicitly codifying health as a human right, have clear health-related implications. Numerous international human rights treaties, including the *Convention on the Prevention and Punishment of the Crime of Genocide*<sup>5</sup> (hereafter the Genocide Convention), the *International Covenant on Civil and Political Rights*<sup>6</sup> (ICCPR), the *Convention on the Elimination of All Forms of Discrimination Against Women*<sup>7</sup> (CEDAW), the *Convention against Torture and other Cruel, Inhuman, or Degrading Punishment*<sup>8</sup> (hereafter the Torture Convention), and the *Convention on the Rights of the Child*<sup>9</sup> (CRC), contain provisions involving fundamental health-related rights.

Adopted in 1951, the Genocide Convention prohibits acts that have self-evident connections to the health of targeted persons and groups, including killing and causing serious bodily or mental harm, that are committed with the intent to destroy, in whole or in part, members of particular national, ethnic, racial, or religious groups. The ICCPR, which entered into force in 1976, codifies numerous provisions that articulate fundamental human rights with clear health-related implications. These provisions include prohibitions against the arbitrary deprivation of life (Article 6), prohibitions against torture (Article 7), and prohibitions against slavery (Article 8). CEDAW, which came into force in 1979, codifies numerous provisions that articulate fundamental human rights related to particular health challenges and needs faced by women across the globe. Specifically, CEDAW asserts that women have a right to equal access to family planning information (Article 10, par. 1h), the right to protection of health and safety in working conditions (Article 11, par. 1f), to maternity leave with pay or comparable social benefits (Article 11, par. 2b), to special protections during pregnancy in potentially harmful work (Article 11, par. 2d), to equal access to health care, including family planning services (Article 12, par. 1), and to appropriate health services related to pregnancy, birth, and post-natal care (Article 12, par. 2). Entering into force in 1987, the Torture Convention reiterates and elaborates on the ICCPR's prohibitions against torture and other forms of cruel, inhuman and degrading treatment. The convention's definition of torture (Article 1) as any act in which severe pain or suffering, either physical or mental, that is intentionally inflicted on a person for the purpose of obtaining information or confessions, for punishment or as a form of intimidation or coercion, makes clear that the international legal prohibition against torture has clear connections to physical and mental health. Finally, the *Convention on the Rights to the Child*, which entered into force in 1989, contains provisions that articulate health-related rights for children, including an inherent right to life (Article 6), the right to state-provided protections against all forms of mental or physical violence, injury, abuse, neglect, maltreatment, or exploitation (Article 19), and special protections for mentally or physically disabled children (Article 23).

As this long list of treaty provisions indicates, health-related rights are well-established in existing international human rights law. Elsewhere, a human right to health is explicitly articulated in binding international human rights treaties. Most prominently, the *International Covenant on Economic, Social and Cultural Rights*<sup>10</sup> (ICESCR) explicitly codifies a human right to health in its recognition of "... the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12). The ICESCR also recognizes other health-related rights essential to attaining the highest standard of physical and mental health, including the right to safe and healthy working conditions (Article 7), the right to an adequate standard of living, including food, clothing, and housing (Article 11, par. 1), and the right to be free from hunger (Article 11, par. 2). In its explicit codification of a human right to health, the ICESCR is the core international legal document that establishes a human right to health under international law. The *Convention on the Rights of the Child*, which contains many health-related rights articulations, also explicitly codifies a human right to

health for children and provides that all children have a right to the highest attainable standard of health (Article 24.) Finally, the *Convention on the Rights of Persons with Disabilities*, which entered into force in 2008, recognizes the right to the highest attainable standard of health, without discrimination, for persons with disabilities (Article 25).

What might a Framework Convention on Global Health add to the already-codified human right to health and other health-related rights in international human rights law? The progressive development of international human rights law in other issue areas provides some insight into the potential promise of a framework convention. To this end, a brief examination of the ways in which the Torture Convention has augmented previously-existing prohibitions against torture and other forms of cruel, inhuman or degrading punishment demonstrates the potential benefits of pursuing the development of an independent legal regime governing the human right to health.

As previously discussed, the ICCPR codifies a prohibition against torture and other forms of cruel, inhuman or degrading punishment. The Torture Convention reaffirms this prohibition and augments the ICCPR's legal prohibition in a number of important ways. The Torture Convention provides a legal definition of torture, something not included in the ICCPR. Arguably, this development represents an essential step in ensuring that the international legal prohibition against torture can be applied—whether in a judicial context or by political actors—in a meaningful way. The Torture Convention also specifies, in ways that the ICCPR does not, that state parties “shall take effective legislative, administrative, judicial, or other measures to prevent acts of torture in any territory under its jurisdiction” (Article 2). The Torture Convention calls upon state parties to make torture a criminal offense under their national laws (Article 4) and to cooperate with each other in criminal proceedings against offenses constituting torture under the treaty (Article 9). The Convention calls upon states to ensure that education and information about the legal prohibition against torture is included in the training of police and military personnel (Article 10). In short, the Torture Convention provides important details regarding the acts that constitute torture and the concrete steps that state parties are supposed to take to prevent and prosecute torture.

In similar ways, the FCGH could augment the human right to health as codified in the ICESCR. The framework convention could specify a clear, binding definition of health under international law. General Comment 14, adopted by the Committee on Economic, Social, and Cultural Rights in 2000, offers a full definition of the human right to health in its interpretation of Article 12 of the ICESCR. According to General Comment 14, the human right to health is a fundamental right that is indispensable for the exercise of other rights and involves the “enjoyment of the highest attainable standard of health conducive to living a life in dignity.”<sup>11</sup> A FCGH could codify this definition of global health in a binding treaty. Further, the FCGH could articulate concrete obligations and specific duties that must be upheld by state parties to ensure progress towards attaining a human right to health.

The authors of the perspectives paper call for the FCGH embrace this view of the promise of the progressive development of international law governing the



human right to health. They offer a range of suggestions regarding the substantive content that should be included in the FCGH in an effort to specify and clarify the meaning of a human right to health under international law. In their view, the FCGH should include standards grounded in a population-based strategy that would emphasize access to food, water, clean air, injury prevention and other conditions for good health.<sup>12</sup> They also call for universal access to all levels of health care and financial protection that would prevent financial devastation as a result of catastrophic health expenditures.<sup>13</sup> The authors call for a health financing framework that would require state parties to commit the necessary funds to achieve the aforementioned goals. In general, they call for a framework convention with strong standards and rigorous monitoring and enforcement mechanisms.<sup>14</sup>

As this brief discussion illustrates, the FCGH might enhance the legal standing of a human right to health at the international level. Although this right is already recognized under international human rights law, the absence of an independent treaty governing the human right to health means it lacks the legal specificity of other human rights associated with specialized treaties, including prohibitions against torture, women's rights, and children's rights. It also means that the human right to health has not been institutionalized via the same monitoring bodies and human rights machinery that have grown out of the specialized treaties governing these other human rights norms. Indeed, one of the primary arguments for pursuing the FCGH is to contribute to the prioritization of global health on the political agendas of important international and state actors and to ensure that it has the same status and profile of other human rights issues governed by specialized treaties.

According to its proponents, the FCGH would articulate clearer standards and norms, increase accountability, enhance state compliance, and be more likely to generate the international funding necessary to make gains towards the attainment of health as a human right.<sup>15</sup> The potential benefits are significant, and there are good reasons for proponents of greater equity in global health to consider formal law as a possible mechanism for leveraging advancement in the progressive realization of the human right to health. Nevertheless, there are also perils implicit in this approach. These perils should be carefully considered before significant human and financial resources are invested in an effort to advance the FCGH and to institutionalize an independent international legal regime governing global health.

### **THE LIMITATIONS OF INTERNATIONAL LAW AS A TOOL FOR HUMAN RIGHTS PROMOTION**

The pace and scale in the development of international human rights law in the post-World War II period has been truly remarkable. Prior to this time, international human rights law did not exist as a distinct formal body of international law. To be sure, international legal norms governing state conduct during war as well as norms prohibiting slavery existed. Nevertheless, specific international treaties codifying universal human rights did not exist. In the immediate aftermath of World War II, the development of a formal international

human rights regime began apace, starting with the U.N. General Assembly's adoption of the *Universal Declaration of Human Rights* in 1948. Subsequent to this time, the progressive development of international law has been steady and prolific. The ICCPR and the ICESCR remain the core legal treaties in the international human rights regime. These binding legal documents codify an expansive list of universal human rights and represent the broadest articulation of human rights norms in international law.<sup>16</sup>

Growing out of these broad-based human rights treaties, the international human rights regime has steadily expanded via the development of specialized human rights treaties that have fleshed out human rights norms and created monitoring bodies and other human rights machinery in particular issue areas, including: genocide, refugees, slavery, racial discrimination, torture, women's rights, children's rights, and disability rights.<sup>17</sup> The development of the FCGH would represent a natural outgrowth of this trend and might be especially valuable in furthering the development of the international human rights regime in the area of economic, social, and cultural rights—an area that has received less sustained global attention than the category of civil and political rights.

The progressive development of international human rights law has had notable political and legal effects. Both states and non-state actors deploy human rights norms in articulating political positions on critical policy issues, in both the areas of domestic and foreign policy. The creation of international judicial bodies, including ad hoc tribunals and a permanent International Criminal Court, signal the potential promise that the progressive development of international human rights law will help contribute to the establishment of meaningful and effective institutions of global governance. Likewise, the citation of international human rights laws by national courts suggests that these laws may have significant legal consequences, even in the absence of the development of formal governance structures at the international level.

Nevertheless, idealism regarding the effects of international human rights law needs to be tempered by the reality that the changes resulting from such laws have been mostly at the margins. The continued existence of systematic and egregious human rights violations across the globe—in general and in every issue area governed by a specialized treaty regime—to date, indicates that even codified and institutionalized human rights norms remain largely aspirational. Yet, if it is obvious to note that formal international human rights law is not sufficient to promote the attainment of human rights in practice, does that mean that international human rights treaties are not necessary or potentially beneficial?

International law is a system of law that is created, interpreted, and implemented by states. Although non-state actors may play a significant role in driving the development of treaty regimes and in shaping the content of draft treaties, international treaties will not be adopted without explicit state consent. Thus, treaty content inevitably ends up reflecting, in large measure, state interests, preferences, and concerns. It could not be otherwise, or the requisite number of states would never agree to sign or ratify international treaties. Thus, despite its articulation of aspirational norms, international human rights law has had limited effects on actual state behavior and policy.<sup>18</sup> The state-centric nature of international human rights law is reflected in its ambivalent language,

loopholes, ill-defined state obligations, and a lack of concrete enforcement mechanisms.

### *Ambivalent Language*

The fact that international human rights law has codified fundamental human rights in binding and unprecedented ways is beyond question. Yet, these norms are articulated in ambivalent language that limits the impact that these laws have in practice. The ICCPR's codification of an inherent right to life to be protected by law and that cannot be arbitrarily deprived does not settle thorny questions regarding the state's role in deciding policy questions related to when life begins or the state's role in governing individual decision-making regarding end-of-life care. Similarly, the ICCPR's assertion of a clear, binding and non-derogable prohibition against torture, cruel, inhuman and degrading treatment and punishment does not identify which acts—by state or non-state actors—can be characterized as such.

It might be argued that imprecise definitions have potentially positive as well as negative consequences. On the one hand, vague definitions may mean that certain violations of human rights are not formally recognized as such because they are not explicitly covered in treaty language. On the other hand, ambivalent definitions might also create space for the broad-based application of treaty provisions to actions that might not be specifically mentioned in definitional clauses. Non-state actors might embrace expansive applications of treaty definitions to advocate on behalf of particular human rights issues. Similarly, national courts may interpret provisions of international treaties in expansive ways. However, state actors with the primary responsibility and authority for implementing human rights treaties are more likely to exploit ambivalent language to rationalize policies that deviate from treaty provisions when they believe it is in their interest to do so, such as when states justify political repression in the name of national security or when states embrace austerity policies, in the service of the “national interest”, that limit their capacity to provide a social safety net for vulnerable populations.

Of more immediate concern to the subject of this article, the ICESCR's assertion that all human beings have a binding legal right to the enjoyment of the highest attainable standard of physical and mental health does not provide clarity regarding what constitutes health and which actors will have legal authority in making such determinations. The lack of cross-cultural consensus on the meaning of health—both physical and mental—inevitably means that states representing diverse cultures will interpret this provision in varying ways.<sup>19</sup> Likewise, the differential resource capacities of states means that what represents the “highest attainable standard” of health in a low-income country will be different than the “highest attainable standard” in a high-income country. At the outset, then, it is apparent that this “universal” right will not be interpreted or implemented in universal ways.

On the one hand, the lack of cross-cultural consensus on the meaning of health or the appropriate paths for pursuing the highest attainable standard of health is consistent with the notion, built into the ICESCR, that implementation

will proceed according to the “progressive realization” of human rights at different paces in particular countries, each with a unique socio-economic context shaping its capacity to fulfill treaty obligations. In this way, the concession to differential state paths towards the fulfillment of a human right to health is a conscious one that creates a reasonable and flexible obligation for states that makes it more likely that the treaty can be successfully implemented by state parties. On the other hand, the treaty-based acknowledgement that states have different understandings of the meaning of health, divergent perspectives on the appropriate policy mechanisms for pursuing the highest attainable standard of health, and uneven capacities for promoting health as a human right ultimately defers to state sovereignty in ways that beg the question of how much the ICESCR actually changes the state-centric dynamics that characterize the politics of global health. One does not have to subscribe to Jeremy Bentham’s characterization of abstract natural rights as “nonsense on stilts” to see that the lack of definitional and conceptual specificity in the articulation of human rights norms limits their effectiveness in generating concrete and enforceable state obligations.

Indeed, it is precisely the potentially ambivalent nature of codified human rights norms that has led to the creation of specialized treaty regimes. A primary goal of these specialized treaties is to clarify legal definitions in an effort to generate clear-cut standards to guide states in their efforts to implement the rights in question. Although specialized treaties do not necessarily provide clear-cut standards and definitions, they do tend to provide more detailed guidelines and specific obligations for state parties. Yet, the development of specialized treaties does not necessarily produce global consensus on the content and meaning of the human rights in question, let alone produce meaningful changes in state policies’ behaviors.

Once again, the Torture Convention is an instructive example. The Torture Convention defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person” by, at the instigation, or with the consent or acquiescence of a public official or other person acting in an official capacity for the purposes of obtaining information or a confession (Article 1). This definition certainly adds meaning to the prohibition against torture in the ICCPR. Yet, it is far from providing the conceptual clarity that would be required to generate meaningful global progress in achieving gains in the legal prohibition against torture in practice. Notably, the Torture Convention does not specify whether particular acts constitute torture. On the one hand, the failure to list particular acts makes sense because such a list might be seen as limiting and exclusive of unlisted acts that might otherwise match the legal definition of torture. On the other hand, the lack of specificity means that states may claim leeway in interpreting whether or not particular acts constitute torture. To wit, whereas human rights advocates criticized U.S. interrogation practices used against suspects in the “war on terror” as torture, representatives of the U.S. government claimed that they were merely engaging in “enhanced interrogation”, a rhetorical practice common among states that rely on aggressive interrogation tactics in the face of external or internal threats.<sup>20</sup> (In this instance, the fact that the United States has not ratified the Torture Convention means that the U.S.

government does not recognize the treaty's applicability to its actions in any case.)

It is unlikely that the FCGH would be able to avoid such definitional and conceptual dilemmas. No doubt, a framework convention could enhance the ICESCR's assertion of a human right to enjoy the highest attainable standard of physical and mental health by expanding upon the basic meaning of health. The progressive development of international human rights law in other—probably more controversial issue areas—suggests that generating state agreement on a basic definition should be feasible. Yet, experience in other issue areas also suggests that any definition likely would still contain ambiguities that did not settle questions about how the general norm of a human right to health should be translated into concrete state obligations in practice. In this regard, cross-cultural diversity and a lack of global consensus on the meaning of health would continue to limit the effectiveness of the FCGH.

### *Legal Loopholes and Ill-defined State Obligations*

International human rights law also includes critical loopholes that limit its effectiveness as a tool for holding states accountable to its core provisions. Article 4 of the ICCPR is a primary example of a loophole that limits the effectiveness of international human rights law. According to this article, state parties may take measures derogating from their treaty obligations “[in] time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed...” State parties may not, under any circumstances, derogate from certain obligations, including the right to life and prohibitions against torture and slavery, and they may not derogate from other norms on strictly discriminatory grounds. Yet, this provision reflects the ways in which international law is ultimately deferential to state sovereignty. The clause makes it possible for states to ratify the treaty, with potential legitimacy gains from an endorsement of the aspirational norms codified therein, without committing to concrete obligations that might limit their ability to maneuver in the context of security threats, a context most likely to motivate a state impulse towards human rights violations.

International human rights law is also grounded in ill-defined state obligations that limit its impact. Article 2 of the ICESCR is an instructive example. This article provides that a state party to the treaty “...undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.” The imprecision of this obligation could not be more pronounced. States do not need to take clearly specified actions to realize the rights codified in the treaty. They do not even need to take steps towards this end. Merely, they need to “undertake to take steps” to realize the rights provided for in the treaty. No other clause better illustrates the weakness of the system of law governing international human rights. Yet, this sort of flimsy language characterizes the political compromises necessary to generate state buy-in to these treaty regimes. Further, the language indicating that states are only bound

to undertake to take steps “to the maximum of its available resources” makes a great deal of sense. Suggesting that states have obligations that resource constraints would prevent them from fulfilling would set the treaty up for failure at the outset.

Both legal loopholes and ill-defined state obligations reflect the ways in which international human rights law ultimately defers to state sovereignty. Such loopholes and weak obligations help to incentivize membership in international human rights regimes by pairing low cost barriers to joining treaties with potentially large legitimacy gains. The political dynamics that produced the ICCPR and ICESCR are not unique. Proponents of the FCGH have called for a robust framework with clear-cut obligations and rigorous enforcement mechanisms. The reality is that any treaty able to generate sufficient support among state parties will likely include strong aspirational norms undermined by loopholes and ill-defined state obligations that will limit the effectiveness of the treaty in achieving the desired outcomes.

### *Lack of Concrete Enforcement Mechanisms*

The international human rights regime has a wide range of implementation bodies, including the International Court of Justice, the Human Rights Council, treaty-monitoring bodies, and the UN High Commissioner for Human Rights. In general, the UN human rights system emphasizes norm creation, information gathering, weak monitoring, and, in some cases, public condemnation as tools for implementing human rights norms. In all cases, these bodies tend to defer to state sovereignty when it comes into tension with universal human rights.<sup>21</sup> (The International Criminal Court operates outside of the UN system of law. Although this permanent international court represents a stronger approach to enforcement than the primary UN bodies, it remains to be seen whether it will develop into an effective mechanism for prosecuting and punishing violations of human rights.)

The FCGH would likely follow the institutional model of the other specialized human rights treaties, for which treaty-monitoring bodies are the primary form of enforcement. The UN human rights system includes seven treaty-monitoring bodies responsible for overseeing the implementation of the associated treaty: the Human Rights Committee (which monitors the implementation of the ICCPR); the Economic, Social, and Cultural Rights Committee; the Committee on the Rights of the Child; the Committee on the Elimination of Discrimination against Women; the Committee on the Elimination of Racial Discrimination; the Committee Against Torture; and the Committee on the Rights of Persons with Disabilities. These committees, whose job is to “...endeavor to establish a constructive dialogue with State parties to assist them in fulfilling their treaty obligations and to offer guidance for future action through suggestions and recommendations”, have a non-adversarial relationship with member states.<sup>22</sup>

Each treaty-monitoring body has particular monitoring processes, and the Human Rights Committee has the unique authority to consider individual complaints and to issue non-binding judgments under the Optional Protocol to

the ICCPR. Despite differences, the monitoring process for each body share similarities that illustrate their limitations. In essence, the treaty-monitoring bodies review reports that are periodically submitted to each committee by state parties to the treaty. Based on these reports, each committee has the authority to make non-binding recommendations.

The cooperative relationship between the treaty-monitoring bodies and states makes sense in that an adversarial relationship would likely deter states from participating in the treaty bodies altogether. At the same time, this non-adversarial approach reflects the fundamental weaknesses of a state-centric system of law. States, in essence, have agreed to police themselves, and policing in this case means voluntarily reporting on human rights progress with no real consequences for states that do not report or that are failing to protect or promote the human rights norms in question. Given that state support would be essential for its establishment, there is no reason to expect that the FCGH would be able to avoid this dilemma by creating a global health regime with concrete state obligations and strong enforcement mechanisms.

The ineffective enforcement of the binding International Health Regulations (IHR) also provide a cautionary note regarding presumptions that formal international law will provide an effective platform for advancing a human right to health and improving health outcomes at a global level. The IHR, adopted by the World Health Assembly in 1951 and revised in 1969 and 2005, create binding rules for responding to infectious disease threats. Despite the creation of clear and binding rules governing transnational disease control, the IHR have been relatively ineffective and do not include effective enforcement mechanisms. They have not dramatically altered national responses to disease surveillance, and the international community has not provided financial or technological resources to incentivize compliance with the IHR. Member states of the WHO have generally failed to comply with binding IHR or non-binding WHO recommendations.<sup>23</sup>

### **WITHER THE HARM? THE RISKS OF RELYING ON INTERNATIONAL HUMAN RIGHTS LAW TO PROMOTE A HUMAN RIGHT TO HEALTH**

Despite its limitations, many scholars contend that international law remains an important tool for promoting and protecting fundamental human rights. In their examination of the role of formal law as a mechanism for reducing violence against women globally, for example, Hudson, Bowen and Nielsen argue that law—both domestic and international—is an essential tool for proponents of women’s rights: “While law cannot dictate practice and often stands impotent before it, law is nevertheless generally regarded as a strong normative factor capable of modifying practice over time, and importantly, of establishing state and community ideals. In this sense, despite the ingrained nature of practice, contestation over law is often a critical first step in changing practice.”<sup>24</sup> In this view, there is nothing to lose in relying on international human rights law as a mechanism for leveraging change and much, potentially, to gain.

In a similar vein, the authors of the perspectives paper calling for the development of the FCGH view international law as a potentially powerful tool

for mobilizing political support for the norm of global health with justice and, eventually, for translating that norm into concrete improvements in population health at the national level. Although the authors acknowledge the various limitations of international law, they downplay the significance of these limitations. In their view, the inclusion of civil society organizations across the globe in a bottom-up effort to mobilize political support for the FCGH would offset the opportunity costs of pursuing this convention by strengthening the ability of domestic non-state actors to engage in advocacy and, ultimately, to produce change at the national level.<sup>25</sup>

Although proponents of international law in general and of the FCGH in particular are correct that formal law—at both the national and international levels—may be a normative factor that can drive desired political, social and economic changes, the ultimate value of formal law as a mechanism for promoting the fulfillment of fundamental human rights in practice remains in question. Further, the potential that international law may have counter-intuitive and counter-productive consequences indicates that this option is not cost-free.

Empirical work on the effects of international human rights law in the area of political repression lends a cautionary note to this discussion. In a statistical examination of the effectiveness of “naming and shaming” practices rooted in the international human rights regime, Hafner-Burton found that public condemnation of states with poor human rights records led to improvements in some areas (most commonly, in areas related to voting or political participation) but also correlated—in a statistically significant way—with *continued or even increased* human rights abuses in other areas, particularly in relation to violations involving political repression and political terror.<sup>26</sup> This counter-intuitive outcome may be explained by a range of factors, including the possibility that international condemnation emboldens domestic opposition which then leads to greater repression by the state and/or that states make changes in visible policy areas that may increase their international or domestic legitimacy but suppress rights in other areas to maintain their hold on power.

Regardless of the explanation, this example illustrates that states adapt to international legal pressures in ways that they perceive to be consistent with their own strategic interests and policy preferences. There is no reason to expect states to behave differently in the area of economic, social and cultural rights. The legal prohibition against torture is a non-derogable provision of international law that cannot be legally violated under any circumstances. Despite its ostensible non-derogability, international legal prohibitions against torture are routinely violated by states that have ratified the ICCPR. The human right to health, along with other economic, social, and cultural rights, does not have the same non-derogable status. Thus, it is reasonable to assume that states will be as if not more likely to fail to uphold their obligations under the ICESCR as under the ICCPR. The fact that state obligations are more ambivalent and ill-defined under the ICESCR than the ICCPR further suggests that states will prioritize their own strategic interests and policy preferences over international legal obligations in approaches to the implementation of economic, social and cultural rights as much as in the case of civil and political rights.



In addition to the possibility that states will adapt to an FCGH regime in ways that are inconsistent with the intent of its proponents, the development of the FCGH has numerous downside risks. A systematic review of the scholarly literature by Steven J. Hoffman and John-Arne Rottingen revealed a range of potential costs associated with the FCGH. Foremost among these costs, the FCGH is duplicative of existing international human rights treaties that already establish a human right to health. Thus, the initiative to create the FCGH risks the expenditure of significant resources merely to replicate already-codified legal norms and to duplicate the functions of monitoring and review bodies that already work on global health and health-related human rights, most notably the World Health Organization.<sup>27</sup> Such duplication threatens to dilute scarce resources (financial and human), to fragment the global health infrastructure, and to add in potentially unproductive ways to regime complexity.<sup>28</sup>

Other major risks of the FCGH are that it lacks feasibility, would have questionable impact relative to the costs of negotiating and implementing the treaty, and would represent a form of institutionalized paternalism that prioritizes the perspectives and policy preferences of high-income countries over low-income countries. Political realities suggest that negotiating state agreement to the FCGH will be challenging, especially in terms of building state consensus on rigorous norms that would limit state sovereignty or would involve binding financial commitments.<sup>29</sup> Negotiating and implementing the FCGH would involve a significant commitment of resources, including travel to major international conferences and funding to staff an FCGH bureaucracy.<sup>30</sup> Given sparse evidence that formal international law has contributed to significant improvements to population health,<sup>31</sup> the costs associated with the FCGH may be hard to justify.<sup>32</sup> The risks of increased administrative burdens and transaction costs associated with the FCGH are most likely to have negative consequences for weaker states with fewer economic resources.<sup>33</sup> Because the FCGH risks being a replicative treaty with imprecise state obligations and weak enforcement mechanisms that potentially burdens the states facing the greatest resource constraints, it is reasonable for critics to ask whether the funding directed at the development of the FCGH would crowd out funding for other global health initiatives that might more directly advance a human right to health in practice.

### **ALTERNATIVE MECHANISMS FOR PROMOTING HEALTH AS A HUMAN RIGHT**

Even some proponents of the value of formal international law as a tool for promoting global health acknowledge that it plays a secondary role in global efforts to reduce global health inequities and to address global health challenges. States—rather than international organizations—have both the primary duty and capability to adopt laws and policies designed to improve global health. In this regard, international organizations may contribute to the shared governance of global health primarily by generating and disseminating knowledge, empowering individuals and groups, providing technical assistance, financial aid, and advocacy, and coordinating institutions to avoid redundancy. However, international laws governing health will accomplish little if individuals, non-governmental organizations, and states do not internalize the global norms

contained in these laws.<sup>34</sup> Because formal international legal frameworks will play at best a secondary role in advancing global health, alternative frameworks should be pursued.

A range of potential alternatives exist for promoting health as a human right. At the outset, it is essential to note the central role of states in achieving the highest possible standards of population health. In the long-run, public health infrastructure and national health care systems are vital components of any effort to produce sustainable improvements in the health of populations across the globe. Furthermore, a focus on national political and economic systems would properly embed efforts to promote and institutionalize a right to health in local and national contexts and, in doing so, might avoid the international paternalism that sometimes characterizes global health initiatives. The political and economic challenges involved in producing the necessary changes within national political and economic systems across the globe are vast (some would say insurmountable), but the central role of national health systems and public health infrastructure must be mentioned in any serious discussion of mechanisms for promoting a human right to health.

Proponents of the FCGH might argue that an effort to promote this framework convention is consistent with simultaneously pursuing policy changes at the national level. However, in the context of scarce resources, legitimate questions can be asked about how the scholars and practitioners mobilizing around the FCGH might most effectively use their time and energy as well as limited funds for global health initiatives. In this regard, the role of epistemic communities—the network of knowledge-based experts in particular domain or issue areas—is critical. Epistemic communities can play a critical role in “articulating the cause-and-effect relationships of complex problems, helping states identify their interests, framing the issues for collective debate, proposing specific policies, and identifying salient points for negotiation” in coordinating national and international policy discussions.<sup>35</sup> The proponents of the FCGH represent an important constituency in a “global health epistemic community.” Arguably, the time, energy, and money of the knowledge-based experts in this community would be better spent working directly with the key state actors involved in health policy debates to help shape state preferences and interests in this issue area, to frame national debates, and to propose and advocate for specific policies at the national level rather than in pushing for yet another specialized treaty in an international human rights regime that already recognizes a human right to health.

In addition to working on creating viable national health care systems and public health infrastructures, Hoffman and Rottingen suggest several alternatives for promoting global health, including reforming existing international legal institutions that work on global health, including the World Health Organization, and the negotiation of state contracts and political declarations as more flexible and cost-effective approaches to generating state support for global health initiatives.<sup>36</sup> The negotiation of new public-private partnerships to advance specific health aims would be a related approach.<sup>37</sup>

Ruger puts forward another alternative to the FCGH that would still be grounded in international law. Rather than creating a formalized treaty regime

governing global health, Ruger suggests that the international community should develop a Global Health Constitution (GHC) that would set out guiding principles and objectives, clarify jurisdiction and responsibilities among global health actors, and provide an integrative, non-binding framework for global health work.<sup>38</sup> Building on Ruger's Global Health Constitution, Hoisington proposes the creation of a Global Health Governance Constitution (GHGC), a non-binding instrument that would bring together various state and non-state actors that play a central role in advancing global health. These actors would convene annually in a World Health Governance Forum that would continually review and update GHGC norms with a commitment to improving efforts to advance global health. According to Hoisington, a GHGC would represent a "meta-institution of governance" based on a cooperative, fluid, broad-based approach to collective problem-solving in the area of global health. The non-binding nature of this approach would serve as an advantage by emphasizing collaborative, dynamic, responsive approaches to global health that engage not only states but also non-governmental organizations involved in critical efforts to promote and protect global health.<sup>39</sup>

According to its proponents, an informal constitutional approach to the legal advancement of global health norms would avoid the pitfalls associated with efforts to rely on treaty frameworks. Although they are typically characterized by significant gaps between their written provisions and actual outcomes, treaties are based on the presumption that the creation of binding, enforceable legal provision are the central mechanism for promoting global norms. In contrast, a global health constitutional framework could articulate common principles and might solve international coordination problems without emphasizing legal enforceability. In this way, a global health constitution would be designed to govern relations and to encourage cooperation among a range of diverse actors, including non-governmental organizations as well as states, with a stake in the advancement of global health. In short, a constitutional approach to global health might articulate a normative framework for global health governance that would not rely on the creation of formal governmental institutions with concrete enforcement powers, the latter goal being unlikely to receive sufficient political support among states.<sup>40</sup>

Although a framework emphasizing the essential roles to be played by non-state as well as state actors outside of an international treaty structure offers an important alternative to the FCGH, global health constitutional frameworks still represent a top-down legalistic approach to promoting global health that does not entirely surmount the political obstacles that limit formal international law as a mechanism for advancing health and human rights. There is certainly potential value in generating support for a common normative framework that individuals, non-governmental organizations, and states might leverage in their efforts to advance domestic laws and policies intended to further global health. However, the value of a GHC framework relative to its costs is unclear. The benefits of creating a common normative framework via a GHC would be indirect—states and non-governmental organizations could rely on GHC norms to advance global health goals in domestic political contexts. Yet, these actors can already advocate on behalf of global health justice absent a universalistic GHC.

Indeed, it may be that advocacy on behalf of global health justice reflecting specific socio-cultural perspectives in particular societies may have greater political resonance. At the same time, the potential costs of creating a GHC are similar to those involved in the creation of the FCGH. There would be significant costs—in terms of money, human resources, and time—associated with negotiating and maintaining a dynamic GHC that might be better spent on other global health initiatives focused more on concrete improvements to health outcomes rather than generating global consensus on norms. Oversight of a GHC would, likewise, involve administrative burdens and transaction costs that may not be warranted given the limited and indirect benefits of a constitutional approach at the global level.

Another legalistic alternative to a comprehensive FCGH would be to develop specialized legal regimes in narrow issue-based or functional areas. In this regard, the WHO Framework Convention on Tobacco Control provides a useful model. Adopted by the World Health Assembly in 2003 and entering into force in 2005, the Framework Convention on Tobacco Control (FCTC) seeks to promote international cooperation on the regulation and control of tobacco.<sup>41</sup> The FCTC contains a range of provisions designed to both reduce demand for and supply of tobacco products, including calling for member states to tax tobacco products, to prohibit and criminalize the sale of tobacco products to minors, to adopt measures designed to limit exposure to smoke, to raise public awareness about the risks of tobacco use, and to fund programs designed to create alternative economic opportunities for populations for whom the tobacco industry is a primary source of income. A large majority of the over-170 state parties to the framework are complying with the treaty's reporting requirements. According to these reports, eighty percent of members have created educational programs designed to raise public awareness about tobacco-related health risks. A similarly high percentage of members have put prohibitions on the sale of tobacco to minors in place. Adoption of other recommendations included in the treaty, including calls for bans on advertising, the establishment of smoke-free public spaces, or the creation of economic alternatives for populations whose income comes from tobacco production, is not as high.<sup>42</sup> The mixed record of the FCTC suggests that narrow, issue-based or functional legal regimes will not avoid the problems with more broad-based international laws. Nevertheless, the areas of implementation effectiveness indicate that specialized legal regimes may show promise of success in generating voluntary cooperation among states on certain highly focused objectives.

Finally, proponents of a human right to health should consider emphasizing the potential role of professional associations in advancing a concept of global health with justice. For example, professional codes of ethics might serve to advance support for rights-based approaches among health professionals who would then be in a position to change medical practices in ways that advance a human right to health among the populations with whom they work. The World Medical Association's Declaration of Geneva provides a prominent example of such a code. This declaration articulates a physician's oath calling for physicians to pledge to work in the service of humanity and to refrain from using medical knowledge contrary to the laws of humanity, even when

threatened.<sup>43</sup> The WMA Declaration represents a voluntary code, and physicians may or may not take the WMA pledge depending on national laws governing medical licensing in particular countries, the guidelines and requirements of professional medical associations, and national standards for medical education. In addition to variation in standards across countries, particular standards vary according to areas of medical specialization. The plethora of national and professional actors involved in this area indicates that the path towards adopting and applying rigorous and consistent standards in professional medical associations would not necessarily be easy or straightforward. That said, professional medical associations have regular professional meetings at which these normative codes might be easily placed on the agenda without significant additional costs. Thus, this approach could be an efficient and effective method for advancing the understanding and application of health-related human rights norms among professionals with the capacity to generate meaningful changes that directly affect the individual patients they treat.

The role of the Royal Dutch Medical Association (KNMG) in driving substantive changes to cultural practices related to the non-therapeutic genital cutting of children provides an interesting example of the potential role of professional associations in promoting a human right to health outside of formal law and governance. Consistent with its strong position against female genital cutting, the KNMG has taken the position that the circumcision of male minors is “not justifiable except on medical/ therapeutic grounds.” Further, the KNMG argues that, to the extent that there are medical benefits, male circumcision should be delayed until potential risks become relevant and a boy can decide whether or not he wants the procedure to minimize any health risks. The KNMG position paper articulating this stance “calls for a dialogue between doctors organizations, experts and the religious groups concerned in order to put the issue of non-therapeutic circumcision of male minors on the agenda and ultimately restrict it as much as possible.”<sup>44</sup> Notably, the KNMG advocates reducing the prevalence of the non-therapeutic genital cutting of children via cooperation with religious and cultural groups that engage in ritual genital cutting rather than through legal prohibitions against the practice. It is too soon to tell whether the KNMG position will dramatically reduce the prevalence of the non-therapeutic genital cutting of children in the Netherlands. Regardless, this example illustrates the potential of working through professional medical associations to advance fundamental health-related human rights as a potential alternative to expanding the body of formal international human rights law and its attendant bureaucracy.

Each of these alternatives faces its own set of political constraints, and a thorough vetting of these alternatives goes beyond the scope and space constraints of this article. Nevertheless, prior to investing significant resources in the development of the FCGH, deeper consideration of whether any of these alternatives would offer a more cost-effective, impactful, and/ or sustainable approach to promoting a human right to health is warranted.

## CONCLUSIONS

The progressive development of international human rights law represents a triumph of ideas, and the global norms codified in the major human rights treaties matter. These norms can be mobilized by international organizations, states, and non-governmental organizations to generate support for specific policy mechanisms intended to advance particular human rights. The international human rights regime has changed the global political landscape in dramatic ways. It has “shifted the goalposts for what is acceptable and also motivated foreign policy on human rights.”<sup>45</sup> Notably, the human rights regime has succeeded in contributing to real human rights protections, especially in a small number of countries that already have relatively strong human rights records.<sup>46</sup>

Nevertheless, international human rights law remains an imperfect mechanism for leveraging social, political, and economic changes at all levels, from the local to the global. Because of the central role of state in the international system and the trumping effects of state sovereignty, formal international law does not guarantee that norms will be effectively translated into concrete policy mechanisms that generate the intended outcomes. Further, formal law has the potential to generate perverse and unexpected consequences. Indeed, certain human rights violations have increased in tandem with growth in the number of states that have ratified international human rights instruments.<sup>47</sup> Despite law’s potential distorting effects, we would not argue that local or national political systems should abandon law as a critical tool of governance, and the purpose of this critique is not to negate the potential value of international human right law. Yet, the limitations of formal law in translating legal norms into effective governance in practice is especially pronounced at the global level, and the gap between the rhetoric of international rights law and the reality of the status of fundamental human rights is often vast.

In this context, it is worth questioning whether or not it makes sense to contribute to the proliferation of specialized human rights treaties and the associated—and likely redundant—human rights bureaucracy that would inevitably follow. International human rights law primarily functions as a political tool that can be used to advance specific rights-based causes. Arguably, existing treaties already provide potential political levers that proponents of a human right to health can use to try to advance global health initiatives at both the national and international level. The global resources—both human and financial—that would need to be marshaled to develop, implement, and maintain the FCGH have the potential to crowd out funding for alternative approaches that might better serve the advancement of global human rights norms across the globe.

The promotion of a framework convention articulating a universalistic claim to a human right to health is a noble goal. However, the state remains a critical actor in global health, and state sovereignty typically trumps universal norms. Additionally, political dynamics and socio-economic structures—more than international legal aspirations or constraints—shape state preferences and behavior. Considering this reality, alternative mechanisms that involve more

direct and efficient engagement with the state (most importantly, efforts to shape national health systems and public health infrastructure) and other approaches that circumvent the state (such as global health promotion via professional associations) may prove to be more efficient and effective tools for the progressive realization of a human right to health.

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<sup>1</sup> Lawrence O. Gostin, Eric A. Friedman, Kent Buse, Attiya Waris, Moses Mulumba, Mayowa Joel, Lola Dare, Ames Dhair, and Devi Sridhar, "Towards a Framework Convention on Global Health," *Bulletin of the World Health Organization* 91 (2013): 790-93. Available online at: <http://www.who.int/bulletin/volumes/91/10/12-114447/en/>

<sup>2</sup> Prior to the publication of the perspectives paper, Lawrence O. Gostin authored an earlier version of a proposal for the development of a Framework Convention on Global Health. Lawrence O. Gostin, "A Proposal for a Framework Convention on Global Health," *Journal of International Economic Law* 10: 4 (2007): 989-1008.

<sup>3</sup> Gostin et. al.: 790.

<sup>4</sup> Debra L. DeLaet and David E. DeLaet, *Global Health in the 21<sup>st</sup> Century: the Globalization of Disease and Wellness* (Boulder, CO: Paradigm Publishers, 2012): 160-161.

<sup>5</sup> Adopted and opened for signature, ratification, and accession by Resolution 260 (III) A of the U.N. General Assembly on 9 December 1948. Entry into force: 12 January 1951, in accordance with Article 13.

<sup>6</sup> Adopted and opened for signature, ratification, and accession by Resolution 2200A (XXI) of the U.N. General Assembly on 16 December 1966. Entry into force: 23 March 1976, in accordance with Article 49.

<sup>7</sup> Adopted and opened for signature, ratification and accession by Resolution 34/180 of the U.N. General Assembly on 18 December 1979. Entry into force: 3 September 1981, in accordance with article 27(1).

<sup>8</sup> Adopted and opened for signature, ratification and accession by Resolution 39/46 of the U.N. General Assembly on 10 December 1984. Entry into force 26: June 1987, in accordance with article 27 (1).

<sup>9</sup> Adopted and opened for signature, ratification and accession by Resolution 44/25 of the U.N. General Assembly on 20 November 1989. Entry into force 2 September 1990, in accordance with article 49.

<sup>10</sup> Adopted and opened for signature, ratification and accession by Resolution 2200A (XXI) of the U.N. General Assembly on 16 December 1966. Entry into force: 3 January 1976, in accordance with article 27.

<sup>11</sup> Office of the High Commissioner of Human Rights, CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-Second Session of the Committee on Economic, Social, and Cultural Rights, on 11 August 2000 (Contained in Document E/C. 12/2000/4). Available online at: <http://www.refworld.org/docid/4538838do.html>.

<sup>12</sup> Gostin et al.: 791-92.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Debra L. DeLaet, *The Global Struggle for Human Rights: Universal Principles in World Politics* 2d Ed. (Stamford, CT: Cengage Learning, 2014): 31-34.

<sup>17</sup> Ibid.: 34-35.

- <sup>18</sup> Emilie M. Hafner-Burton, *Making Human Rights a Reality* (Princeton, NJ: Princeton University Press, 2013): 44-66.
- <sup>19</sup> M. Bullinger, R. Anderson, D. Celia, and N. Aaronson, "Developing and Evaluating Cross-cultural Instruments from Minimum Requirements to Optimal Models," *Quality of Life Research* 2 (1993): 451-459.
- <sup>20</sup> Andrew Sullivan, "Verschärfte Vernehmung," *The Atlantic*, May 29, 2007. "
- <sup>21</sup> DeLaet (2014): 141-142.
- <sup>22</sup> Office of the High Commissioner of Human Rights, "United Nations Human Rights Programme." Available online at: <http://www.unhchr.ch/html/abo-intr.htm>.
- <sup>23</sup> Jennifer Prah Ruger, "Normative Foundations of Global Health Law," *The Georgetown Law Journal* 96 (2008): 434-439.
- <sup>24</sup> Valerie M. Hudson, Donna Lee Bowen, and Perpetua Lynn Nielsen, "What is the Relationship between Inequity in Family Law and Violence against Women? Approaching the Issue of Legal Enclaves," *Politics & Gender* 7: 4 (December 2011): 456.
- <sup>25</sup> Gostin et al.: 792-793.
- <sup>26</sup> Emilie M. Hafner-Burton, "Sticks and Stones: Naming and Shaming the Human Rights Enforcement Problem," *International Organization* 62 (Fall 2008): 700-707.
- <sup>27</sup> Steven J. Hoffman and John-Arne Rottingen, "Dark Sides of the Proposed Framework Convention on Global Health's Many Virtues: a Systematic Review and Critical Analysis," *Health and Human Rights* 15:1 (June 2013): 119-120.
- <sup>28</sup> As Hoffman and Rottingen note, regime complexity is not inherently a negative feature of international law. Rather, fragmented and diffuse institutional power can create competitive dynamics among bodies working in the same issue area that allow more effective institutions to circumvent ineffective, sclerotic, and dysfunctional bodies, criticisms that have been levied against the World Health Organization. Yet, duplication and fragmentation also generate significant inefficiencies and unnecessary expenditures. In the case of the FCGH, the critical risk is that it will add to layers of global bureaucracy by creating yet another body with a mandate that overlaps with existing U.N. bodies and affiliated agencies that work on global health but with similarly limited functions and powers. Ibid.: 123.
- <sup>29</sup> Ibid.: 119-120.
- <sup>30</sup> Ibid.: 121.
- <sup>31</sup> Ibid.: 119-120.
- <sup>32</sup> Ibid.: 119-120.
- <sup>33</sup> Ibid.: 123.
- <sup>34</sup> Ruger (2008): 425-433.
- <sup>35</sup> Peter M. Haas, "Introduction: Epistemic Communities and International Policy Coordination," *International Organization* 46: 1 (Winter 1992): 2-3.
- <sup>36</sup> Hoffman and Rottingen: 124-125.
- <sup>37</sup> Michael Reich, ed. *Public-private Partnerships for Public Health* (Cambridge, MA: Harvard Center for Population and Development Studies, 2002).
- <sup>38</sup> Jennifer Prah Ruger, "A Global Health Constitution for Global Health Governance," *Proceedings of the Annual Meeting (American Society of International Law)* 107 (2013): 267-70.
- <sup>39</sup> Matthew Holsington, "A Special Role for the World Health Organization in the Creation of a Living, Breathing, Global Health Governance Constitution," *Global Health Governance* 7:2 (2013): 7-9. Available online at: [http://blogs.shu.edu/ghg/files/2014/02/GHGJ\\_62\\_124-134\\_HOISINGTON.pdf](http://blogs.shu.edu/ghg/files/2014/02/GHGJ_62_124-134_HOISINGTON.pdf).
- <sup>40</sup> Ruger (2013): pp. 268-269.
- <sup>41</sup> *History of the World Health Organization Framework Convention on Tobacco Control* (World Health Organization, 2009). Available online at: [http://whqlibdoc.who.int/publications/2009/9789241563925\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563925_eng.pdf)
- <sup>42</sup> Haik Nikogosian, "WHO Framework Convention on Tobacco Control: a Key Milestone," *Bulletin of the World Health Organization* (2010). Available online at: <http://www.who.int/bulletin/volumes/88/2/10-075895/en/>.
- <sup>43</sup> World Medical Association, *Declaration of Geneva* (1948, 1968, 1983, 1994, 2005) excerpted in Stephen P. Marks, *Health and Human Rights: Basic International Documents*, 2d. Ed. (Cambridge, MA: Harvard University Press, 2006): 27.
- <sup>44</sup> Royal Dutch Medical Association (2010). *Non-therapeutic Circumcision of Male Minors*



Position Paper.

<sup>45</sup> Hafner-Burton, *Making Human Rights a Reality*: 2.

<sup>46</sup> Ibid.: xvi.

<sup>47</sup> Ibid.: 74-75.

# **It's Not Just for States Anymore: Legal Accountability for International Organizations under the Framework Convention on Global Health**

Mara Pillinger

*Ensuring legal accountability for the right to health is among the core goals of a Framework Convention on Global Health (FCGH). Current FCGH proposals promote legal accountability in innovative ways, including the extension of accountability for rights to health to both private actors and states. Nevertheless, these proposals overlook the crucial role of international organizations (IOs). IOs can play an important role in defending and extending health rights and access to healthcare but, as the Haitian cholera outbreak illustrates, their activities may also threaten individuals' health. When this occurs they need to be held accountable to and by the individuals they harm. Thus, to be truly comprehensive, the FCGH must establish legal accountability for IOs as well as states and private actors.*

## **INTRODUCTION**

Ensuring accountability, particularly legal accountability for the right to health is among the core goals of a Framework Convention on Global Health (FCGH).<sup>1</sup> Legal accountability is crucial because it promotes enforcement and empowers individuals to claim their rights by providing concrete targets and formal processes around which to mobilize.<sup>2</sup> Current FCGH proposals promote legal accountability in sophisticated and innovative ways—most notably, by extending accountability for health rights to private actors (e.g. transnational corporations) and states.<sup>3</sup> Several authors have assessed the strengths and weaknesses of these proposals.<sup>4</sup> Nevertheless, both the proposals and assessments overlook an important dimension of accountability: legal accountability of international organizations (IOs). IOs play an important role in defending and extending health rights and access to healthcare, but occasionally their activities may also threaten peoples' health. When this occurs, IOs need to be held accountable by and to the individuals they harm. Thus, to be truly comprehensive, the FCGH must establish legal accountability for IOs as well as states and private actors.

There is no better illustration of the need for IO legal accountability than the Haitian cholera epidemic. Cholera was brought to Haiti by UN peacekeepers, and the epidemic began after poor sanitation practices at the peacekeepers' base contaminated one of Haiti's major water sources.<sup>5</sup> But, as of December 2015, the UN has refused to accept responsibility or provide redress to cholera victims. Through its inaction the UN has arguably violated the victims' human rights to health and effective remedy. But there are no legal mechanisms through which the victims can hold the UN accountable for these violations.<sup>6</sup>

This paper argues the need for IO legal accountability and asserts that the FCGH can play an important role in promoting it. I begin by describing the Haitian cholera epidemic and the obstacles to health justice and the UN responsibility in greater detail. Next, I review the ways in which FCGH proposals currently address legal accountability, stressing the lack of attention to IOs. Finally, while acknowledging the challenges involved, I suggest several ways in which the FCGH can advance IO legal obligations and accountability.

## **CHOLERA IN HAITI<sup>7</sup>**

In October 2010, Haiti reported its first cholera outbreak in at least a century.<sup>8</sup> The epidemic spread through the country in a matter of days, and with one new infection occurring each minute, Haiti soon had more cholera cases than the rest of the world combined.<sup>9</sup> As of November 2015, over 750,000 people (~7% of Haiti's population) became sick, and approximately 9,000 died.<sup>10</sup> Multiple independent epidemiological investigations, environmental surveys, molecular biological analyses, and eyewitness reports have concluded that cholera was brought to Haiti by Nepalese peacekeepers serving as part of the UN Stabilization Mission in Haiti (MINUSTAH).<sup>11</sup> Although cholera is endemic in Nepal and cases are often asymptomatic, the peacekeepers were not screened for infection prior to deployment.<sup>12</sup> Upon arrival in Haiti, they occupied a base in Mirebalis, on a tributary of the Artibonite River. Sanitary conditions on the base were substandard, even negligent—cracked and poorly-laid plastic pipes discharged raw sewage through a drainage canal into the river and human waste was dumped in open-air pits that overflowed during heavy rains.<sup>13</sup> As a result, one of Haiti's main water sources for consumption and household use was contaminated with cholera.<sup>14</sup>

Given rumors about waste dumping and that the first cases appeared around the UN base, many Haitians concluded that MINUSTAH was to blame for the epidemic. When confronted with these accusations, the UN responded with denials, dissembling, and arguably a cover-up.<sup>15</sup> UN representatives repeatedly released incorrect information about whether the peacekeepers had been screened for cholera, whether tests detected cholera on the MINUSTAH base, and whether waste management practices on the base conformed to international standards.<sup>16</sup> At the beginning the UN discouraged investigation into the source of the outbreak, arguing that such efforts were not helpful, would divert attention and resources from fighting the epidemic, and could even lead to dangerous scapegoating and violence.<sup>17</sup> They also obstructed a Haitian Ministry of Health investigation by refusing to allow epidemiologists access to the MINUSTAH base.<sup>18</sup> Once this access was finally granted, it became clear that the peacekeepers had attempted to hide evidence of negligence, scrubbing feces out of the drainage canal and duct-tapping cracks in the pipes.<sup>19</sup>

In December 2010, the Secretary-General bowed to pressure and agreed to appoint an Independent Panel of Experts to investigate the outbreak. The Panel determined that it was “a result of human activity; more specifically...the contamination of the Méyè Tributary System of the Artibonite River with a

pathogenic strain of the current South Asian type *Vibrio cholera*.”<sup>20</sup> But they also maintained that because “[t]he introduction of this cholera strain as a result of environmental contamination with feces could not have been the source of such an outbreak without simultaneous water and sanitation and health care system deficiencies...[T]he Haiti cholera outbreak was caused by the confluence of circumstances... and was not the fault of, or deliberate action of, a group or individual.”<sup>21</sup> However, a raft of subsequent studies challenged this last conclusion and placed the blame squarely on MINUSTAH.<sup>22</sup> In light of these studies, the Panel members revised their position, publishing an updated report in which they stated that “the preponderance of the evidence and the weight of the circumstantial evidence does lead to the conclusion that personnel associated with the Mirebalais MINUSTAH facility were the most likely source of introduction of cholera into Haiti.”<sup>23</sup>

According to these findings it seems clear that the UN was unintentionally responsible for violating Haitians’ human rights to life, health, clean water and sanitation, and an adequate standard of living.<sup>24</sup> If nothing else, the UN violated the “do no harm” principle. For an organization whose core mission includes leveraging moral authority to promote human rights and the rule of law, these are serious charges. UN officials have continued to cite the “confluence of circumstances” to avoid acknowledging culpability for the epidemic. Anthony Banbury, the Assistant Secretary General for Field Support, stated that “[w]e don’t think the cholera outbreak is attributable to any single factor,” while Edmond Mulet, the Under Secretary-General for MINUSTAH protested that it was “really unfair to accuse the UN for bringing cholera into Haiti [sic].”<sup>25</sup> Michel Bonnardeaux, a spokesman for the UN Department of Peacekeeping Operations, stated that “[a]nyone carrying the relevant strain of the disease in the area could have introduced bacteria into the river.”<sup>26</sup>

In addition to denying responsibility for the epidemic, the UN has sidestepped its legal obligation to provide effective remedy to the cholera victims. The conditions of the UN liability were established by the 1946 Convention on the Privileges and Immunities of the United Nations (CPIUN), elaborated in several General Assembly Resolutions and Secretary-General’s Reports, and reiterated in the 2004 UN-Haiti Status of Forces Agreement (SoFA) governing MINUSTAH.<sup>27</sup> According to the CPIUN §2, the UN enjoys absolute immunity from prosecution in national courts. But this immunity was not intended to allow the UN to operate with total impunity or to insulate it from responsibility for harms caused to individuals (except in cases of operational necessity). On the contrary, the CPIUN (§29) also establishes that the UN has an obligation to provide appropriate alternative modes of dispute settlement for private law claims (e.g. contract disputes, property loss/damage, personal injury). Likewise, the SoFA (§55) states that the UN will establish a standing claims commission to resolve any third-party private law claims. Taken together, the immunity and alternative dispute resolution provisions are meant to ensure that governments cannot use prosecution to harass or pressure the UN while preserving individuals’ rights of access to court and effective remedy.<sup>28</sup>

Legal activists have attempted to hold the UN accountable for the cholera epidemic. In November 2011, the Institute for Justice and Democracy in Haiti/Bureau des Advocats Internationaux filed a Petition for Relief with the UN on behalf of 5,000 cholera victims. The petition accused the UN of “negligence, gross negligence, recklessness, and deliberate indifference for the lives of Haitians” and demanded that MINUSTAH establish a standing claims commission to receive the victims’ claims and award financial compensation at a minimum of \$50,000 for severe illness and \$100,000 per death.<sup>29</sup>

The UN rejected these demands. While expressing concern for the situation in Haiti and outlining its efforts to combat the epidemic, the UN stated that because “consideration of these claims would necessarily include a review of political and policy matters...these claims are not receivable pursuant to Section 29 of the [CPIUN].”<sup>30</sup> Without detouring into legal technicalities, the UN’s position can be summarized as following: the CPIUN and SoFA require the UN to receive private law claims, but because the cholera victims’ claims involve political/policy matters (e.g. whether the UN’s policy of not screening peacekeepers constitutes negligence), they are public (not private) law claims and therefore this requirement does not apply.<sup>31</sup>

Although the legal merit of this argument is strongly disputed, the UN’s decision is likely to be final. Because there are no international judicial review mechanisms accessible to individuals, the victims essentially have no way to appeal the UN’s decisions. They have filed several class action lawsuits against the UN in US District Court (*Georges et al. v. UN et al.*, *Laventure et al. v. UN et al.*, and *Jean-Robert et al. v. UN et al.*), hoping that the court would hold the UN liable and enforce the ruling. However, in January 2015, the first of these lawsuits was dismissed on the grounds that “[t]he U.N. is immune from suit unless it expressly waives its immunity.”<sup>32</sup> The victims are appealing but the same outcome is expected, as US courts have consistently refused to pierce UN immunity.<sup>33</sup> Thus while in theory, the UN has a legal obligation to provide remedy, in practice the organization effectively sets the terms of its own responsibility. In short, we have a case in which an IO was responsible for violating the human right to health twice: first, by unintentionally causing a cholera epidemic; and second, by stymying victims’ attempts to hold the violators accountable and defend their rights to health, access to court, and effective remedy.

## LEGAL ACCOUNTABILITY IN THE FCGH

The goal of the FCGH is to prevent such outcomes. Promoting accountability, particularly legal accountability, for the right to health is one of its core goals: “people [must] have the opportunity to understand and question government policies and actions, get answers, challenge responses, and obtain redress for rights violations.”<sup>34</sup> FCGH advocates argue that a new Framework is necessary because existing treaties and instruments that articulate health rights are inadequate. They are abstract, lack specific commitments or accountability structures, and are poorly implemented and enforced.<sup>35</sup> In order for health rights to be meaningful, at least three conditions are necessary. First, the rights must be

clearly defined. Second, actors who provide healthcare or whose activities significantly impact the health of populations must acknowledge specific, binding right-to-health obligations. Third, individuals must be aware of their rights and empowered to hold actors responsible if those rights are violated or obligations go unfulfilled. The FCGH provides a framework for realizing these conditions. More specifically, it aims to:

- “• Clarify right-to-health obligations, including obligations related to equity, participation, and accountability, utilizing maximum available resources towards rights, areas requiring immediate realization and the nature of progressive realization, respecting and advancing the right to health in other states, and ensuring accountability for transnational corporations [sic].
- Empower people to claim and enforce the right to health, build the capacities required to achieve this right, and ensure immediate and effective enforceability of the right to health.
- Enhance right to health accountability at local, national, and global levels, including a robust regime of compliance to the FCGH itself...[and]
- Improve international partner harmonization and alignment with national health strategies, ensure country ownership, and guarantee mutual accountability.”<sup>36</sup>

FCGH advocates place special emphasis on making the right to health justiciable and on the creation of legal mechanisms that would be equally accessible to everyone, including the poorest and most marginalized.<sup>37</sup> Legal approaches offer several advantages over political ones, especially at the national level. First, in theory codification can strengthen commitments by increasing their precision, encouraging their prioritization, and distancing them from messy politicking.<sup>38</sup> Second, litigation represents a concrete, institutionalized, and (ideally) impartial process for seeking remedy from violations, whereas political processes may be more obscure and less accessible.<sup>39</sup> Third, legal processes can act as a focal point for activists, empowering them to pursue change.<sup>40</sup> Finally, especially when law is enforceable, legalization and human rights discourse change the nature of the game by turning discretionary commitments into obligations. Without law, “there are only political processes left” and “mechanisms to hold governments accountable to the right to health [will] lack the power to be effective where governments are not interested in complying”.<sup>41</sup> Replace the word “governments” with “IOs” and this is precisely the problem in the Haiti case.

FCGH advocates have proposed and debated several legal accountability mechanisms, ranging from judicial or quasi-judicial processes to alternative modes of dispute resolution.<sup>42</sup> Just Haffeld, Harald Siem and John-Arne Røttingen discuss an International Court of Health with enforcement capabilities, whereas Eric Friedman, Jashodhara Dasgupta, Alicia Yamin, and Lawrence Gostin indicate that existing human rights treaty bodies might do.<sup>43</sup> Friedman and Gostin also suggest that the FCGH could inspire national courts to adopt a

progressive, adaptable stance in enforcing the right to health.<sup>44</sup> Martin Hevia and Carlos Herrera Vacaflor envision a judicial procedure similar to an *amparo* remedy that would offer individuals and groups a simple, expedited process for bringing charges against public or private actors; they also recommend an ombudsperson or public defender.<sup>45</sup>

One of the most innovative features of FCGH proposals is their expansive view of who should be held legally accountable—not just states, but also transnational corporations, civil society organization, and aid donors and recipients.<sup>46</sup> Some even suggest that non-state actors participate as signatories.<sup>47</sup> Accountability should also extend beyond the health sector itself to encompass policies, actors, and activities that impact health in all spheres, including trade, investment, and the environment.<sup>48</sup> In short, FCGH advocates “are steadfast that the FCGH must ensure accountability of all actors—state and non-state, local, national and international.”<sup>49</sup>

### **MISSING DIMENSION: IO ACCOUNTABILITY**

Despite its ambitious scope, current FCGH proposals pay little attention to IOs.<sup>50</sup> Instead they focus on development of accountability mechanisms and promotion of justice at the national level. This omission is puzzling since a) the FCGH is relevant to IOs as well as states and private actors, and b) IOs cannot be held accountable through the same national-level processes as states and private actors on account of their immunity. Thus, to be truly comprehensive, the FCGH must include additional, IO-specific legal accountability mechanisms. In the following sections, I elaborate on why the FCGH should apply to IOs, propose ways in which current FCGH proposals can be extended, and identify potential obstacles involved.

The FCGH's core principles and objectives are as applicable to IOs as to states and private actors. First, the FCGH demands accountability from all actors that have responsibility for, or can have a significant impact on, the health of large groups. IOs are increasingly in this position. The cholera case demonstrates the risk of peacekeepers transmitting diseases, and as record numbers of peacekeepers are deployed around the world, this risk increases. The presence of peacekeepers may also pose other health risks for local populations (e.g. sexual violence). Furthermore, the UN occasionally acts as a quasi-governmental “temporary administrator” in post-conflict settings (e.g. Kosovo, East Timor) and may create or permit conditions that adversely impact health. For example, over 800 internally displaced persons in Kosovo attempted to bring personal injury claims against the UN, alleging that they had suffered lead poisoning as a result of contamination in UN-run camps. Similar to the cholera case, the UN refused to respond to these claims arguing that they were a matter of public rather than private law.<sup>51</sup> Finally, UN programs and specialized agencies such as UNICEF and WHO may directly deliver or coordinate provision of healthcare, water, and sanitation (e.g. during emergency relief missions or vaccination campaigns).<sup>52</sup> In view of these activities, accountability and justiciability cannot be limited to states and private actors—they also must extend to IOs.

Second, the FCGH aims to overcome barriers and correct inadequacies within existing accountability frameworks. Yet nowhere are these barriers and inadequacies more severe than with respect to IOs. For example, the FCGH aims to “unlock[] the potential for litigation to enforce [health rights] where other routes (e.g., constitutional right to life, judicially enforceable international treaties, and legislation) are unavailable or insufficient”.<sup>53</sup> The ultimate goal is to create accountability mechanisms robust enough to ensure that health justice is accessible even “where governments are not interested in complying”.<sup>54</sup> Yet, as the Haiti case demonstrates, the ability of individuals to obtain justice from IOs on their own behalf is entirely dependent on organizations’ willingness to comply.<sup>55</sup> Once the UN refused to receive the cholera victims’ claims, there were effectively no legal avenues through which the cholera victims could challenge that decision or obtain remedy (US lawsuits notwithstanding).<sup>56</sup> In short, Haffeld et al. argue that violations of health rights and “problems with access to health services appear where no formally responsible government exists, or the moment a government chooses to neglect their duty to the people, or indeed assumes that no such duty exists.”<sup>57</sup> This is true of IOs as much as governments and so the FCGH must address itself to both.

A second objective of the FCGH is to promote strong leadership and good governance for health, especially from WHO.<sup>58</sup> Good governance means that

“[p]ublic officials, who have the power to allocate resources and make policy, owe a duty of stewardship—an to act in the interest of the population they serve... It is transparent, in that institutional processes and decision-making are open and intelligible. It is deliberative, in that public officials meaningfully engage stakeholders, giving them the right to provide genuine input into policy making. Good governance is also accountable, in that political leaders give reasons for decisions and take responsibility for successes or failures...”<sup>59</sup>

The UN’s response to the cholera epidemic has not exemplified these characteristics. While the epidemic itself was not intentional, the UN’s subsequent efforts to evade responsibility were. This conduct does not inspire trust or reflect good stewardship. Nor has the UN been transparent and deliberative—beyond issuing a brief statement rejecting the victims’ claims, UN officials failed to provide a full explanation of their legal reasoning or to meet with the victims and their lawyers.<sup>60</sup> And overall, the UN has failed to take responsibility or demonstrate accountability.

However, the UN did make significant efforts to combat the epidemic, spending over \$140 million on cholera treatment and prevention activities and raising over \$400 million to support a cholera eradication initiative.<sup>61</sup> Unfortunately, this represents only a drop in the bucket—the estimated cost of eradication is \$2.27 billion.<sup>62</sup> The UN’s failure to raise the necessary funding is not due to lack of effort, but some have suggested its refusal to accept responsibility has so undermined its moral authority and credibility that it can no longer be an effective advocate.<sup>63</sup> This impasse has important implications for the



type of IO leadership envisioned in the FCGH. Gostin states that a core component of the WHO's leadership ability is its normative authority, yet the cholera case suggests that normative authority may be significantly undermined by the absence of accountability.<sup>64</sup> The broader point here is that sound governance and strong leadership require accountability from all leaders and governors. We cannot expect IOs to play a leadership role in advancing the right to health if they do not also share obligations and accountability towards it.

### **A SIGNIFICANT CHALLENGE...**

Thus far, I have made the case that in order to fully accomplish its purposes, the FCGH must promote legal accountability for IOs. This will not be an easy task. Since IOs enjoy broad immunity from domestic prosecution, we cannot simply include them in the national-level accountability mechanisms for states and non-state actors that the FCGH already proposes. Instead, FCGH proposals must be augmented with measures that either restrict IO immunity at the national level or innovate new international-level judicial or quasi-judicial review mechanisms that are accessible to individuals. These kinds of innovations would have implications beyond the realm of global health.<sup>65</sup>

Before discussing these options, it is important to acknowledge that FCGH advocates have reason to be leery of tackling IO accountability. First, it would further complicate the negotiation process, which some fear is already too complex and expensive.<sup>66</sup> Binding legal agreements are difficult to negotiate because they establish stronger and more enduring precedents than other types of agreements, and thus parties are less willing make concessions in the negotiation phase. This is even truer when agreements set precedents across multiple spheres of international law. In short, rethinking the terms of IO immunity and legal accountability is a tall order and FCGH advocates may be understandably reluctant to undertake that additional burden.

Second, IOs would play a vital role in shepherding negotiations and enforcing the FCGH, so there is reason to be concerned about alienating them. The FCGH has already been endorsed by IOs, including UNAIDS, the World Bank, and the UN Secretariat.<sup>67</sup> But were FCGH proposals to expand IO legal accountability, it could potential lead them to reconsider this support—e.g. the Secretary-General might withdraw support out of concern for the UN's position in situations such as cholera case. On the other hand, WHO has not yet endorsed the FCGH, but the alienation concern has not deterred debate about whether to tackle WHO reform in the FCGH negotiations or even whether a FCGH might sideline the WHO altogether.<sup>68</sup>

Both of these objections are valid. But we should not let challenges induce caution at the expense of attempting to do what needs to be done. FCGH proposals already innovate in ways that require significant legal changes—for example, by holding non-state actors legally accountable for right-to-health violations. There is no reason to draw the line at IO legal accountability.

### **... BUT A PROMISING OPPORTUNITY**

The FCGH could make a powerful contribution to promoting IO legal accountability in several ways: by strengthening IO's existing legal obligations; by expanding IOs' legal obligations; and/or by creating new, extra-legal accountability mechanisms. Whatever the approach, the FCGH cannot accomplish a sea change alone—that would require reforms that far exceed its scope and authority. But the good news is that the FCGH would not be going it alone. Similar efforts to reform IO accountability are already underway in other spheres of international law, and the FCGH can both capitalize upon and contribute to these efforts.

As the Haiti case demonstrates, the problem is not that the UN has no legal obligations to remedy harm, but rather that there is no way of holding the UN accountable if it fails to comply with those obligations. Thus, the FCGH can promote accountability by reinforcing IO obligations and strengthening enforcement mechanisms. This would be consistent with FCGH Platform principles “S” and “T”, which focus on developing effective mechanisms to remedy harm and the “immediate enforceability” of right-to-health obligations.<sup>69</sup> It would also be consistent with the principles of good governance that the FCGH aims to advance.

One barrier to accountability is that current mechanisms are *ad hoc*. For example, the CPIUN and SoFAs do not require dispute resolution mechanisms (e.g. claims commissions) to be set up until after a dispute has arisen or harm has been caused. But “after the fact” is precisely when IOs have the greatest incentive to stonewall—thus, it is not surprising then that no claims commission has ever actually been established.<sup>70</sup> More problematic is the lack of transparency in the process by which the UN receives claims and the inability to appeal its decisions. “Largely as a result of the internal, confidential and unilateral character of the review boards’ procedure, the UN has never in its history provided an articulated conception” of the standards used to evaluate claims.<sup>71</sup>

The FCGH can chip away at these barriers by clarifying and operationalizing IOs' obligations, at least with respect to the right-to-health and to the IOs that endorse it. It can articulate norms and standards for IOs to follow, such as institutionalizing accountability and remedy mechanisms at the start of a mission/program, publicizing the standards by which claims are evaluated, and establishing ombudspersons to review IO decisions.<sup>72</sup> And it can spur states to incorporate stronger obligations and accountability provisions into their own agreements with the UN (e.g. SoFAs). While an ombudsperson and a set of accountability standards are not legal mechanisms *per se*, they would at least create an avenue for official review of IO decisions.

Additionally, the FCGH can make progress towards creating new norms, standards, and mechanisms for IO responsibility. Specifically, it can seek to limit IOs' immunity, expand their obligations, and/or open new avenues through which victims can seek remedy. In pursuing these changes, FCGH advocates would be joining broader efforts already underway across spheres of international law. Scholars and activists are working to ensure that IO immunity does not preclude the human right to effective remedy by seeking either to

downgrade IO immunity or to better institutionalizing alternative dispute resolution mechanisms and (quasi-) judicial review processes.<sup>73</sup> Consistent with these efforts, the FCGH can promote legal accountability in several ways.

The most ambitious—though not radical—move would be to articulate limits on IO immunity. The UN Charter (Article 105) grants the organization “functional immunity,” a restricted form of immunity that exempts the organization from national prosecution only insofar as is necessary to allow it to fulfill its official mandates. Subsequently, UN immunity was expanded by the CPIUN (§3) and is currently considered absolute—i.e. applicable to all activities and not contingent upon fulfillment of other obligations. However, in response to such situations as Haiti, advocates encourage judges and lawmakers to revive functional immunity.<sup>74</sup> European courts, particularly lower courts, have begun reinterpreting judicial precedent in this direction.<sup>75</sup> By conceptualizing IO immunity in functional terms the FCGH could do the same. If successful, this move would enable IOs to be held accountable through the national-level legal mechanisms already proposed in the FCGH (except in cases of operational necessity).<sup>76</sup>

If the immunity issue is deemed too thorny or out of scope, the FCGH can advance IO legal accountability in other ways. One possibility, mentioned in Platform principle “Y”, would be to create a right-to-health claims body (along the lines of a standing claims commission); if the FCGH establishes right-to-health obligations for IOs, then individuals could pursue remedy for violations under the FCGH.<sup>77</sup> The Haiti case demonstrates the acute need for a claims body that is willing and able to give voice to individuals who otherwise lack legal standing. While individuals and civil society groups are currently able to petition human rights bodies (e.g. the UN Human Rights Commission, the Inter-American Commission on Human Rights), in the Haiti case, these bodies proved unwilling to take up the victims’ claims.<sup>78</sup> This is where a dedicated right-to-health claims body—perhaps sitting outside the UN system—would come in.

In the Haiti case the problem was not simply that the UN refused to receive the victims’ claims, but also that there was no appeal mechanism through which the victims’ could challenge its decision. Therefore, the ultimate goal for a right-to-health claims body would be to exercise some form of oversight on IO decisions.

It is not clear that the FCGH itself could bestow this authority. But here again, the FCGH has the opportunity to capitalize on other international legal developments and operate synergistically with other accountability mechanisms. In 2011, the International Law Commission adopted the Draft Articles on the Responsibility of International Organizations (DARIO) which creates a “law of consequences” for IOs.<sup>79</sup> DARIO takes a broad view of IO liability, holding them responsible for the acts of their subsidiaries, for the failure to act, and even for the failure to conduct due diligence. It also mandates full reparations and remedy, including financial compensation.<sup>80</sup> Most importantly, DARIO governs relations among IOs as well as between IOs and states, so hypothetically, the UN could be held accountable by other international bodies. DARIO’s impact is significantly limited by the fact that it is not legally binding, does not create a

judicial forum in which charges can be pursued, and still fails to grant individuals legal standing—which means that individuals' claims would have to be taken up by a human rights body. But if the FCGH creates a claims body to pursue health justice, DARIO could provide a legal framework for doing so.

Finally, just as the FCGH process can build off of broader debates on IO responsibility, it can also contribute to them. A health rights perspective can bolster demands for IO accountability for two reasons. First, advocates tend to frame IO accountability as a necessary guarantor of the human rights of access to court and effective remedy. However, the Haiti case demonstrates that these rights are essential not only for their own sake, but also to safeguard other human rights, such as the right to health. If IOs cannot be held accountable for rights violations, they have fewer incentives (aside from moral ones) to ensure that those violations are not repeated. This is arguably illustrated by the fact that the UN still does not require that peacekeepers be screened for cholera.<sup>81</sup> Second, the FCGH can formally establish right-to-health obligations for IOs, and because obligations are largely meaningless without accountability, the more obligations IOs hold, the more apparent the need for accountability becomes.

## CONCLUSION

In sum, current FCGH proposals are innovative in their ambitions to ensure that both state and non-state actors are legal accountable for the right to health. But health is not the responsibility of these actors alone. IOs also play a crucial role in promoting health rights and ensuring access to healthcare. However, in some cases, their activities may violate health rights, either unintentionally (as in the cholera case) or intentionally (as with sexual violence). Therefore, to be truly comprehensive, current FCGH proposals must be expanded to address the legal accountability of IOs. Possible contributions include reiterating and strengthening IO's existing legal obligations and accountability mechanisms, limiting IO immunity, or creating a right-to-health claims body. Each of these measures would undoubtedly be legally complicated and politically controversial, and reforming IO accountability is cannot be accomplished by the FCGH alone. But similar efforts are already underway in other spheres of international law, and the FCGH can do much to advance these efforts. FCGH advocates argue that “the right to health [is] a compelling framework for holding states accountable [because] it has wide international acceptance as binding law.”<sup>82</sup> I add that it is also a compelling framework for holding IOs accountable.

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<sup>1</sup> Eric Friedman, Jashodhara Dasgupta, Alicia Yamin, and Lawrence Gostin, "Realizing the Right to Health Through a FCGH?," *Health and Human Rights* 5.1 (2013):1–4; Joint Action & Learning Initiative on National and Global Responsibilities for Health (JALI), "Manifesto on Global Health Justice & the FCGH," (May 2012), <http://www.jalihealth.org/documents/manifesto.pdf>; JALI, "Platform for a FCGH: Realizing the Universal Right to Health" (May 2014), <http://www.jalihealth.org/documents/platform-for-an-fcgh-march-2014-full-4-7-14.pdf>; JALI, "The FCGH and the Post-2015 Development Agenda: Incorporating the Principles of an FCGH into the New Development Goals" (December 2012),

<http://www.jalihealth.org/documents/post-2015-development-agenda.pdf>; JALI, "A FCGH: Securing the Right to Health and Advancing Health Equity" (February 2014), at

[http://www.jalihealth.org/documents/FCGH\\_Overview.pdf](http://www.jalihealth.org/documents/FCGH_Overview.pdf).

<sup>2</sup> Jennifer Edge and Cheryl Liu, "FCGH," in SJ Hoffman, ed., *Student Voices 2: Assessing Proposals for Global Health Governance Reform*, vol. 5 (2011):128–143; Lawrence Gostin and Eric Friedman, "Towards a FCGH: A Transformative Agenda for Global Health Justice," *Yale Journal of Health Policy, Law, and Ethics* 13.1 (2013):1–75; Martín Hevia and Carlos Herrera Vacafior, "Effective Access to Justice Against State and Non-State Actors in the FCGH: A Proposal," *Health and Human Rights* 15.1 (2013):8–16; JALI, "Platform for a FCGH"; JALI, "The FCGH and the Post-2015 Development Agenda."

<sup>3</sup> Current FCGH proposals include the Joint Action and Learning Initiative's (JALI) Manifesto and Platforms, as well as literature describing or proposing features of a FCGH. See, for example: Eric Friedman and Lawrence Gostin, "Pillars for Progress on the Right to Health: Harnessing the Potential of Human Rights through a FCGH.," *Health and Human Rights* 14.1 (2012):4–19; Hevia and Vacafior, "Effective Access to Justice"; JALI, "Platform for a FCGH"; JALI, "Platform of the Campaign for a FCGH (Draft)" (December 2013), <http://www.jalihealth.org/documents/Framework.pdf> (3/30/14); JALI, "Manifesto on Global Health Justice & the FCGH"; JALI, "A FCGH: Securing the Right to Health and Advancing Health Equity."

<sup>4</sup> Edge and Liu, "FCGH"; Just Balstad Haffeld, Harald Siem, and John-Arne Røttingen, "Examining the Global Health Arena: Strengths and Weaknesses of a Convention Approach to Global Health Challenges," *Journal of Law, Medicine & Ethics* (Fall 2010): 614–28; Steven Hoffman and John-Arne Røttingen, "Dark Sides of the Proposed FCGH's Many Virtues: A Systematic Review and Critical Analysis," *Health and Human Rights* 15.1 (2013):117–134.

<sup>5</sup> Jonathan Katz, *The Big Truck That Went By* (Palgrave Macmillan, 2013); Yale Law School Transnational Development Clinic, Yale School of Public Health Global Health Justice Partnership, and Association Haitienne de Droit de l'Environnement (hereafter Yale), *Peacekeeping without Accountability: The UN's Responsibility for the Haitian Cholera Epidemic* (2013), [http://www.law.yale.edu/documents/pdf/Clinics/Haiti\\_TDC\\_Final\\_Report.pdf](http://www.law.yale.edu/documents/pdf/Clinics/Haiti_TDC_Final_Report.pdf).

<sup>6</sup> Kristen Boon, "Haiti Cholera Update: The UN Doesn't Budge," *Opinio Juris* (July 12, 2013), <http://opiniojuris.org/2013/07/12/haiti-cholera-update-the-un-doesnt-budge/>; Ryan Scoville, "UN Immunity in the Haitian Cholera Litigation," <http://law.marquette.edu/facultyblog/2013/10/11/un-immunity-in-the-haitian-cholera-litigation/ra-litigation/>.

<sup>7</sup> For a more comprehensive discussion of the cholera epidemic and subsequent legal disputes, see Mara Pillinger, Ian Hurd, and Michael Barnett, "How to Get Away With Cholera: The UN, Haiti & International Law", *Perspectives on Politics* 14.1 (forthcoming 2016).

<sup>8</sup> "Editorial: The UN's Duty in Haiti's Cholera Outbreak," *Washington Post* (August 11, 2013), [http://www.washingtonpost.com/opinions/the-united-nations-duty-in-haitis-cholera-outbreak/2013/08/11/523dd25c-013d-11e3-9a3e-916de805f65d\\_story.html](http://www.washingtonpost.com/opinions/the-united-nations-duty-in-haitis-cholera-outbreak/2013/08/11/523dd25c-013d-11e3-9a3e-916de805f65d_story.html).

<sup>9</sup> Yale, *Peacekeeping Without Accountability*, p.1.

<sup>10</sup> Pan-American Health Organization, "Atlas of Cholera Outbreak in La Hispaniola, 2010-2014," [http://new.paho.org/hq/images/Atlas\\_IHR/CholeraHispaniola/atlas.html](http://new.paho.org/hq/images/Atlas_IHR/CholeraHispaniola/atlas.html).

<sup>11</sup> Katz, *The Big Truck That Went By*; *Georges et al. v. UN et al.*, (October 9, 2013), <http://www.ijdh.org/wp-content/uploads/2013/10/Cholera-Complaint.pdf>, ¶142-171.

<sup>12</sup> While the failure to screen might seem negligent, there is debate about whether screening and/or giving prophylactic antibiotics is sound policy; at present, they are not recommended by WHO or required by the UN. See American Society of International Law (ASIL), "Remedies for Harm Caused by UN Peacekeepers," (February 26, 2014), [www.asil.org/live](http://www.asil.org/live); BBC, "Haiti Cholera Outbreak: Nepal Troops Not Tested," (December 8, 2010), <http://www.bbc.co.uk/news/world-south-asia-11949181>; Haiti Support Group (HSG), "UN Rejects Cholera Experts' Recommendations to Change Medical Protocols," *Haiti Briefing* No.74 (June 2013), [http://www.haitisupportgroup.org/index.php?option=com\\_content&view=article&id=785:un-rejects-cholera-experts-recommendations-to-change-medical-protocols&catid=99:analysis&Itemid=256](http://www.haitisupportgroup.org/index.php?option=com_content&view=article&id=785:un-rejects-cholera-experts-recommendations-to-change-medical-protocols&catid=99:analysis&Itemid=256); Fabini Orata, Paul Keim, and Yan Boucher, "The 2010 Cholera Outbreak in Haiti: How Science Solved a Controversy," *PLoS Pathogens* 10.4 (2014), p.2.

<sup>13</sup> There are contradicting reports about whether waste was treated before dumping. See Katz, *The Big Truck That Went By*, pp.227-231; Georges et al. v. UN et al., ¶6.

<sup>14</sup> Yale, *Peacekeeping Without Accountability*, p.18.

<sup>15</sup> Donald G. McNeil, Jr., "Cholera's Second Fever: An Urge to Blame," *New York Times* (November 20, 2010), <http://www.nytimes.com/2010/11/21/weekinreview/21mcneil.html>; Katz, *The Big Truck That Went By*.

<sup>16</sup> Katz, *The Big Truck That Went By*, p.226.

<sup>17</sup> This argument was echoed by representatives from PAHO and CDC, aid workers, diplomats, and public health experts. Other experts took the opposite stance, arguing that there were important scientific, political, practical, and public health- and safety-related reasons for identifying the outbreak's source. See Randal Archibold, "Officials in Haiti Defend Focus on Cholera Outbreak, Not Its Origins," *New York Times* (November 17, 2010), <http://www.nytimes.com/2010/11/17/world/americas/17haiti.html>; Jonathan Katz, "Experts Ask: Did UN Troops Infect Haiti?," *Associated Press* (November 3, 2010), [www.nbcnews.com/id/39996103/ns/health-infectious\\_diseases/t/experts-ask-did-un-troops-infect-haiti/#.UyDVd9ywOqo](http://www.nbcnews.com/id/39996103/ns/health-infectious_diseases/t/experts-ask-did-un-troops-infect-haiti/#.UyDVd9ywOqo); Katz, *The Big Truck That Went By*, pp.235-9; McNeil, "Cholera's Second Fever,"; Deborah Sontag, "Haiti's Cholera Outraced the Experts and Tainted the UN," *New York Times* (March 31, 2012), <http://www.nytimes.com/2012/04/01/world/americas/haitis-cholera-outraced-the-experts-and-tainted-the-un.html?pagewanted=all>; Yale, *Peacekeeping Without Accountability*.

<sup>18</sup> Georges et al. v. UN et al., ¶107.

<sup>19</sup> One might also interpret this housekeeping not (only) as an attempted cover-up but instead/also as an attempt to prevent further contamination. See Katz, *The Big Truck That Went By*, p.234.

<sup>20</sup> Alejandro Cravioto et al., *Final Report of the Independent Panel of Experts on the Cholera Outbreak in Haiti* (2011), <http://www.ijdh.org/2011/05/topics/health/final-report-of-the-independent-panel-of-experts-on-the-cholera-outbreak-in-haiti-u-n-independent-panel/#.U5UcbBacLrc>, p.4.

<sup>21</sup> Ibid.

<sup>22</sup> Chen-Shan Chin et al., "The Origin of the Haitian Cholera Outbreak Strain," *New England Journal of Medicine* 364.1 (2011):33-42; Rene Hendriksen et al., "Population Genetics of *Vibrio cholera* from Nepal in 2010: Evidence on the Origin of the Haitian Outbreak," *mBio* 2.4 (2011):e00157-11; Renaud Piarroux et al., "Understanding the Cholera Epidemic, Haiti," *Emerging Infectious Diseases* 17.7 (2011), pp.1161-8; Yale, *Peacekeeping Without Accountability*.

<sup>23</sup> Daniele Lantagne et al., "The Cholera Outbreak in Haiti: Where and How Did It Begin?," *Current Topics in Microbiology & Immunology* (May 2013), p.18.

<sup>24</sup> Institute for Justice & Democracy in Haiti/Bureau des Advocats Internationaux (IJDH/BAI), *Petition for Relief* (November 2011), <http://ijdh.org/wordpress/wp-content/uploads/2011/11/englishpetition REDACTED.pdf>, ¶81-83.

<sup>25</sup> Sontag, "Haiti's Cholera Outraced the Experts".

<sup>26</sup> Reuters, "UN Haiti Cholera Panel Avoids Blaming Peacekeepers," (May 5, 2011), <http://www.reuters.com/article/2011/05/05/us-haiti-cholera-panel-idUSTRE74457Q20110505>.

<sup>27</sup> See, for example, UN Docs A/Res/51/13, A/51/398, A/51/903, and A/Res/52/247.

<sup>28</sup> These rights are widely established in human rights law. See Kristen Boon, "Privileges and Immunities of IOs," *Opinio Juris* (June 11, 2013), <http://opiniojuris.org/2013/06/11/privileges-and-immunities-of-international-organizations/>; Patrick Lewis, "Who Pays for the United Nations' Torts?: Immunity, Attribution, and 'Appropriate Modes of Settlement' Immunity of the UN," *North Carolina Journal of International Law & Commercial Regulation* 39.2 (2013): 259–331.

<sup>29</sup> These compensate payments would now total approximately \$32 billion, or rough four times the UN's entire peacekeeping budget for 2013–14. See IJDH/BAI, "Petition for Relief," ¶108–110; Brett Schaefer, "Haiti Cholera Lawsuit Against the U.N.: Recommendations for U.S. Policy," *Heritage Foundation Backgrounder*, No.2859 (November 12, 2013), <http://www.heritage.org/research/reports/2013/11/haiti-cholera-lawsuit-against-the-un-recommendations-for-us-policy> (3/1/14); UN Doc A/C.5/68/21.

<sup>30</sup> Letter from Patricia O'Brien to Brian Concannon, (February 21, 2013), <http://www.ijdh.org/wp-content/uploads/2011/11/UN-Dismissal-2013-02-21.pdf>.

<sup>31</sup> Legal scholars are highly skeptical of this argument; their firm consensus seems to be that the victims' claims are a textbook example of private law claims. They also suggest that the UN's argument in this case is inconsistent with its own past practice. Furthermore, a number of UN officials have rejected the official position and called upon the UN to acknowledge culpability and provide some form of restitution. These include High Commissioner for Human Rights Navi Pillay; former UN Special Envoy for HIV/AIDS in Africa Stephen Lewis; the UN's Independent Experts on Human Rights in Haiti, Gustavo Gallon; and former UN Special Envoy on Human Rights in Haiti, Michel Forst. See Roger Annis, "Stephen Lewis says UN Must Be Accountable for Cholera in Haiti," *Rabble.ca* (October 14, 2013) <http://rabble.ca/blogs/bloggers/haiti-canada-blog/2013/10/stephen-lewis-says-united-nations-must-be-accountable-chole>; ASIL, "Remedies for Harm Caused by UN Peacekeepers"; BBC, "Senior UN Expert Calls for Haiti Cholera Compensation," (March 2, 2014), <http://www.bbc.com/news/world-latin-america-26397373>; Kristen Boon, "UN Flatly Rejects Haiti Cholera Claim," *Opinio Juris* (February 22, 2013), <http://opiniojuris.org/2013/02/22/un-flatly-rejects-haiti-cholera-claim/2/22/13>; Trenton Daniel, "UN Official Makes Rare Case for Compensation for Haiti Cholera Victims," *Associated Press* (October 8, 2013), [http://www.huffingtonpost.com/2013/10/08/un-haiti-compensation\\_n\\_4066697.html](http://www.huffingtonpost.com/2013/10/08/un-haiti-compensation_n_4066697.html); Lewis, "Who Pays for the UN's Torts?"; Frederic Mégret, "UN Responsibility in the Time of Cholera (English abstract)," (2013), <http://ssrn.com/abstract=2242902>.

<sup>32</sup> Jean-Robert et al. v. UN et al. has also been dismissed and Laventure et al. v. UN et al. has been stayed pending the outcome of the Georges et al. v. UN et al. appeal. See Georges et al. v. UN et al. Opinion & Order (2015), [http://www.ijdh.org/wp-content/uploads/2011/11/Dkt62\\_Opinion\\_and\\_Order\\_01\\_09\\_15.pdf](http://www.ijdh.org/wp-content/uploads/2011/11/Dkt62_Opinion_and_Order_01_09_15.pdf), p.6.

<sup>33</sup> "[I]n the near-totality of cases national courts scrupulously stick to the UN's immunity." The most famous example of this is the *Mothers of Srebrenica* case, where Dutch courts held that the Netherlands' obligation to respect UN immunity took precedence over the obligation to guarantee the Mothers' right of access to court. Likewise, the US government has made its position clear—both the State Department and the US Attorney for the Southern District have asked the courts to respect UN immunity. Jan Wouters and Pierre Schmitt, "Challenging Acts of Other United Nations' Organs, Subsidiary Organs, and Officials," in Lewis, "Who Pays for the UN's Torts?," p.278. See also: Jacob Gershman, "Obama Administration Backs UN in Disputes Over Haiti Cholera Epidemic," *Wall Street Journal Law Blog* (March 12, 2014), <http://blogs.wsj.com/law/2014/03/12/obama-administration-backs-u-n-in-disputes-over-haiti-cholera-epidemic>; August Reinisch, "Privileges and Immunities," In Jacob Katz Cogan, Ian Hurd, and Ian Johnstone eds. *The Oxford Handbook of International Organizations*, (Oxford University Press, 2015).

<sup>34</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," p.6.

<sup>35</sup> JALI, "Platform for a FCGH," pp.2–3.

<sup>36</sup> Lawrence Gostin and Eric Friedman, "Aspiring Towards a FCGH," *Global Health Forum* (October 1, 2014), <http://ghf.globalhealthforum.net/2014/02/25/aspiring-towards-a-framework-convention-on-global-health>.

<sup>37</sup> Haffeld et al., "Examining the Global Health Arena," p.615; Hevia and Vacaflor, "Effective Access to Justice," p.8.

<sup>38</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health".

<sup>39</sup> Of course, these benefits often not manifested in practice. The existence of law does not guarantee enforceability or an unbiased, equally accessible justice system. See Hevia and Vacaflor, "Effective Access to Justice," p.8; Hoffman and Røttingen, "Dark Sides of the Proposed FCGH's Many Virtues," p.120-121.

<sup>40</sup> Edge and Liu, "FCGH," p.136.

<sup>41</sup> Haffeld et al., "Examining the Global Health Arena," p.622; JALI, "Platform for a FCGH," p.3.

<sup>42</sup> Haffeld et al., "Examining the Global Health Arena," pp.615, 622.

<sup>43</sup> However, these bodies have not helped the Haitian cholera victims pursue remedy from the UN, partially because of complications with legal standing and partially because they appear reluctant to confront the UN Secretary-General and challenge UN immunity (see below note 78). See *Ibid.*, p. 624; Friedman et al., "Realizing the Right to Health Through a FCGH?," p.2.

<sup>44</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," pp.10-11.

<sup>45</sup> The *amparo* remedy requests court protection from government violations of personal rights, similar to *habeas corpus*, but applied only to rights other than unwarranted detention. See Hevia and Vacaflor, "Effective Access to Justice," pp.9-10.

<sup>46</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," pp.7,13; Lawrence O Gostin, "A FCGH: Health for All, Justice for All," *Journal of the American Medical Association* 307.19 (2012): 2087-2092; Haffeld, Siem and Røttingen, "Examining the Global Health Arena," p.621-622; JALI, "Platform for a FCGH," p.4.

<sup>47</sup> Haffeld et al., "Examining the Global Health Arena," p.625.

<sup>48</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," p.13.

<sup>49</sup> JALI, "Manifesto on Global Health Justice & the FCGH," p.2.

<sup>50</sup> JALI's Manifesto and FCGH Platform contain only one explicit reference to IOs: "[key principle] 10h. Promote health-in-all policies and regulate the social determinants of health, including by ensuring that all government ministries and international regimes, such as the World Trade Organization and International Monetary Fund, protect and promote the right to health." *Ibid.*, p4.

<sup>51</sup> ASIL, "Remedies for Harm Caused by UN Peacekeepers"; Lewis, "Who Pays for the UN's Torts?," p.270.

<sup>52</sup> Abby Stoddard et al. "Cluster Approach Evaluation," *Overseas Development Institute Report* (October 2007), <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/4955.pdf>, pp.5-6, 31-33.

<sup>53</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," p.5.

<sup>54</sup> JALI, "Platform for a FCGH," p.3.

<sup>55</sup> Individuals have the best chance of receiving remedy if their governments pursues claims on their behalf, a process known as diplomatic protection. Unlike individuals, states have a variety of legal options for holding IOs accountable. However, pragmatically speaking, the ability of states to take legal action against the UN may be complicated by political dynamics and capacity limitations. Whether for peacekeeping, transitional administrative or humanitarian purposes, the UN generally operates in weak/transitioning states or situations in which governments are depending upon the UN for security/stability or other resources, meaning that the states mostly likely to require legal accountability from the UN are precisely the states least able to seek it. For a lengthier discussion of Haiti's predicament in the cholera case, see Pillinger, Hurd & Barnett, "Politics of Legal Responsibility".

<sup>56</sup> However, the Haitian government could have opted to pursue these claims on the victims' behalf through multiple channels. See Pillinger et al., "How to Get Away with Cholera: The UN, Haiti, & International Law."

<sup>57</sup> Haffeld et al., "Examining the Global Health Arena," p.624.

<sup>58</sup> Gostin, "A FCGH: Health for All, Justice for All," pp.2089-2091.

<sup>59</sup> *Ibid.*



<sup>60</sup> Letter from Patricia O'Brien to Brian Concannon, (February 21, 2013); Letter from Patricia O'Brien to Brian Concannon (July 5, 2013),

<http://www.ijdh.org/wpcontent/uploads/2013/07/20130705164515.pdf>.

<sup>61</sup> Letter from Secretary-General Ban Ki-moon to Congresswoman Maxine Waters, (July 5, 2013),

<http://www.ijdh.org/wp-content/uploads/2013/07/UNSG-Letter-to-Rep.-Maxine-Waters.pdf>;

UN News Centre, "Cholera Eradication in Haiti Will Take 'Some Years,' Says Outgoing UN Coordinator", (June 30, 2015),

<http://www.un.org/apps/news/story.asp?NewsID=51303#.VZdIcHh7Rtd>.

<sup>62</sup> Yale, *Peacekeeping Without Accountability*, p.15.

<sup>63</sup> HSG, "UN Special Envoy on Cholera: 'Silence is the Worst Response'," *Haiti Briefing*, No. 74

(2013), [http://www.haitisupportgroup.org/index.php?option=com\\_content&view=article](http://www.haitisupportgroup.org/index.php?option=com_content&view=article)

&id=784:un-special-envoy-on-cholera-qsilence-is-the-worst-response&q&catid=99:analysis&Itemid=256.

<sup>64</sup> This is not to suggest that the UN's stance in the cholera case has directly affected WHO's moral authority. See Gostin, "A FCGH: Health for All, Justice for All," p.2098.

<sup>65</sup> Proponents already suggest that the FCGH might influence international law beyond the sphere of global health. See Friedman and Gostin, "Pillars for Progress on the Right to Health," p.13.

<sup>66</sup> Edge and Liu, "FCGH"; Haffeld et al., "Examining the Global Health Arena"; Hoffman and Røttingen, "Dark Sides of the Proposed FCGH's Many Virtues".

<sup>67</sup> JALI, "A FCGH: Securing the Right to Health and Advancing Health Equity," p.5.

<sup>68</sup> Hoffman and Røttingen, "Dark Sides of the Proposed FCGH's Many Virtues"; G. Ooms et al., "Great Expectations for the World Health Organization: A FCGH to Achieve Universal Health Coverage," *Public Health* 128 (2014), pp.173–178.

<sup>69</sup> JALI, "Platform for a FCGH", p 5.

<sup>70</sup> Boon, "UN Flatly Rejects Haiti Cholera Claim"

<sup>71</sup> Mégret, "UN Responsibility in the Time of Cholera (English abstract)," ; see also Kristin Boon,

"The Haiti Cholera Case Against the UN," *Opinio Juris* (October 26, 2012)

<http://opiniojuris.org/2012/10/26/the-haiti-cholera-case-against-the-un/>.

<sup>72</sup> The UN has already taken some steps in this direction. For example, it has created an ombudsman position for peacekeeping missions (albeit one that lacks resources and enforcement power), reformed its internal dispute resolution processes, and helped craft accountability standards for the Humanitarian Ombudsman Project. See Rishi Gulati, "The Internal Dispute Resolution Regime of the UN," in A. von Bogdandy and R. Wolfrum, eds. *Max Plank Yearbook of UN Law*, Vol. 15, (2011), pp.489-539; Lewis, "Who Pays for the UN's Torts?," pp.273; Yale, *Peacekeeping Without Accountability*, p.46.

<sup>73</sup> Annis, "Stephen Lewis says UN Must Be Accountable for Cholera in Haiti"; "Brief of International Law Scholars and Practitioners as *Amici Curiae* in Support of Plaintiffs-Appellants and Supporting Reversal", *Georges et al. v. UN et al.* (June 3, 2015) (No.15-455); "Brief of European Law Scholars and Practitioners as *Amici Curiae* in Support of Plaintiffs-Appellants and Supporting Reversal", *Georges et al. v. UN et al.* (June 3, 2015) (No.15-455); "Brief of Constitutional Law Scholars and Practitioners as *Amici Curiae* in Support of Plaintiffs-Appellants and Supporting Reversal", *Georges et al. v. UN et al.* (June 3, 2015) (No.15-455); Rosa Freedman, "UN Immunity or Impunity? A Human Rights Based Challenge," *European Journal of International Law* 25.1 (2014), pp.239-254; Mégret, "UN Responsibility in the Time of Cholera (English abstract)"; Jordan Paust, "The U.N. Is Bound By Human Rights: Understanding the Full Reach of Human Rights, Remedies, and Nonimmunity," *Harvard International Law Journal Online* 51 (2010), pp.1-12; Anastasia Teletsky, "Binding the United Nations: Compulsory Review of Disputes Involving International Responsibility Before the ICJ," *Minnesota Journal of International Law* 21 (2012), pp.75-119.

<sup>74</sup> Ibid.

<sup>75</sup> However, where UN immunity is concerned, these decisions have been consistently overturned by higher courts. See *supra* note 35; Boon, "Privileges and Immunities of IOs"; August Reinisch, "Privileges and Immunities".

<sup>76</sup> However, the distinction between absolute and functional immunity becomes more ambiguous in application. See Reinisch, "Privileges and Immunities".

<sup>77</sup> JALI, "Platform for a FCGH", p 6; see also Haffeld et al.'s proposal for an International Court of Health in "Examining the Global Health Arena," p.622.

<sup>78</sup> The victims petitioned these bodies but received no response. See Faculdade de Direito de Santa Maria, "Petition to the Inter-American Commission on Human Rights," (October 2011), <http://www.fadisma.com.br/acaopelohaiti/peticaohaiti/2011.10.17%20-%20Denuncia%20a%20CIDH%20-%20versao%20portugues-oficial-final%20%5Btexto%2Bdocs%5D%20%5BA%5D.pdf> (accessed 2/2/14); International Association of Democratic Lawyers, "Statement to the 20th Session of the UNHRC" (June 18, 2012), <http://www.iadllaw.org/en/node/483> (accessed 6/6/14).

<sup>79</sup> The Draft Articles are currently under consideration by the UN General Assembly. See Kristen Boon, "New Directions in Responsibility: Assessing the International Law Commission's Draft Articles on the Responsibility of International Organizations," *Yale Journal of International Law Online* 37 (2011), pp.1-10.

<sup>80</sup> *Ibid.*, pp.1-3, 6.

<sup>81</sup> HSG, "UN Rejects Cholera Experts' Recommendations to Change Medical Protocols".

<sup>82</sup> Gostin and Friedman, "Towards a FCGH," pp.35, 69-70.

# Why the World Health Organization Should Take the Lead on the Future Framework Convention on Global Health

Florian Kastler

*The absence of a clear and committed choice of a host for the Framework Convention on Global Health (FCGH) weakens the instrument. It sends a confused and uncertain message to the global health community. The World Health Organization (WHO) should not only participate but also act as a leading authority. This would mutually benefit the FCGH and WHO by realizing the former and strengthening the latter, whose reputation has been tarnished, again recently by the Ebola outbreak response. Nonetheless, the Organization, despite identified challenges, offers a unique legitimacy stemming from its constitutional mandate and its limited normative experience. Further, other potential institutions, which provide a legal alternative, appear less suitable for the instrument's ambition. Though taking on this project presents some risk of failure, WHO must take advantage of the reform context to learn from its difficulties and engage in the development of this instrument, a role that could reinforce its credibility as a leading global health authority.*

## INTRODUCTION

The lack of sufficient response to the recent Ebola outbreak serves as another wake up call for the World Health Organizations (WHO), who appeared (or decided) to be sidelined<sup>1</sup> from the crisis until action was finally taken during the last World Health Assembly (WHA)<sup>2</sup>. This crisis raises, yet again, concerns regarding the ability of WHO to fulfill its constitutional mandate to be the leading and coordinating agency for global health<sup>3</sup>. However, it also highlights the future challenges with which the WHO will be confronted if it remains without fundamental reform. In particular, the WHO and its Secretariat, including the Director General, as well as the Member States have to decide of the future role of this international organization. It can either limit WHO's role to a purely scientific and technical authority or, once and for all, fulfill a more expansive mandate to serve as a normative authority for global health<sup>4</sup>. Considering the scarcity of and limited control WHO has on its funding, this article seeks to analyze why WHO should draw efforts towards its normative function by taking a leading role in the future Framework Convention on Global Health (FCGH).

The doctrinal debates surrounding the FCGH as envisioned by the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) mainly focuses on its content,<sup>5</sup> with little concern on the actual form this instrument could take and under which authority it should be adopted<sup>6</sup>. In one of their latest papers, JALI states that the FCGH “would be adopted by the United Nations General Assembly, the World Health Organization's World Health Assembly or the World Health Assembly under the mandate of a UN resolution<sup>7</sup>.” Yet, despite the focus on the crucial question of the substance of this instrument, choosing the relevant host for this instrument needs further attention. Both the substance and the mechanisms for its leadership and implementation will have an impact on its success.

This paper will argue that the World Health Organization (WHO), because of its unique legitimacy, potential capacity, and recent experience with its normative

function must be part of this discussion. Missing out on the opportunity to solidify WHO's authority in global health governance could turn out to be an irreversible error for WHO. As Haman states "reform debate demonstrates that whether one is a WHO-supporter or WHO-scrapper, the institution remains central to global health governance and is a key to accelerated development."<sup>8</sup> Thus, despite initial support from the United Nations<sup>9</sup> and with careful attention and sufficient efforts to take into account the weaknesses of such a normative adventure, WHO should be considered a first choice as this would mutually benefit the FCGH and WHO by realizing the former and strengthening the latter.

However, the original intention to make WHO the leader in global health, which has been reaffirmed by WHO itself since the reform process<sup>10</sup>, by some Member States<sup>11</sup>, and some scholars<sup>12</sup>, is currently being challenged by a number of criticisms. These criticisms all converge to the lack of authority and—to a certain extent—legitimacy of WHO within global health governance stemming both from poor consideration for the agency as well as the reluctance of WHO to engage in normative activity. Thus, other scholars consider that there is a need to rethink WHO's continuing centrality in global health governance<sup>13</sup> for "collective health needs in a rapidly globalizing world."<sup>14</sup> As a result, WHO, which has recognized its difficulties,<sup>15</sup> is going through a complicated yet essential process of reform to provide answers to those criticisms. The FCGH advocates must take advantage of this context to influence and seek fundamental changes in WHO.

Nonetheless the extent of the implications of WHO developing the FCGH is questionable. The WHO could either use its treaty-making function to be the sole authority of this instrument or simply play a role of international forum to facilitate the establishment of such an instrument. The instrument could also be developed outside of WHO with the support of other international institutions or through a plurilateral international agreement. Further, taking part in the development of the FCGH—no matter to what extent—could turn out to be risky for WHO. Indeed, any failures of the FCGH throughout the process whether in its development or in not achieving results will necessarily imply failure of WHO. This would have a direct and/or indirect negative impact the Organization, harming once more its legitimacy and credibility as the leading authority in global health governance.

Therefore, once it discusses the potential of WHO and the institutional alternatives to this Organization, this article will address both the promise of and obstacles to this role in the development of the FCGH. In order to achieve this analysis, an overview of the main features of the FCGH is discussed to demonstrate that the scope of the FCGH falls within the scope of WHO's priorities. This paper will argue that theoretically and practically it would be legitimate to have WHO as a lead authority in this process.

## **THE FCGH'S SCOPE – PART OF WHO'S GLOBAL HEALTH PRIORITIES**

### *An ambitious goal*

Since its first proposal in 2008<sup>16</sup> and despite criticism<sup>17</sup> and hesitations regarding its content, it is generally agreed that the FCGH seeks to act as a global health treaty based in the right to health to reduce national and global health inequities. It has the ambition of reimagining global governance for health by placing the right to health at the center of global health policy and global governance for health by clarifying present ambiguities in the right to health. The FCGH "would reaffirm existing right to health principles and obligations and would codify newly expanded ones."<sup>18</sup>

Further, JALI states that the FCGH “would be grounded in the human right to health, achieve universal health coverage, establish far greater accountability, raise the priority of health in other legal regimes, and meet major challenges in global governance.”<sup>19</sup>

Using a bottom-up inclusive process, the FCGH seeks to fulfill ambitious objectives. According to Gostin and Friedman<sup>20</sup>, a framework convention/protocol approach to global health would (1) set globally-applicable norms and priorities for health systems and essential human needs; (2) afford countries flexibility to meet domestic needs and take “ownership” of national policies and programs; (3) establish a sustainable funding mechanism or framework scalable to needs; (4) effectively govern the proliferating number of actors and activities in a crowded global health landscape; (5) create methods for holding state and non-state actors accountable to their obligations under the right to health, including for monitoring progress and achieving compliance with the FCGH itself; and (6) devise a process for the international community to establish further commitments beyond those in the initial Convention.

Specific results are expected such as establishing guidelines for universal health coverage, establishing domestic and international health financing targets, clarifying the right to health obligations, defining the responsibilities of the states to the health of people beyond their borders, and ensuring the immediate and effective enforceability of the right to health.<sup>21</sup> Simply put, the FCGH seeks to “give true force to international law and extend its reach into the communities where we live to create the conditions for health and wellbeing for everyone.”<sup>22</sup> The advocates of the FCGH consider it as a “milestone along the way to full health equity.”<sup>23</sup>

### *A common objective*

It appears that Margaret Chan has made universal health coverage (UHC) a priority stating that she “regards universal health coverage as the single most powerful concept that public health has to offer.”<sup>24</sup> Therefore, considering the proximity between FCGH’s ambition to create the conditions for health and the recent WHO objective towards achieving UHC, arguments in favor of entirely bypassing the WHO of this normative effort seem unsubstantiated. Indeed, objectives such as facilitating increased global cooperation on global health<sup>25</sup>; contributing to broader improvements in national governance and ensuring health services and goods to all people, are part of the UHC priority set by WHO, which seeks to ensure that all people obtain the health services they need without suffering financial hardship when paying for them with the objective of having a direct impact on population’s health.<sup>26</sup>

In fact, the FCGH advocates seem to acknowledge the potential of collaboration between the FCGH and WHO as they intend to adapt the content of the FCGH to include objectives of WHO. For example, considering the global movement towards UHC spearheaded by WHO, they offer to define and codify this obligation.<sup>27</sup> They even propose to go beyond UHC as defined by WHO and ensure universal conditions for good health.<sup>28</sup> Further, some key issues of the FCGH such as the potential to revamp global health governance institutions and to improve accountability, compliance, enforcement, transparency, and stewardship<sup>29</sup> are two main axes of the WHO reform increasing the similarities between the FCGH and WHO.

Finally, the FCGH seeks to strengthen WHO “by affirming WHO’s role as the global health leader and include measure to support this role, including to strengthen

its leadership in other international legal regimes that impact health.”<sup>30</sup> Further, a key principle of the FCGH is to “empower WHO to effectively achieve its mandate of global health leadership”<sup>31</sup> and “strengthen global leadership on the right to health, including that of WHO.”<sup>32</sup> Thus the role of WHO is considered as a fundamental feature of the FCGH. In fact, the mandate and spirit of WHO have been influential in the development of the FCGH. This shows that the FCGH’s advocates had at some point considered the WHO central to the process. Therefore how could WHO—whose leadership seeks to be reinforced by this global health treaty—not be at least part of the process of developing the Convention? It seems difficult to argue against WHO’s participation in the process of developing the FCGH<sup>33</sup>, not only because the ambition is similar but also because the FCGH itself identifies WHO as a key partner.<sup>34</sup> As admitted by Hoffman and Rottingen, a “FCGH could not fully escape WHO’s long shadow.”<sup>35</sup>

Nonetheless, once we concede that WHO has to be part of this international normative effort, the extent of its role and the viable alternatives to WHO that exist within the UN system and the international health community in general must be considered.

### **ALTERNATIVES TO WHO—LEGAL BUT LESS LEGITIMATE**

One of the most important arguments in favor of the FCGH—emphasized by its advocates—is the tentative support given by the UN General Secretary, Ban Ki Moon who stated in 2011—in the specific context of AIDS—that it should “set the stage for a future United Nations Framework Convention on Global Health.”<sup>36</sup> Indeed, this helped the project gain visibility and support from the international community. At the same time this opened the door to discussions to limit the role of WHO. Indeed, having support from the highest UN official combined with the context of WHO reform and the difficulties of the agency to bounce back from recent difficulties, has fostered distrust in the capacity of WHO to take in charge this instrument.

This absence of consensus was strengthened—despite initial and continued support for the WHO<sup>37</sup>—by the lack of definitive choice from the FCGH’s advocates leaving open the question of legal forum.<sup>38</sup> Indeed, the current position is to debate with all parties and see which organization will be most likely to support and provide for the development of the FCGH. This “in between” position, where they hope for WHO’s support and at the same time seek for other forums, is not favorable for the future of this project because of the confusing message it sends to the global health community. This contributes to the uncertainty of the overall project. The influences of the host on the content of the instrument will be different whether WHO, the UN or a group of developing countries leads the process as health concerns, priorities and interests may vary. Also, uncertainty in their choice of institutional forum will prevent WHO from giving full consideration to the advancement of the FCGH. Thus, the advocates of the FCGH need to make a clear choice in favor of an international host. Empowering whichever organization is most willing to support the FCGH could be counterproductive. Indeed, trying to gather the most support might lead to the loss of all support.

It is important though to consider these alternatives to understand why they would be less suitable for the development of the FCGH and how disastrous the message sent from the international community would be to a disowned WHO, even though it might serve as a strong signal of alert for the global health community within the reform context.

*Outside the UN system: limited precedent*

A potential alternative host for a FCGH includes the creation of a new entity outside both WHO and UN. Indeed, following international law and the principle of state sovereignty, the countries can always agree to international conventions outside the UN system. This was the case with the Mine Ban Treaty in 1999. The main advantage of such a venture is that the treaties would not need to be negotiated with the participation of all 194 UN members<sup>39</sup>, which should increase compliance and improve content.<sup>40</sup> Only the states interested in the instrument would participate in the development of the instrument.

Nonetheless, housing the FCGH outside of the UN system might result in adoption by a more limited number of countries. The instrument would thus lack one of the essential features of any global health instrument: universality. The universal participation, in particular in health, is crucial to the success of the instrument. The efforts have to be accepted by a maximum number of states. Further, the transnationality of health implies that health matters not only concern every single person but will also depend on the actions and interactions between countries in a globalized world. Thus, the need for global actions appears ill-suited for bilateral or plurilateral instruments.

Further, the example of the Mine Ban Treaty could be considered as *sui generis* as it was elaborated in a specific context following an atypical process.<sup>41</sup> Also the UN General Assembly—despite not hosting the instrument—endorsed the need for such a treaty urging countries to ratify it. Finally, banning landmines is different from promoting global health. Indeed, within the context of international relations, avoiding the horrible use of inhuman destructive weapon provides a stronger incentive for states to create an international treaty and support such an initiative. They have a direct interest in avoiding the use of land mines. Further, the former has a clear identified object ('landmines') with a clear objective ('banning') compared to the more inclusive and wider approach considered for the promotion of global health. As a consequence, achieving results appear more feasible not only because of the limited scope of the treaty and worldwide support from states but also because the results can be assessed easily by simply identifying whether the land mines are banned within a contracting party. On the contrary, the results in the promotion of global health are diffuse making the causal link between the implementation of the legal instrument and the result more difficult to establish. Therefore, these favorable circumstances make it less realistic for an international instrument on global health to be adopted outside the UN system.

In fact, this effort could be counterproductive to the elaboration of a FCGH. In case of insufficient continued state support the FCGH might not even survive the crucial process of negotiation. As a matter of fact, this process will need institutional support to serve as a trigger and forum to follow the discussions and maintain continuity, such as the role played but the UN in the elaboration of the human rights treaties. Despite the difficulties of finding consensus between all the member states at the WHA or at the UN General Assembly, this kind of instrument could greatly benefit from the support of an international organization to at least supervise the process. The issue of choosing the relevant international organization appears more complicated.

*The UN system: experienced but limited legitimacy*

As stated above, the initial support came from the UN General Secretary himself. Hoffman and Rottingen also consider it a viable option to bypass WHO by creating a separate political platform.<sup>42</sup> They suggest that FCGH advocates should either seek fundamental WHO reform or they should completely circumvent that agency. They further argue that establishing the FCGH and strengthening WHO at the same time “remains unsubstantiated,”<sup>43</sup> because of the risk of competition between the governing bodies and the secretariat. They anticipate that over time the secretariat and conference of parties will “develop its own strategic interests and resist WHO’s control or influence<sup>44</sup>.” It is arguable, considering UN’s legal authority, for it to host the FCGH including through UN bodies such as the Security Council, the Human Rights Council (HRC) and the Economic and Social Council. Either the HRC including civil society or the General Assembly could draft the treaty.<sup>45</sup> The UN has experience in using its normative function with the adoption of several human rights treaties<sup>46</sup> including in the last decade the Convention on the Rights of the Child in 1999 elaborated by the Human Rights Commission (the Council’s predecessor) or the Convention on the Right of Persons with Disabilities in 2006 for which the treaty process was led by the UN General Assembly. The rich normative production of the UN is proof of its capacity to lead an international convention.

However, the challenge with the FCGH would be for the UN to host an instrument that concerns health as a core objective. Indeed, until now—in accordance with its mandate—the UN has adopted instruments that addressed vulnerable people such as women, children, and minorities, with no specific focus on their health. These instruments were not conceived solely around health issue with the objective of the attainment of health for all but sought the promotion of human rights. The main purpose with the FCGH is global health and not a specific category of people to whom rights are being granted. For instance, for the UN treaties, the idea is to reinforce their rights of which the right to health is part. The scope of the FCGH is wider and seeks to encompass any health related issue worldwide.

Further, it could be argued that adopting the FCGH as a human right treaty would limit the ambition of this instrument to the realization of the human right to health. Sure, this objective is part of the mandate of the FCGH as envisioned by its advocates but the scope of the FCGH goes beyond the realization of the right to health<sup>47</sup>. In addition, the ongoing criticism regarding the effectiveness of human rights treaty and their limited implementation would not necessarily serve the FCGH. Not qualifying the instrument on global health as a human right treaty but rather following a framework approach would certainly allow it to have a wider impact. This is the position of the advocates of the project who are in favor of a framework convention approach rather than a human right treaty. Yet, the UN has had limited and mitigated experience with the framework approach as illustrated by the UN Framework Convention on Climate Change. Thus, even though the Director General, Ban Ki Moon mentioned it, the idea of a UN interest that would lead to full support by the UN system for the FCGH appears vague and uncertain. Indeed, this position has not been reaffirmed by the UN Director General since his initial comments.

Finally, at a political level, the issue here is whether the message that would be sent to the international community would be to the detriment of WHO, potentially questioning the organization as it currently exists. A parallel can be drawn with the situation in 1994 and the AIDS epidemic. Indeed, when the UN decided to create the Joint United Nations Program on HIV/AIDS (UNAIDS) in 1996 with the mandate to



accelerate, comprehensive and coordinated global action on the HIV/AIDS epidemic—because of the absence of a sufficient reaction by WHO—it was considered as a sanction of the lack of success of the agency in the fight against the AIDS epidemic. It is still perceived as a failure of WHO. Indeed, UNAIDS, was the world's largest global health response, yet the states decided that it could not be led by the world's largest global health agency. Further, putting the human rights at the center of UNAIDS' work, reinforced WHO as a "largely technical, health-sector-focused agenda."<sup>48</sup>

Bypassing WHO again on a wider topic such as global health might have an irreversible effect on the agency especially regarding its normative function. With the envisioned FCGH, part—if not all—of the mandate of WHO will be impacted. Leaving WHO sidelined would clearly state that it was unable to fully achieve its mandate. The gravity of bypassing WHO on its reputation seems not fully grasped. Indeed, the creation of the FCGH will be seen as an alternative to WHO, with little or no control nor influence from the agency. This would have an international impact on global health and governance and the message would be loud and clear: WHO is not considered to be the health agency of the United Nations anymore. This is not the message the world is looking for.

These alternatives, though legal, are less legitimate. Indeed, the critics stated underestimate the importance for the WHO to fulfill its role of global coordinator in health as enshrined in its constitution. The WHO is not a default choice and should not be marginalized. It should not be chosen because the alternatives are not up for the challenge, but because WHO is prepared and has arguments to defend its position of hosting the FCGH as a stand-alone treaty or leading an international consortium. Taking into account the current reform combined with the theoretical legal grounds and experience in global health law, WHO is a serious candidate, not only as a partner but also as a leader for the envisioned FCGH.

### **WHO AS LEAD ROLE—LEGAL, LEGITIMATE, AND APPROPRIATE**

Despite being hesitantly supported by scholars, the idea of handing the elaboration and adoption of the FCGH to WHO is not new. In fact, the advocates of the FCGH recognized that the WHO would be the "natural home" for the FCGH.<sup>49</sup> Further, prominent scholars have strongly advocated for the increased use of WHO's lawmaking power.<sup>50</sup> In 1992, Taylor argued that WHO might have the authority and the means to institutionalize efforts to improve global health conditions and propose a legal framework for universal access to the conditions of health.<sup>51</sup>

The previous experience with the Framework Convention on Tobacco Control (FCTC) has tempered the hopes of many that WHO could lead a global health treaty process. However, WHO had to engage in the process to gain experience in conventional lawmaking. Thus lessons can be learned from this experience to improve future normative instruments. The issue is not whether the WHO should take on such a role—as it has already done so with the FCTC—but rather should it continue and, if so, how it could improve it by building on its past experience. Some scholars suggest that WHO should take the lead in the development of the FCGH and have great expectations for the agency.<sup>52</sup> The WHO's reform demonstrates great interest around its leadership role in global health governance. The development of the FCGH is an opportunity for WHO and the global health community to ground its leadership as the global health authority by confirming the use of its normative function, especially in the current context of reform.

The two main reasons for WHO to take a leading roles in the FCGH are that WHO has the international recognition and legitimacy stemming from its Constitution and has an existing—yet limited—experience in global health lawmaking.

### *International recognition and legitimacy*

In addition to WHO's mandate as the coordinating agency in health, the legitimacy and international recognition of WHO's authority is partly expressed—as it is with most UN agencies—by the universality of its membership. As argued by Frenk and Moon, “the WHO is the only actor in the global health system that is built on the universal membership of all recognized sovereign nation states.”<sup>53</sup> Indeed, as of today, WHO has 194 State members giving it a “near-universal ratification.”<sup>54</sup> This makes it the UN agency with the most member states of all the UN system including the UN itself.<sup>55</sup>

Universality as stated above is a key feature of governing health because of the transnationality of these issues and the necessity of international cooperation. The WHO still today is the primary international organization providing actions for health in the world. Further, for some observers, WHO has positioned itself on this matter. In a recent article of the Bulletin of the WHO, scholars stated that Margaret Chan, “has championed a ‘soft’ ‘framework for global health,’ which the World Health Assembly could adopt as a code of practice or global strategy under the WHO Constitution.”<sup>56</sup>

Historically, WHO—the first UN agency—was “conceived as an organization with a primarily directing and normative role”<sup>57</sup> within its Constitution. Article 2 grants WHO the power (k) “to propose conventions, agreements and regulations, and make recommendations with respect to international health matters” and (v) “to take all necessary actions to attain the objective of the Organization.” As a result, the Constitution provided WHO with important and extensive powers: articles 19, 21 and 23 enable WHO to adopt international instruments such as conventions, regulations and recommendations. Burci and Vignes suggest that WHO's Constitution envisioned an organization that would use law, and exercise powers to proactively promote the attainment of the highest possible level of health.<sup>58</sup> As Fidler stated “WHO's international legal powers were not intended to be admired, but to be used.”<sup>59</sup> The WHO itself has set out 6 core functions for 2014-2019 including providing leadership on matters critical to health and setting norms and promoting and monitoring their implementation.<sup>60</sup> As scholars recognize, the treaty-making powers of WHO are remarkable and extraordinary.<sup>61</sup> Most certainly, if an international institution on health were to be created in today's world, it would be difficult to grant it the same normative powers. These powers are not only important because they exist in the Constitution at an international level but because of their innovative content.

According to article 19, WHO can adopt binding conventions or agreements with respect to any matter within the competence of the organization. These instruments must be adopted by two-thirds of the WHA and will come into force for each member when accepted by it. Further, the Constitution affirmatively requires, according to article 20, that each member states, within 18 months after the adoption by the WHA, take action relative to the acceptance of such convention or agreement. In addition, the member is required to notify the Director-General of the action taken, and if it does not accept such convention or agreement it must state the reasons for non-acceptance. This article combined with the ambitious objective of

WHO's mandate with its expansive definition of health, gave theoretically WHO a treaty-making power with "virtually limitless potential."<sup>62</sup> Article 19 would most certainly serve as the legal basis for the adoption of the FCGH as envisioned by its advocates. Nonetheless, alternative legal instruments could be considered within the powerful normative function of WHO, especially to initiate the normative process. For instance, according to article 23, WHO has the power to adopt recommendations "in respect to any matter within the competence of the Organization."

Finally WHO's three level organizational structure—global, regional, national—could benefit the implementation and monitoring of the FCGH. Indeed, regions and national offices could help promote and realize the objectives of the FCGH. Likewise, the FCGH could build on—provided some reform—the existing decentralized structure, especially considering the relationship between the Geneva headquarters and the Regional offices in WHO's norm-setting functions as provided by the Constitution.<sup>63</sup> If the FCGH were to be adopted outside the WHO process, it would have to organize its network for implementation. Why lose time and resources when a network—admittedly insufficient—already exists?

WHO's law making power provides an opportunity because of the variety and flexibility it offers to the agency, which allows adaptation to the evolving international context. This combined with the structural and institutional capacity of WHO in a majority of countries could provide a more effective level of implementation for the envisioned FCGH. Therefore, WHO has both the legal powers and the legitimacy to adopt such an instrument and create international law. Further, it also has experience in lawmaking demonstrating its capacity as a global health law authority.

### *Lawmaking experience: thin but looking to grow*

The use of WHO's lawmaking power to create health norms is thin if we consider that only three international health instruments have been adopted since the agency was created 67 years ago, including two at the establishment of WHO. It is important though to understand the recent shift in favor of international lawmaking. It can be argued that there has been a change in the approach taken by WHO towards its lawmaking powers, initiated by the adoption of the Framework Convention on Tobacco Control (FCTC).

The FCTC is the first treaty negotiated under the auspices of WHO and is an evidence-based treaty that reaffirms the right to all people to the highest standard of health. The convention emphasizes the importance of balancing demand reduction strategies with supply control strategies.<sup>64</sup> Nonetheless, despite criticisms regarding the implementation of the FCTC—including that it is an instrument with no teeth—it is argued that the FCTC has had an impact on tobacco consumption especially due to tax increases.<sup>65</sup> In addition Margaret Chan describes it as having the "power of being first, and of being so successful."<sup>66</sup> As we celebrate the tenth anniversary of the FCTC's entry into force, this instrument has proved the capacity of WHO in hosting a binding instrument at a global level.

The particularity of the framework convention approach would enable parties to later adopt protocols on specific topics in addition to the treaty that States would need to separately ratify. This theoretical reasoning has practical application with the example of the FCTC. Indeed, after the adoption of the FCTC, the parties adopted in 2012 a Protocol to eliminate illicit trade in tobacco products. This approach thus allows flexibility and leaves room to future developments, essential to international relations.

The advocates of the FCGH recognized that it has been influenced by the framework convention approach used for the FCTC under article 19 of the WHO constitution.<sup>67</sup> They often note that parallels can be drawn between those two normative experiences. The initial discussions for the FCTC started in 1979<sup>68</sup> and developed into an international strategy for tobacco control in 1995,<sup>69</sup> and then into an international framework convention for tobacco control in 1996.<sup>70</sup> By May 24, 1999 the WHA unanimously agreed to establish a FCTC, despite lack of previous experience,<sup>71</sup> which led to the adoption of the FCTC in 2003. The FCGH started in 2007 as a research project; it is now in the phase where scholarly discussions are taking place as to the feasibility of the project. It will then potentially enter a phase where strategies and plans will be developed through recommendations leading hopefully to a treaty-based instrument. The support and experience of WHO at all stages is essential.

Finally, it can be argued that there is a momentum for international global health lawmaking. The adoption of the FCTC constituted, at the time and despite reluctance from WHO initially, a “turning point” in WHO’s global activity and a “new era in international health cooperation.”<sup>72</sup> The FCTC has opened the way to normative activity. In addition to its conventional lawmaking power, the WHO has shown experience as a lawmaking authority—essential to the elaboration of any international legal instrument—with the adoption of other legal instruments. WHO used its normative power in 1948, during its first session, to adopt the World Health Regulation Number 1 “nomenclature with respect to diseases and causes of death.” Also, even though the initial discussion predated the agency with the sanitary conferences held in Europe during the second half of the nineteenth century, WHO adopted the modest International Sanitary Regulations in 1951, which was revised in 2005. This revision revolutionized the regulatory power of WHO by greatly expanding its authority in global governance.<sup>73</sup> Adopting the FCGH would greatly contribute to the newly established normative authority of WHO, which is illustrated by the implementation of the revised IHR (2005). As Ooms et al. argues the FCGH would simply push that “logic of shared responsibility to a higher level.”<sup>74</sup> These various legal instruments—despite remaining challenges—serve as useful experience for WHO in the elaboration of the FCGH.

WHO should pursue this legal movement,<sup>75</sup> which is supported by some scholars and civil society. They are debating on the need to develop new international conventions on various health topics such as alcohol,<sup>76</sup> research and development,<sup>77</sup> and obesity.<sup>78</sup> The WHO could either propose these multiple conventions or use the FCGH to include and incorporate these other proposals under a common framework that would enable a wider coverage of global health issues. This point needs to be clarified by the advocates of the FCGH.

As discussed, the envisioned FCGH should preferably be adopted under article 19 similar to the FCTC as it would imply binding obligations. However, the flexibility offered by its normative function enables WHO to adapt the international instrument according to the ripeness of the context. Indeed, one important benefit of WHO is the possibility to engage discussion for the development of an international instrument of global health law on the basis of codes of practice, action plans or other soft law instruments mechanisms. This would ensure greater support of the countries with limited binding obligations. The use of soft norms is valuable as it would allow “creative compliance within a non-binding framework on the path to a binding treaty.”<sup>79</sup> WHO has also gained experience with the adoption of the WHO Code of Marketing Breast milk Substitutes in 1981 or recently the WHO Global Code of Practice on the International Recruitment of Health Personnel as well as the “quasi-

legal form such as a global social contract along the lines of WHO's innovative Pandemic Influenza Preparedness Framework.”<sup>80</sup>

The WHA could later convert this non-binding instrument into a binding instrument, provided that sufficient support and political will existed to move in this direction. In sum, WHO could use its normative power whether for a binding or non-binding instrument, to strengthen and legitimize its position as global health lawmaking authority.

### OVERCOMING OBSTACLES—AN OPPORTUNITY FOR WHO AND THE FCGH

Recognizing the difficulties of developing a FCGH, WHO has to overcome a number of obstacles if it wants to lead this process. Some of these challenges are inherent to WHO's reluctance to engage in normative activity while others stem from the criticism which led to the current reform process.

#### *A multilayered reluctance*

Historically, WHO has been reluctant to fully address its normative function. In particular, regarding human rights, Meier and Onzivu explain that “although WHO served this vital human rights leadership role in the first five years of its existence, the political constraints of the Cold War led WHO to reposition itself in international health as a purely technical organizational.”<sup>81</sup> This historical conservatism of the WHO in exercising its normative authority—some times to its detriment—and “reluctance to cooperate with the UN in human rights [...] limited WHO's ability in 1970s to carry out global health policy.”<sup>82</sup> This left the WHO's AIDS program in a state of disarray, which ultimately led HIV concerns out of WHO through the creation of the UNAIDS program, under direct supervision of the UN system. Efforts were made to reinforce its human rights mandate by hiring human rights advisors, by incorporating human rights law in the work of the WHO headquarters and by creating a Human rights team at WHO headquarters in 2003. Nonetheless, in 2011, WHO human rights staff were shifted within the Secretariat and became part of a department dealing with gender, equity and human rights. Thus the future of human rights at WHO is still uncertain, with a risk of reverting “to its institutional isolation and human rights abnegation” according to Meier and Onzivu.<sup>83</sup>

This reluctance was further illustrated during the FCTC negotiations. Indeed, initially “there was considerable resistance among WHO officials.”<sup>84</sup> As Taylor explained “WHO's traditional reluctance to utilize law and legal institutions to facilitate its health strategies [was] largely attributable to the internal dynamics and politics of the organization itself.”<sup>85</sup> This self-destructive reluctance by WHO can partly be explained by the contextual difficulties allowing WHO to act.

Again drawing on the FCTC experience, it can be considered almost *sui generis* considering the various contextual factors that triggered this initiative. First, the priorities set out by Margaret Chan, director general, are the WHO reforms and universal health coverage (UHC).<sup>86</sup> Even though the FCGH seeks to achieve UHC, it is not guaranteed that a global framework convention is the preferred means to achieve it in the eyes of Director-General Chan. This clearly contrasts with the remarkable ambition in tobacco control of Gro Harlem Brundtland—then Director-General—who played a decisive role in the establishment of the FCTC. Further, the difficulty in identifying harmful “enemies” such as tobacco companies—for instance wine producers in France are not seen as harmful—may hinder global and popular support. Also, the mixed results of the FCTC compared to what was expected—the

FCTC has achieved results but is criticized for lack of implementation and compliance as well as uncertain causal link to the health results—has led to a lack of contextual ripeness for future conventions, where limited political will and economic interest trumps public health.

Finally, not all international forums have the sufficient capacity and legitimacy to take on this ambitious project. The issue is whether WHO is suitable taking into account its capacity to handle this leadership. Considering the financial difficulties, the cost both to prepare and take in charge the development of the FCGH is crucial. Thus, if WHO has the theoretical constitutional capacity to actually host such an envisioned framework, the practical capacity is less obvious. Not only will this project require funding in elaborating the content but also to develop, monitor, and control the implementation of the FCGH. For instance, the FCTC has a secretariat within WHO to ensure functions such as supervising the implementation reporting mechanism.

Both the financial and the human resources needs are currently lacking. The financial crisis of WHO downsized the staff and “it is unclear how current staff levels can meet the burgeoning health challenges facing the agency.”<sup>87</sup> Further, efforts need to be made in hiring the kind of staff that the WHO would need to be qualified and experienced in international lawmaking. The current proportion of legal staff at WHO appears clearly insufficient, accounting for 1.4 percent.<sup>88</sup> As considered by Gostin et al, WHO’s reluctance to develop norms “may well be because it lacks the requisite funding and expertise, and does not see its comparative advantage over other UN institutions.”<sup>89</sup>

In addition to the political reluctance of member states (which can be overcome as illustrated by the experience of the International Code of Marketing of Breast Milk Substitutes),<sup>90</sup> some criticisms are targeted against a proactive and dominant role of WHO in the development of the FCGH mainly because of the lack of legitimacy and credibility of the organization. However, the current reform process engaged in 2011 could serve as a platform to provide answers to these criticisms as well as to this multilayered reluctance.

### *A reform context: an opportunity to act*

Learning from the experience of UNAIDS, WHO must understand that if the health issue is not tackled within its domain, it will be taken care of by other organizations such as the UN in the case of HIV. Further, the UNAIDS precedent illustrates the need for WHO to engage *ab initio* in the discussions. The HIV crisis offered WHO the “opportunity to apply interconnected human rights to address inter-sectoral determinants of HIV.”<sup>91</sup> A similar opportunity is offered with the FCGH and it would be wise for WHO not to miss that opportunity twice. Whether this effort will lead to a binding instrument or not, WHO has to participate in order to avoid being completely bypassed.

First of all, the FCTC has shown that the establishment of a framework convention on global health needs full support of WHO meaning the Director-General and the Secretariat. Considering its power and personal incarnation, the Director-General can greatly influence the agenda of the Organization as did Gro Harlem Brundtland with tobacco control. Therefore, Director-General Chan could support the FCGH initiative as a priority of her mandate. This will enable funding and staff to be allocated to the development of this project. For Gostin et al. this is a “design choice in setting its agenda, allocating its resources, and developing its workforce.” Indeed, “it is not reflected in the WHO’s constitutional mandate” that

WHO should be reluctant to normative authority. WHO should provide itself the means to achieve better health.

The involvement of WHO could start off minimally, similarly to the FCTC experience, which would not require an important amount of funding. Indeed, WHO could incorporate the FCGH into existing work to develop the obligations of the FCGH. WHO could dedicate legal office staff or develop a new unit for this normative function. Providing human and legal capacity to FCGH will both show WHO's support and enable FCGH to deepen its research and further the development of its project. This dedicated staff and/or new unit will also be able to work or support the work on the codification of the FCGH, in particular, through resolutions at the WHA. This could lead to the actual adoption of the FCGH following a similar approach to the FCTC.

Secondly, to convince WHO to participate in the elaboration of the FCGH, proof of the necessity of such an instrument must be demonstrated. In other words, advocates of this project must show the anticipated effectiveness of this binding instrument compared to other instruments or no instrument at all. Hoffman and Rottingen have identified criteria:<sup>92</sup> Are these criteria currently met by the FCGH? Will the FCGH be effective to achieve its goal? In addition, assessing the potential economic impact would serve as an argument towards skeptical member states and reluctant WHO. JALI has demonstrated such an impact, but further rigorous evaluation must be undertaken.

Finally, considering that the FCGH itself has the objective of reinforcing WHO within global health governance, it appears that the FCGH and WHO could mutually benefit of such an effort—in combination with the ongoing WHO reform—by strengthening the agency to better achieve its constitutional mandate and by providing the support of an international organization to the FCGH. This could certainly help WHO ground its normative authority at a global level and overcome its reluctance to engage in normative activity.

Nonetheless, this decision does not come without risks. In case the FCGH fails and does not overcome one of the numerous steps of in a process that includes drafting, adoption, vote, and national ratification, the Organization may lose legitimacy and credibility regarding its lawmaking power and its global health authority.

Further, success in establishing a FCGH will send a strong message to the international community and to its member states that the WHO has not only ambitious objectives but also strong means to achieve them. Once adopted, it could have a great impact on WHO's leadership. The political message sent would be remarkable. Some difficulties will remain such as the implementation and monitoring of the FCGH, as illustrated by the FCTC. Nonetheless, this combination—FCGH and WHO—would certainly constitute a shift in the governance of global health. This shift is critical today considering the increasing needs in global health.

It can be argued that the current reform is insufficient to tackle the difficulties of WHO and that further in-depth reforms need to be taken to fully recover WHO's legitimacy. The momentum created by the FCGH discussion must serve to further reform WHO by confirming its ambition of taking a leadership role in health governance and providing the means to achieve it. For instance, WHO will need funding for the development of the FCGH, but also once adopted to ensure implementation and monitoring. Nonetheless, funding concerns will apply whatever a decision is made regarding the institutional forum of the FCGH. Even though it is difficult to obtain funding that is not earmarked for specific purposes, securing the financing of the FCGH will require an increase in unencumbered contributions from

member states. This would allow WHO to have sustainable funding making WHO's agenda driven by the preferences of its funders rather than by the organization's impartial assessment of appropriate priorities.<sup>93</sup> Further, the legitimacy of WHO would also greatly benefit from the improved participation of civil society who has been "sidelined at WHO."<sup>94</sup> With the FCGH, WHO has the opportunity to better arm itself with a globally binding instrument to attain a higher level of health for all.

## CONCLUSION

This paper argues that the time is now ripe for WHO to take the lead in global health governance by taking on a prominent role in the FCGH. Further, it would ground WHO's lawmaking authority. Regardless of whether the current FCGH project needs changes or not or whether it is an achievable project, WHO must be part of this global lawmaking effort—either solely or collectively with other partners—for it to fully work, for the benefit both of the FCGH and of WHO. The solution is not to marginalize WHO. Who could envision a global health treaty circumventing WHO without irrevocably impacting it?

This paper also emphasizes the connections between the positions advocated by the FCGH and the role of WHO. The ambiguity on which institution or institutions should take a leading role in the FCGH shows the lack of trust in WHO by the FCGH advocates, despite having one of its objective to improve WHO's place in global health governance. The advocates cannot have it both ways: hoping to have WHO's support and at the same time seeking for other forums. In the long run, this contradiction will not benefit the FCGH's advancement. WHO also has to position itself and overcome its reluctance to engage in normative activities to provide sufficient guarantees that it will follow through with this project.

According to Gostin, the "FCGH would represent a historical shift in global health."<sup>95</sup> Considering the legitimate authority of WHO, part of global health history for more than 60 years, not using the constitutional lawmaking power would be a historical turn for the global health agency but not in the right direction. Despite the identified flaws, the potential advantages of having WHO leading the FCGH makes WHO a serious and legitimate candidate for the elaboration of the FCGH if not the only one. The FCGH could serve as a tool for WHO to better accomplish its mandate by providing a binding instrument to improve health inequalities.

WHO is usually criticized for being reactive.<sup>96</sup> This time it has the chance to be proactive. WHO must take this opportunity to overcome its political and self-destructive reluctance to engage in normative activity. The WHO is ripe to lead this adventure.

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<sup>1</sup> Sarah Roache, *et al.*, "Lessons from the West African Ebola epidemic: Towards a legacy of strong health systems," *Briefing Paper No. 10*, O'Neill Institute, 2014, 11.



<sup>2</sup> Address by Dr Margaret Chan, Director-General, to the Sixty-eighth World Health Assembly, A68/3, 18 May 2015.

<sup>3</sup> Michael T. Osterholm, *et al.*, “Public health in the age of Ebola in west Africa”, *JAMA International Medicine*, (10 October 2014) E2.

<sup>4</sup> See for example: Lawrence O. Gostin, Devi Sridhar and Dan Hougendobler, “The normative authority of the World Health Organization”, *Public Health* (2015).

<sup>5</sup> JALIS’s website lists 18 publications on the Framework Convention on Global Health, all focusing mainly on its content, [www.jalihealth.org](http://www.jalihealth.org) (Accessed September 5g, 2014).

<sup>6</sup> See expressions such as “Regardless of the pathway [...]” in Lawrence O. Gostin *et al.*, “Towards a framework convention on global health”, *Bull World Health Organization* 91 (2013) 792 and “Whatever the formal process [...]” in Lawrence O. Gostin & Eric A. Friedman, “Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice”, *Yale Journal of Health Policy, Law, and Ethics*, Volume 13 Issue 1 Article 1 (2013) 72.

<sup>7</sup> JALI, “Platform for a FCGH: Realizing the Universal Right to Health - Fundamental Principles and Joining the Platform”, (2014) 2.

<sup>8</sup> Sophie Hamman, “Is time up for WHO? Reform, resilience and global health governance”, *Future United Nations Development system*, Briefing 17 (May 2014) 4.

<sup>9</sup> UN Secretary-General, “Uniting for Universal Access: Towards Zero New HIV infections, Zero Discrimination and Zero AIDS-Related Deaths”, *Report of the Secretary General*, Doc A/65/797 (2011) 20.

<sup>10</sup> See for example: WHO, “The future of financing for WHO”, *Report by the Director-General*, EB128/21 (2010) 3-4.

<sup>11</sup> See for example: French Minister of Health, Marisol Tourraine, at the World Health Assembly, May 21<sup>st</sup>, 2013 (“[...] comfort even more the role of the WHO as the true global authority of public health”)

<sup>12</sup> See ‘JALI Materials’ on [www.jaliglobalhealth.org](http://www.jaliglobalhealth.org)

<sup>13</sup> See Special Issue *Public Health*, January 2014 especially Kelley Lee and T. Pang, “WHO : retirement or reinvention”, *Public Health*, Vol. 128, Issue 2, p. 119-123 ; Jon Lidén, “The World Health Organization and Global Health Governance : post 1990”, *Public Health*, Vol. 128, Issue 2, p. 141-147 ; Suerie Moon, “WHO’s role in the global health system : what can be learned from global R&D debates ?”, *Public Health*, Vol. 128, Issue 2, p. 167-172 ; Steven J. Hoffman and John-Arne Rottingen, “Split WHO in two : strengthening political decision-making and securing independent scientific advice”, *Public Health*, Vol. 128, Issue E, p.188-194 and R. van Pas and L.G. van Schaik, “Democratizing the World Health Organization”, *Public Health*, Vol. 128, Issue 2, p. 195-201.

<sup>14</sup> Kelley Lee and T. Pang, WHO : retirement or reinvention, *op. cit.*, note 13.

<sup>15</sup> See for example: WHO, “WHO reform: report by the Director-General”, World Health Assembly Document, 165/40 (2012) 4; WHO, “Draft Twelfth General Programme of Work”, WHA 66/6 (2013) 13; WHO, *WHO’s role in global health governance: report by the Director-General*, Executive Board Report, EB 132/5 Add.5 (2013) 5.

<sup>16</sup> Lawrence O. Gostin, “Meeting Basic Survival needs of the World’s Least healthy People Towards a Framework Convention on Global Health”, *Georgetown University, O’Neill Institute for national and Global Health Law Scholarship*, Research paper No.1, (2007) 1-51.

<sup>17</sup> Steven J. Hoffman and John-Arne Rottingen, “Dark sides of the proposed framework convention on global health’s many virtue: a systematic review and critical analysis”, *Health and Human Rights*, Special Issue, Volume 15, No. 1 (June 2013) 117-133.

<sup>18</sup> Eric A. Friedman *et al.*, “Realizing the right to health through a framework convention on global health?” *A Health and Human Rights Special Issue*, Volume 15, No. 1 (June 2013) 1.

<sup>19</sup> JALI, “Fact Sheet”, (April 2012) 1.

<sup>20</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 55.

<sup>21</sup> *Ibid.*

<sup>22</sup> JALI, “Health for All: Justice for All – A Global Campaign for a Framework Convention on Global Health”, (May 2012) 1.

<sup>23</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 55.

<sup>24</sup> Citation from WHO’s website ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/)) from Margaret Chan (retrieved 09/09/2014).

<sup>25</sup> JALI, Framework Convention on Global Health, “Preliminary Answers to 5 Priority Questions” (February 2012) 5.

<sup>26</sup> See WHO’s website : [www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/)

<sup>27</sup> JALI, “Health for All: Justice for All (...)”, *op. cit.*, note 22, 2.

- <sup>28</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 55.
- <sup>29</sup> *Ibid.* 10.
- <sup>30</sup> JALI/ Framework Convention on Global Health, “Preliminary (...)”, *op. cit.*, note 24, 9.
- <sup>31</sup> JALI, “Platform for a FCGH: Realizing the (...)”, *op. cit.*, note 7, 4.
- <sup>32</sup> *Ibid.* 5.
- <sup>33</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72.
- <sup>34</sup> *Ibid.* 55. (“Along with placing WHO at the center of global governance for health, the FCGH could include other measures to enhance WHO’s leadership”)
- <sup>35</sup> Steven J. Hoffman and John-Arne Rottingen, “Dark sides (...)”, *op. cit.*, note 17, 126.
- <sup>36</sup> UN Secretary-General, “Uniting for Universal Access: Towards Zero New HIV infections, Zero Discrimination and Zero AIDS-Related Deaths”, *Report of the Secretary General*, Doc A/65/797 (2011) 20.
- <sup>37</sup> Lawrence O. Gostin, “Meeting Basic Survival (...)”, *op. cit.*, note 16, 51; Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72.
- <sup>38</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72 (“Several forum could be home to the FCGH”).
- <sup>39</sup> Steven J. Hoffman and John-Arne Rottingen, “Dark sides (...)”, *op. cit.*, note 17, 126.
- <sup>40</sup> *Ibid.*
- <sup>41</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72.
- <sup>42</sup> Steven J. Hoffman and John-Arne Rottingen, “Dark sides (...)”, *op. cit.*, note 17, 125.
- <sup>43</sup> *Ibid.*
- <sup>44</sup> *Ibid.*
- <sup>45</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72.
- <sup>46</sup> See the Convention on the Elimination of All Forms of discrimination against Women in 1979 and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1984.
- <sup>47</sup> Lance Gable and Benjamin Mason Meier, “Global health rights: employing human rights to develop and implement the Framework Convention on Global Health”, *Health and Human Rights*, Special Issue, Volume 15, No. 1 (June 2013) 17 – 31.
- <sup>48</sup> Ilona Kickbush, “How should the Who reform”, *Global health programme working paper*, No. 11, 2014, p.23.
- <sup>49</sup> Lawrence O. Gostin and Eric A. Friedman, “Towards a Framework Convention on Global Health (...)”, *op. cit.*, note 6, 72.
- <sup>50</sup> Allyn L. Taylor, “Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health”, *American Journal of Law and Medicine*, 18 (1992) 301-346; David P. Fidler, “The Future of the World Health Organization: What Role for International Law?”, *Vanderbilt Journal of Transnational Law* 31 (1998) 1112 (“WHO should take international law more seriously in the future”).
- <sup>51</sup> Allyn L. Taylor, “Making the World Health Organization Work (...)”, *op. cit.*, note 48, 301.
- <sup>52</sup> G. Ooms et al., “Great expectations for the World Health Organization: a Framework Convention on Global Health to achieve universal health coverage”, *Public Health*, (2013).
- <sup>53</sup> J. Frenk and S. Moon, “Governance Challenges in Global health”, *The New England Journal of Medicine*, 368; 10 (March 7, 2013) 937.
- <sup>54</sup> Steven J. Hoffman and John-Arne Rottingen, “Dark sides (...)”, *op. cit.*, note 17, 125.
- <sup>55</sup> The UN Organization has 193 Member States (<http://www.un.org/en/aboutun/index.shtml>)
- <sup>56</sup> Lawrence O. Gostin et al., “Towards a framework convention (...)”, *op. cit.*, note 6, 792.
- <sup>57</sup> Gian Luca Burci and Claude-Henri Vignes, *World Health Organization*, (Kluwer Law International, 2004) 244.
- <sup>58</sup> *Ibid.*
- <sup>59</sup> David P. Fidler, “The Future of the World Health Organization (...)”, *op. cit.*, note 48, 1088.
- <sup>60</sup> See WHO, “Twelfth General Programme of Work for 2014-2019– Not merely the absence of disease” (2013) 20.
- <sup>61</sup> Allyn L. Taylor, “Making the World Health Organization Work (...)”, *op. cit.*, note 48, 301-346; Lawrence O. Gostin, “Meeting Basic Survival (...)”, *op. cit.*, note 16, 26.
- <sup>62</sup> David P. Fidler, “The Future of the World Health Organization (...)”, *op. cit.*, note 48, 1087.
- <sup>63</sup> See Article 50 of the Constitution listing the functions of the regional committees in particular “(a) formulate policies governing matters of an exclusively regional character (..) (e) to tender advice,

through the Director-General, to the Organization on international health matters which have wider than regional significance”.

<sup>64</sup> WHO, History of the WHO Framework Convention on Tobacco Control (2009) 28.

<sup>65</sup> WHO, “2012 global progress report on implementation of the WHO Framework Convention on Tobacco Control” (2012) 1-91; WHO, “10<sup>th</sup> Anniversary of the WHO Framework Convention on Tobacco Control – Saving Lives For a Decade” (2015).

<sup>66</sup> Margaret Chan, WHO Director-General in “History of the WHO Framework Convention on Tobacco Consumption” (2009) 35.

<sup>67</sup> Lawrence O. Gostin et al., “Towards a framework convention (...), *op. cit.*, note 6, 792.

<sup>68</sup> WHO, “WHA23.32 - Health Consequences of Smoking”, 5-22 May 1970

<sup>69</sup> WHO, “WHA48.11 - An international strategy for tobacco control”, 1-12 May 1995

<sup>70</sup> The World Health Assembly (WHA) adopted Resolution 49.17 on May 1996 calling upon WHO “to initiate the development of a framework convention [on tobacco control] in accordance with article 19 of the WHO Constitution (WHO, “International Framework Convention for Tobacco Control”, WHA Res. 49.17, World Health Assembly, 49th Ass., WHA A49/VR/6, May 25, 1996).

<sup>71</sup> Benjamin Mason Meier, “Breathing Life into the Framework Convention on Tobacco Control : Smoking Cessation and the Right to Health”, *Yale Journal of Health Policy, Law and Ethics* 5 (2005) 146.

<sup>72</sup> Allyn Taylor, “Global Health Governance and International Law”, *Whittier Law Review* 25 (2003) 261-62. (“I believe that the FCTC may signal a turning point—a new era in international health cooperation. The WHO’s unconventional consideration of the role of international law and institutions in promoting public health policies suggests an expansion of the organization’s traditional scientific, technical approaches to public health, and perhaps, an evolution of its traditional culture.”).

<sup>73</sup> R. Katz and J. Fisher, “The Revised International health Regulations: A Global Framework for Global Pandemic Response”, *Global Health Governance*, Volume II, No. 2 (Spring 2010) 3.

<sup>74</sup> G. Ooms et al., “Great expectations (...)”, *op. cit.*, note 50, 4.

<sup>75</sup> Allyn Taylor, “Leveraging non-binding instruments for global health governance : reflections from the Global AIDS reporting mechanism for WHO reform”, *Public Health* (2013)2: “Although WHO’s constitutional lawmaking authority was historically neglected until the adoption of its first convention a decade ago, widespread consensus in favour of a central lawmaking role in a reformed WHO [...]”.

<sup>76</sup> See in favor C O Record, *A framework convention on alcohol control*, *The Lancet*, Vol 370 December 22/29, 2007 ; Contrary view: Allyn Taylor et S. Dhillon, “An international legal strategy for alcohol control: not a framework convention—at least not yet”, *Addiction* 2013 March 108(3):450-5.

<sup>77</sup> “An Essential Health and Biomedical R&D Treaty”, submission by Health Action International Global, Initiative for Health & Equity in Society, Knowledge Ecology International, Médecins Sans Frontières, Third World Network (TWN), (22 Juin 2011).

<sup>78</sup> See in favor: Editorial, “Urgently needed: a framework convention for obesity control”, *The Lancet*, Vol 378 (August 27, 2011), 741; Contrary view: Steven J Hoffman and John-Arne Røttingen, “A framework convention on obesity control?”, *The Lancet*, Vol 378 (August 27, 2011), 2068.

<sup>79</sup> Lawrence O. Gostin et al., “Towards a framework convention (...), *op. cit.*, note 6, 792.

<sup>80</sup> *Ibid.*

<sup>81</sup> Benjamin Mason Meier and W. Onzivu, “The evolution of human rights in World Health organization policy and the future of human rights through global health governance”, *Public Health* (2015) 181.

<sup>82</sup> Benjamin Mason Meier, “Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement, *Stanford Journal of International Law* Volume 46 (2010) 43-44 (“Compounded by WHO’s reluctance to cooperate with the U.N. in human rights, desire to avoid politicizing its work during the height of the Cold War, and grounding in the conservative organizational culture of medical professionals, these vicissitudes in institutional leadership for human rights ultimately limited WHO’s ability in the 1970s to carry out global health policy (...)”).

<sup>83</sup> Benjamin Mason Meier and W. Onzivu, “The evolution of human rights in World Health organization (...), *op. cit.*, note 79, 181..

<sup>84</sup> Ruth Roemer, Allyn Taylor, Jean Larivière, “Origins of the WHO Framework Convention on tobacco control”, *American Journal of Public health* (2005) 937; Benjamin Mason Meier, “Breathing Life (...)”, *op. cit.*, note 69, 145. “Although Resolution 49.17 met with substantial resistance both inside and outside the WHO.”

<sup>85</sup> Allyn L. Taylor, “Making the World Health Organization Work (...)”, *op. cit.*, note 48, 303.

<sup>86</sup> Citation from WHO's website ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/)) from Margaret Chan "I regard universal health coverage as the single most powerful concept that public health has to offer." (retrieved 09/09/2014).

<sup>87</sup> Lawrence O. Gostin, Devi Sridhar and Dan Hougendobler, "The normative authority of the World Health Organization", *Public Health* (2015) 9.

<sup>88</sup> WHO, "Human resources: annual report, *Report by the Secretariat*, Sixty-sixth World health assembly, A66/36, 14 May 2013, Table 13 "Distribution of occupied posts in the professional and higher categories across main occupational groups" (p.45).

<sup>89</sup> Lawrence O. Gostin, Devi Sridhar and Dan Hougendobler, "The normative authority (...), *op. cit.*, note 85, 9.

<sup>90</sup> Despite the United-States being the only member states voting against, with 3 abstentions and 118 countries in favor, the Code was adopted. Further, progress has been made since the Code's adoption though further improvement should be made. See Benjamin Mason Meier and Miriam Labbok, « From the Bottle to the Grave : Realizing a Human Right to Breastfeeding through Global Health Policy, *Case Western Reserve law Review* 60 (2010) 1073-1142.

<sup>91</sup> Benjamin Mason Meier and W. Onzivu, "The evolution of human rights in World Health organization (...), *op. cit.*, note 79, 181..

<sup>92</sup> Steven J. Hoffman, John-Arne Rottingen and Julio Frenk "Assessing proposals for new global health treaties: an analytic framework", *American Journal of Public Health*, "First, there must be a significant transnational dimension to the problem being addressed. Second, the goals should justify the coercive nature of treaties. Third, proposed global health treaties should have a reasonable chance of achieving benefits. Fourth, treaties should be the best commitment mechanism among the many competing alternatives."

<sup>93</sup> G. Ooms et al., "Great expectations (...)", *op. cit.*, note 50, 4.

<sup>94</sup> *Ibid.*

<sup>95</sup> Lawrence O. Gostin, "Meeting the Survival Needs of the World's Least Healthy People – A Proposed Model for Global Health Governance", *Journal of the Medical American Association*, Vol 298, No. 2 (2007) 226.

<sup>96</sup> Lawrence O. Gostin, "Meeting Basic Survival (...)", *op. cit.*, note 16, 28.

# Women's Health and a Framework Convention on Global Health

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*This paper considers the role for a Framework Convention on Global Health in addressing key challenges in women's health at a global level. Part I analyses the conceptualization of health in terms of human rights and the linking of women's rights and human rights. Part II seeks to identify pressing issues for women's health, articulating 10 key challenges for women's health. Part III considers the proposal for a Framework Convention on Global Health to meet global health needs. Finally, Part IV asks whether international law can provide a valuable platform to support recognition and achievement of women's health rights and identifies key elements for supporting and promoting women's health.*

## INTRODUCTION

In 2000, the 189 Member countries of the United Nations adopted the Millennium Declaration, articulating a statement of values and principles at the start of the new millennium. This Declaration also set out eight Millennium Development Goals (MDGs), with the achievement of these goals measured against specified targets and indicators. There have been some real advances in global health in the period since the adoption of the MDGs. There have, for example, been real reductions in extreme poverty, with the proportion of people in developing regions living on less than \$1.25 a day falling from 47% in 1990 to 14% in 2015.<sup>1</sup> This dramatic reduction means that the world met its MDG target of reducing extreme poverty to half its 1990 level.<sup>2</sup> However, despite this achievement, there are still more than 800 million people living in extreme poverty.<sup>3</sup> Compounding these figures is the fact that many of the world's poorest countries bear the heaviest burden in terms of infectious diseases such as cholera, tuberculosis, and malaria.<sup>4</sup> The poorest areas are increasingly bearing a heavy burden of non-communicable diseases as well, including cancers, cardio-vascular disease, smoking-related illnesses, and obesity.<sup>5</sup>

With the adoption of the Sustainable Development Goals (SDGs) in 2015<sup>6</sup> it is fitting to consider what the future holds for women's health. Although there have been significant improvements in the health of women and children in recent years, including as a result of the *Global Strategy for Women's and Children's Health*, launched in 2010,<sup>7</sup> challenges still remain.<sup>8</sup> As noted by UN Women, the tracking of progress of the goal of promoting gender equality and empowering women articulated in MDG3, has been regarded as overly narrow, since the achievement of this goal has been measured only in terms of gender parity in education.<sup>9</sup> Other issues that need to be addressed in order to achieve gender equity and women's empowerment include gender-based violence, wage discrimination, the unequal distribution of unpaid work, the sexual and reproductive health of women and girls, unequal distribution of economic resources, and women's lack of access to decision-making.<sup>10</sup> UN Women recommended that, "a transformative stand-alone gender equality goal must be a core element of the post-2015 development framework and the SDGs."<sup>11</sup> The Sustainable Development Goals include as SDG5 the goal to "achieve gender equality and empower all women and girls."<sup>12</sup>

This paper analyzes the key challenges for women's health and asks whether a Framework Convention on Global Health (FCGH) could help to support improvements in women's health. Part I analyzes the conceptualization of health in terms of human rights, and the linking of women's rights and human rights. Part II articulates 10 key challenges for women's health. Having identified these challenges, an important question is whether law can play a valuable role in promoting and improving women's health. Part III outlines the proposal for a Framework Convention on Global Health. Finally, Part IV asks whether international law can provide a valuable platform to support recognition and achievement of women's health rights. This paper argues that a Framework Convention on Global Health could play an important role in improving the health of many of the world's poorest people, most of whom are women and children. However, if it is to achieve its full potential in terms of women's health, women's health-related rights, and the measures designed to support them, gender-related considerations and targets measured by data that is disaggregated on the basis of sex will need to be key elements of the FCGH.

## HEALTH AND HUMAN RIGHTS

Over the past few decades two important developments have been of particular significance for women's health. The first of these developments has been the conceptualization of health in terms of human rights. While a gendered analysis has not been at the core of the health and human rights trend, the linking of health and human rights has been a significant development with important implications for the conceptualization of health rights generally. The second development is the conceptualization of women's rights and human rights. These two developments combined have reshaped the scope of the potential for women's health into the future, opening new avenues for real and practical improvement in the lives of women around the world.

International human rights law recognises the link between health and human rights. For example, Article 25 of the *Universal Declaration of Human Rights* provides that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family."<sup>13</sup> The link between health and human rights developed further with the articulation of the right to health in the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and the requirement in Article 12 for States Parties to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."<sup>14</sup> The link between health and human rights has become part of international law<sup>15</sup> and the language of human rights is now a defining feature of global health governance.<sup>16</sup>

These are, of course, not the only international instruments relevant to health and human rights. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, the International Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of Persons with Disabilities (CRPD), as well as a number of other instruments, all form part of international human rights law on the right to health.<sup>17</sup> The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>18</sup> has, for example, provided an important vehicle for articulating women's health-related rights.<sup>19</sup> Article 12(1) provides that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the

basis of equality of men and women, access to health care services, including those related to family planning.”

As Sofia Gruskin points out, in the field of global public health, the connection between health and human rights can be traced to four developments.<sup>20</sup> First, in the 1980s, the language of human rights came to be an important aspect of responding to HIV/AIDS, as the human rights approach was a key part of countering the stigma and discrimination associated with the disease. Second, the various United Nations conferences addressing issues relevant to human health, such as the International Conference on Population and Development in 1994, and the declarations and programs for action that developed from them, helped to conceptualize health in terms of human rights. Third, the United Nations has increasingly understood its work on health within a human rights framework. Finally, individual countries themselves have increasingly understood their health-related activities in terms of complying with their international human rights obligations.

Another key development has also been evident in relation to women's health and human rights. Concerns around reproductive rights have been articulated in terms of human rights,<sup>21</sup> and feminist scholars have also challenged the gendered dimensions of international law,<sup>22</sup> asserting that “women's rights are human rights.”<sup>23</sup> Furthermore, as Yamin points out, feminist analyses of reproductive rights, which see rights in broad, contextual terms, have “challenged not only the utilitarian premises of public health but also the individualistic premises of traditional human rights.”<sup>24</sup> The intersection of human rights and reproductive rights has led to new ways of conceptualizing rights related to reproductive health. As Gable has argued:

“The human right to reproductive health exists at the intersection of discourses about reproductive rights and the right to health. However, the human right to reproductive health is not merely a subcomponent of the right to health or one of several rights included under the rubric of reproductive rights. Rather, the human right to reproductive health presents a unique conceptualization of human rights protection focused on considerations of reproductive health and the fulfillment of factors necessary to support good reproductive health.”<sup>25</sup>

By situating the conditions for health within broader social contexts, debates around women's health remind us that health does not exist in a vacuum.

Although this article focuses on women's health, the impact of gender on health is not limited to women. There are gendered dimensions to a range of health indicators. For example, men often have poorer health outcomes than women on a range of measures that include lower life expectancy, and increased mortality rates for accident-related deaths, and alcohol-related harm.<sup>26</sup> Such disparities demand that we develop gendered understandings of health that address the distinct needs of both men and women.<sup>27</sup> The focus in this article on women's health aims to analyze these needs for women. However, it is recognized that similar work is needed on men's health. As we move towards the implementation of the Sustainable Development Goals, and as we consider the proposal for a Framework Convention on Global Health, we need to understand the health needs of both women and men, and identify those needs that are shared and those that are sex- or gender-specific.

## 10 KEY CHALLENGES FOR WOMEN'S HEALTH

In seeking to identify a number of key issues for women's health it is not intended to suggest that these are the only health issues facing women.<sup>28</sup> However, the 10 challenges articulated here affect great numbers of women and for that reason are worthy of focused attention.

### *1. Safe abortion and contraception*

Access to contraception and to safe abortions have both been longstanding priorities for women around the world. With an estimated 21.6 million unsafe abortions globally in 2008,<sup>29</sup> the implications of a lack of access to safe abortion are evident from the grim mortality figures. In 2008, an estimated 47,000 women died from unsafe abortions.<sup>30</sup> Although there has been recognition of the importance of a human right to safe medical care, including safe abortion,<sup>31</sup> access to legal abortion remains a complex issue for women for although 98% of countries permit abortion to save a woman's life, abortion is available on request in only 28% of countries.<sup>32</sup> As the World Health Organization has noted, "The legal grounds [for abortion] largely shape the course for women with an unplanned pregnancy towards a safe or an unsafe abortion."<sup>33</sup>

Of course linked to the issue of access to safe and legal abortion is that of access to safe and effective forms of contraception. While contraceptive use has increased globally, there is still an unmet need for family planning.<sup>34</sup> The lack of access to effective contraception complicates women's reproductive health by potentially exposing them to the risk of unsafe abortions, or to the risks associated with pregnancy and childbirth. SDG3 establishes a target of ensuring by 2030 "universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health information into national strategies and programmes."<sup>35</sup>

### *2. Maternal and infant mortality*

Although mortality rates for children less than five years of age reduced by 53% in developing regions between 1990 and 2015, the reduction in mortality fell well short of the MDG target of reducing child mortality by two-thirds by 2015.<sup>36</sup> Stark disparities exist between countries. In Sierra Leone, for example, the mortality rate for children under 5 years of age is 262 per 1,000 live births. This compares to a rate of 6 per 1,000 in Australia and Canada.<sup>37</sup> SDG3 has a target of reducing "under 5 mortality to at least as low as 25 per 1,000 live births" by 2030.<sup>38</sup>

In 1990, there were an estimated 523,000 maternal deaths.<sup>39</sup> By 2013, this figure had fallen to 289,000, a dramatic reduction of 45%.<sup>40</sup> The maternal mortality ratio decreased from 380 maternal deaths per 100,000 live births in 1990 to a rate of 210 in 2013.<sup>41</sup> However, the developing world accounts for 99% of maternal deaths.<sup>42</sup> SDG3 sets a new target of reducing "the global maternal mortality ratio to less than 70 per 100,000 live births" by 2030.<sup>43</sup>

### *3. Women and sexual health*

Although there have been dramatic increases in the number of people receiving antiretroviral treatment for HIV, there is still a need for further work to ensure universal access by all who need it.<sup>44</sup> Access to information and education about



sexual health is vitally important. The Committee on the Elimination of Discrimination Against Women has stated that: “States Parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls [...] even if they are not legally resident in the country.”<sup>45</sup> Law can play a vital role in supporting the sexual and reproductive health of women through recognition of sexual health rights through human rights frameworks by ensuring equity in access to information and resources, non-discrimination in domestic laws and policies, and removal of legal barriers to women’s access to sexual health services including contraception and abortion.<sup>46</sup>

#### *4. Poverty and women’s health*

Poverty is a key factor in poor health. Lack of access to adequate nutrition, housing and health care are all compounding factors for poor health. Women are particularly likely to experience poverty.<sup>47</sup> Given the well-established links between poverty and poor health outcomes, any gendered dimensions to poverty are likely to correlate to gendered dimensions in terms of health outcomes.

#### *5. Gender-related violence*

Violence against women is widespread, with almost one-third of women (30%) worldwide who have been in a relationship having experienced physical and/or sexual violence from their partner, and 7% of women globally having been sexually assaulted by someone who is not their partner.<sup>48</sup> There is also increasing recognition of the prevalence of sexual violence in the context of war and conflict.<sup>49</sup> Such violence has significant impacts on the health of affected women.<sup>50</sup> In its General Recommendation No. 19, the Committee on the Elimination of Discrimination Against Women stated that “Gender-based violence is a form of discrimination that seriously inhibits women’s ability to enjoy rights and freedoms on a basis of equality with men.”<sup>51</sup>

There is increasing international recognition of the role of law in protecting women’s rights with respect to gender-based violence.<sup>52</sup> UN Women has published a *Handbook for Legislation on Violence Against Women* to provide a framework for model legislation.<sup>53</sup> SDG5 includes as a target the elimination of “all forms of violence against all women and girls in the public and private spheres.”<sup>54</sup>

#### *6. Gender, food and water*

Globally, one in seven children is underweight, with one in four children under five years having stunted growth.<sup>55</sup> SDG2 establishes the goal to “end hunger, achieve food security and improved nutrition and promote sustainable agriculture.”<sup>56</sup>

In its General Recommendation No. 24, which elaborates on Article 12 in CEDAW, the Committee on the Elimination of Discrimination Against Women noted:

“that the full realization of women’s right to health can be achieved only when States Parties fulfil their obligation to respect, protect and promote women’s fundamental human right to nutritional well-being throughout their lifespan by means of a food supply that is safe, nutritious and adapted to local conditions.”<sup>57</sup>

The MDG target of halving the proportion of people without access to improved drinking water has been met, but an estimated 663 million people are still living without improved drinking water.<sup>58</sup> SDG6 is the goal of ensuring “availability and sustainable management of water and sanitation for all.”<sup>59</sup> In many countries women and girls bear the primary burden of collecting water.<sup>60</sup> Furthermore, the gendered distribution of responsibilities for collection of water and solid fuels for domestic use means that women spend time on these tasks that “could otherwise be spent on income-generation, education or care for family members, all of which are related to the health status of women and of their families.”<sup>61</sup> Access to water has been identified as important for the empowerment of women in society.<sup>62</sup> UN Women recommended that progress be measured by indicators that include data which shows, by sex, the average amount of time spent each week on water collection.<sup>63</sup>

### *7. Women and disability*

Article 6 of the CRPD recognises “that women and girls with disabilities are subject to multiple discrimination.”<sup>64</sup> The Preamble to the Convention recognises “that women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.”<sup>65</sup> There is a real need to engage with the Convention and to analyze its role in supporting and protecting the rights of women with disabilities and to understanding the intersectionality of women's lives.<sup>66</sup>

### *8. Gender and aging*

Many developed countries are experiencing the combination of falling birth rates and an aging population. Indeed, in 2010 it was estimated that “within 36 years there will be more people over the age of 60 than children less than 15 years, globally.”<sup>67</sup> This aging of the population does have a gendered dimension as women comprise a greater proportion of the elderly.<sup>68</sup> Furthermore, the aging of the population is not only an issue for developed countries, as more than half of the world's over-60 population lives in developing countries.<sup>69</sup>

Once again, the multiple dimensions to women's lives are evident in the ways that gender, aging and women's roles as caregivers intersect. Older women often play important roles in society as caregivers of children, including of children who have been orphaned through humanitarian crises or diseases such as HIV/AIDS,<sup>70</sup> and as carers of elderly spouses. Indeed, the Committee on the Elimination of Discrimination Against Women has stated that it is

“concerned about the conditions of health-care services for older women, not only because women often live longer than men and are more likely than men to suffer from disabling and degenerative chronic diseases, such as osteoporosis and dementia, but because they often have the responsibility for their ageing spouses.”<sup>71</sup>

### *9. Access to health care*

Access to health care is an essential element of good health. The provision of universal health coverage (UHC) ensures that access to health care is available to all. With international efforts to introduce UHC, a gendered analysis is important in

order to appreciate the gender-related factors that may be a barrier to access to health care.<sup>72</sup> These may include differing access to household resources, family and work responsibilities, social and cultural norms that may limit women's ability to travel unaccompanied, and the need to understand gendered patterns of disease when setting priorities and benefits for UHC,<sup>73</sup> which may not be realized without a gender-based analysis of UHC.

#### *10. Non-communicable diseases*

At the same time as hunger continues to be a problem for many people in developing countries, non-communicable diseases (NCDs) including diabetes and obesity are increasingly taking a toll on the health of the world's poor. With NCDs accounting for 63% of deaths globally in 2008,<sup>74</sup> there is increasing recognition of the need for a global approach to tackling NCDs<sup>75</sup> and of the importance of a human rights approach to combating NCDs.<sup>76</sup> A gendered analysis of NCDs is also particularly important in order to appreciate the impact of NCDs on women's health and to ensure planning of appropriate health services.<sup>77</sup>

### **LEGISLATING GLOBAL HEALTH RIGHTS**

A proposal for a Framework Convention on Global Health (FCGH) has emerged in response to the profound challenges posed by global health disparities. Although significant progress in global health has been achieved through the work on the MDGs, the need to strengthen health systems at both the national and the global level remains an important issue for global health. The recent Ebola crisis in West Africa has also highlighted the need for robust and resilient health systems.<sup>78</sup> The proposal for a new Convention involves a "bottom-up strategy" that would aim to: build capacity; set priorities; engage stakeholders; coordinate activities so as to harmonize the various programs currently operating; and evaluate and monitor progress.<sup>79</sup> Under this approach, States would initially negotiate the terms of the Convention to establish the parameters for common action. During later stages, States would negotiate and ultimately agree on specific protocols aimed at setting out the measures to be taken to address particular issues or concerns.<sup>80</sup>

The FCGH would build upon other international treaties, such as the Kyoto Protocol and the Framework Convention on Tobacco Control, that have taken innovative legal approaches to issues of common international concern.<sup>81</sup> Although the detail of a FCGH would need to be negotiated between key stakeholders, Gostin has proposed some broad principles for the Convention, addressing its mission, objectives, engagement and coordination, obligations of States and other stakeholders, institutional structures, mechanisms for monitoring and enforcement, ongoing scientific analysis, and guidance for subsequent lawmaking.<sup>82</sup> Importantly, Gostin proposes that the mission of the FCGH should be for "Convention Parties [to] seek innovative solutions for the most pressing problems facing the world in partnership with non-State actors and civil society, with particular emphasis on the most disadvantaged populations."<sup>83</sup> Key principles have been articulated for the FCGH, with the principles addressing equitable health systems, the social determinants of health, human rights, global governance for health, and compliance with the Convention.<sup>84</sup>

The objectives of the FCGH would be, according to Gostin, to "Establish fair terms of international cooperation, with agreed-upon mutually binding obligations to create enduring health system capacities, meet basic survival needs, and reduce

global health disparities.”<sup>85</sup> Those advocating the FCGH acknowledge the political challenges associated with its development and implementation.<sup>86</sup> Furthermore, as Gostin notes, although the FCGH creates a space for dialogue and agreement on global health, “it does not ensure consensus on contentious issues.”<sup>87</sup> However, Gostin elaborates that “The framework convention approach has considerable flexibility, allowing Parties to decide the level of specificity that is politically feasible now, saving more complex or contentious issues to be built in later protocols.”<sup>88</sup>

A FCGH would aim to ensure three conditions for good health: universal access to an effective health care system; public health services that provide adequate nutrition, clean water and a clean living environment; and the broader social and economic conditions that contribute to good health, including “employment, housing, income support and gender equality.”<sup>89</sup> Friedman and Gostin propose four pillars to support the progress towards achieving the right to health: (i) incorporating the right to health within laws and policies at the national level; (ii) use of creative strategies to support right-to-health litigation; (iii) empowering civil society groups and individuals to claim the right to health; and (iv) positioning the right to health to the centre of global health governance.<sup>90</sup> Friedman and Gostin argue that the Framework Convention “could help to simultaneously erect all four pillars.”<sup>91</sup> They recognise the need for strong compliance mechanisms to support the FCGH. Such measures could “begin with regular, public country reports on how they are implementing the treaty,”<sup>92</sup> with such reports either developed through an inclusive process or supplemented by consideration of civil society reports, or both. Either way, they argue, “the treaty should ensure that evaluation of compliance is not based simply on states’ say-so.”<sup>93</sup> Importantly, according to Gostin et al, a FCGH could provide “specific standards and forceful accountability behind the post-2015 global commitments, as well as redressing weaknesses.”<sup>94</sup>

## **WOMEN'S HEALTH, LAW, AND HUMAN RIGHTS**

Through its focus on basic health needs, by setting targets and measures, and by providing a formalized framework for progress, the FCGH could help to improve global health, including women's health. Women's groups were disappointed that reproductive rights were not expressly included in the Millennium Development Goals.<sup>95</sup> Feminist legal scholars have also argued that the norms of international law have traditionally failed to adequately address the experiences of women.<sup>96</sup> Importantly, the SDGs include the target of ensuring “universal access to sexual and reproductive health and reproductive rights” within SDG5.<sup>97</sup>

The articulation of women's health needs in terms of rights could be seen as individualizing women's needs, rather than addressing them in terms of social and cultural factors that contribute to women's disadvantage, yet even if we acknowledge the limitations associated with rights,<sup>98</sup> as Charlesworth, Chinkin and Wright have argued, rather than rejecting rights we need to focus on developing analyses of rights that meet women's needs:

“While the acquisition of rights must not be identified with automatic and immediate advances for women, and the limitations of the rights model must be recognized, the notion of women's rights remains a source of potential power for women in international law. The challenge is to rethink that notion so that rights correspond to women's experiences and needs.”<sup>99</sup>

The question of whether international law can support women's health is an important one. Even acknowledging what Charlesworth refers to as "the hidden gender of international law,"<sup>100</sup> the development of an international legal instrument, aimed at addressing global health inequalities, and which included recognition of human rights related to women's health, could provide a real opportunity to improve health outcomes for many of the world's poorest people, most of whom are women and children.

As currently articulated, the FCGH does recognize the relevance of gender. For example, an articulation of key principles for the FCGH provides that a FCGH should:

"Remove all discrimination – both purposeful and in effect, both in law and in fact – and other barriers in law, policy and practice that undermine the right to health; respond to specific health needs of women and other populations that are marginalized or have special needs; and respond to gender-based violence."<sup>101</sup>

As we consider the proposal for a FCGH and move forward in considering the steps to take in supporting and promoting women's right to health there are four key elements to be included in work on the FCGH.

First, it is essential that the right to health is articulated in ways that expressly account for the gendered dimensions of such a right. Addressing women's health-related needs and rights requires a holistic approach to the broad factors that contribute to women's poverty and poor health, including recognition that advancing women's human rights requires consideration of more than just maternal and child health,<sup>102</sup> and needs to consider women's health needs across their lives.<sup>103</sup> The principles articulated for the FCGH recognize that equitable health systems should "provide health care across the life course and continuum of care."<sup>104</sup> A focus on the right to health should also be undertaken within a context that expressly recognises and supports existing international obligations for gender equity such as those in CEDAW.<sup>105</sup>

The second element relates to the setting of targets. The setting of targets is important. They serve to focus attention on important priorities and create incentives for change.<sup>106</sup> However, as Fukuda-Parr and Yamin have argued, targets can also have unintended effects, distorting priorities and taking attention away from other important priorities and programs.<sup>107</sup> Furthermore, although targets may serve to mobilize action around priorities, they may also oversimplify complex matters and sideline consideration of issues, such as rights and development that are not readily quantifiable.<sup>108</sup>

Measurements of success require that data on targets and other indicators be disaggregated on the basis of sex.<sup>109</sup> Indeed, given the multiple factors that impact on women's health, data should also be sufficiently detailed to account for age and disability as well. Disaggregation of data is also essential to identifying disparities that exist within countries.<sup>110</sup> Quantitative measures alone will not be sufficient to achieve gender equity,<sup>111</sup> and there is a need to analyze the role of indicators in human rights analysis.<sup>112</sup> However, when indicators are developed and are provided, sex-based disaggregation is an important element in identifying sex-specific differentials in progress. There is a growing body of research documenting the relevance of sex and gender for health and the need for health research that recognizes diversity.<sup>113</sup> Furthermore, in its General Recommendation No. 24 on women and health, the Committee on the Elimination of Discrimination Against

Women indicated that “States Parties should allocate adequate budgetary, human and administrative resources to ensure that women’s health receives a share of the overall health budget comparable with that for men’s health, taking into account their different health needs.”<sup>114</sup> Without disaggregated data it will be very difficult to track both achievements and failures in women’s health.

Third, we need to recognize that some areas of women’s human rights, including those related to sexual and reproductive health, may be regarded as controversial. The FCGH envisages that while consensus may be reached on some matters, other matters may take longer. It would be unrealistic to expect that the FCGH will provide a “quick-fix” solution to long-standing challenging issues in reproductive rights. However, while women’s human rights are more than just women’s reproductive rights, it is also true that rights relating to sexual and reproductive health are defining issues for women’s health and it is important that these rights are articulated in terms of human rights and are protected as such. Existing health-related rights for women must be a starting point for the FCGH, with clear recognition of current rights articulated in existing international conventions. It will be important to ensure that gender equity is clearly articulated within the goals and standards set by the FCGH, that there are gender-specific analyses of patterns of disease and poor health, and that reporting requirements require data to be disaggregated on the basis of sex.

Finally, there is the critical issue of translating the right to health into meaningful, enforceable rights at a local level. While an international convention on the right to health can set targets and indicators and establish an agreed framework for monitoring outcomes, ultimately health and health care are experienced as lived realities within local and national contexts. Friedman and Gostin acknowledge that the inclusion of a right to health within national constitutions does not guarantee better health outcomes but they argue that “it does provide a foundation for action, whether catalyzing legal and policy reforms or unlocking the potential for litigation to enforce this right where other routes [...] are unavailable or insufficient.”<sup>115</sup> The justiciability of individual rights in the right to health can help to provide legal pathways for formal recognition and enforcement of health-related rights at a national level,<sup>116</sup> although there is recognition of the limits of litigation in promoting global health.<sup>117</sup> The complexity of these issues highlights the need to develop nuanced understandings of the role of law in supporting global health, both individually and communally.<sup>118</sup>

## CONCLUSION

A great deal of work to improve women’s health has been done over many years. There is still a great deal of work to be done. Women’s reproductive and sexual health—including improvements in maternal and infant mortality rates and access to safe abortion—are vital parts of the quest to improve health outcomes for women. However, as is evident from the list of the 10 key challenges for women’s health outlined here, they are only part of the story. Issues of gender-related violence, the gendered dimensions of poverty, the intersections between gender and aging and gender and disability, access to food, water and health care, and the emerging challenges posed by non-communicable diseases are also part of the broader picture of women’s health.

The link between health and human rights can provide a powerful framework for achieving change. In the context of health and human rights, initiatives such as the proposal for a Framework Convention on Global Health could provide a real

opportunity for advancement of global health and in particular, for addressing the needs of the world's poorest women. It is essential though that goals and targets for global health are based on holistic understandings of the gendered dimensions of health, and of the poverty and social and economic disadvantage that contribute to poor health. Such an approach will ensure that law makes meaningful contributions to the task of articulating the relationship between women, health and human rights.

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# The Importance of the Right to Food for Achieving Global Health

Emilie K. Aguirre

*The Framework Convention on Global Health (FCGH) represents a significant opportunity to realize the right to health globally. However, in order to succeed the FCGH must be carefully considered: it must take a new evidence-based approach that departs meaningfully from past shortcomings in realizing the right to health. Central to this approach is recognizing, formally incorporating, and operationalizing the right to adequate food. This right should be correctly interpreted as a right to a standard of nutritional quality and not as a right to a minimum number of calories. Because nutrition is critical to the achievement and maintenance of good health, particularly for the most deprived populations, this right is an indispensable substantive condition of achieving the right to health. In addition to helping the FCGH to be effective, the right to adequate food will help it achieve comprehensiveness, legitimacy, and efficiency. There are several ways the right to adequate food can be operationalized in tandem with the right to health, including through formal enshrinement in health and other policies, and through the enactment of several types of measures to improve dietary behaviors and health outcomes. Incorporating a broadly conceived right to adequate food into the FCGH acknowledges and formally takes steps to address nutrition's critical role in realizing the right to health, particularly for the most deprived populations. It will strengthen the FCGH and improve its chances of success.*

## INTRODUCTION

Great advances have been made in global health over the past several decades. In 1947, for example, about half of the world's population was malnourished, a figure that has remarkably declined to about 12.5 percent currently.<sup>1</sup> However, much work still remains to be done. Nearly one billion people remain undernourished, two billion suffer from micronutrient deficiencies, and 1.4 billion are now overweight with 500 million of those obese.<sup>2</sup> These conditions can lead to serious negative—and preventable—health outcomes, including stunting, infectious diseases, and noncommunicable diseases.<sup>3</sup> In nutrition and in all other areas of health, the proposed Framework Convention on Global Health (FCGH) presents a significant opportunity to realize the right to health globally. However, in order to do so, it must take a thoughtful and measured approach—one that builds on previous successes and identifies and deliberately departs from past shortcomings.

One crucial element of the FCGH approach, which will diverge meaningfully from past approaches, is incorporating the right to adequate food into the Framework, and formally recognizing the indispensability of the right to adequate food to realizing the right to health. This paper will show through a three-part analysis how without the right to adequate food the FCGH cannot succeed in realizing the right to health. In Section II, the paper argues as a threshold matter that the right to food should be properly interpreted as a right to a standard of nutritional quality and not as a right to subsistence or a minimum number of calories. Section III demonstrates, perhaps

uncontroversially, the significance of nutrition to attaining and maintaining good health. Building on these two premises, this paper argues that the right to food is a necessary substantive condition of achieving the right to health and should therefore be explicitly accounted for in the FCGH. Section IV bolsters this substantive argument by offering legitimacy and efficiency reasons for incorporating the right to adequate food in the FCGH. Finally, Section V discusses preliminary ways to operationalize the right to adequate food in tandem with the right to health.

### **THE MEANING OF ADEQUACY: THE RIGHT TO FOOD AS A RIGHT TO NUTRITIONAL QUALITY**

The right to food is codified in several basic human rights instruments. Adopted in 1948, the Universal Declaration of Human Rights (UDHR) is the first document to refer to a right to a standard of living adequate for achieving health, including food.<sup>4</sup> Twenty years later, the UN General Assembly specifically and formally codified a right to adequate food in the International Covenant on Economic, Social, and Cultural Rights (ICESCR). The ICESCR, which has 164 party States, is dedicated to the progressive realization of a set of eight categories of economic, social, and cultural rights: the rights to self-determination, work, family life, an adequate standard of living, the highest attainable standard of physical and mental health, education, and cultural life.<sup>5</sup> The right to adequate food is included under the right to an adequate standard of living.<sup>6</sup> Enforcement of this agreement is primarily the responsibility of each State,<sup>7</sup> though there are also some regional human rights courts such as the Inter-American Court of Human Rights that have enforcement capabilities in this area (though not of ICESCR specifically).<sup>8</sup> The ICESCR also created a Committee on Economic, Social and Cultural Rights (CESCR) responsible for making general recommendations on realizing the rights in ICESCR.<sup>9</sup> CESCR's General Comment 12 interprets the right to adequate food to mean having "physical and economic access at all times to adequate food or means for its procurement."<sup>10</sup> It also notes "the concept of adequacy is particularly significant in relation to the right to food."<sup>11</sup>

Most recently in 2014, the former Special Rapporteur on the Right to Food—an independent expert appointed by the UN Human Rights Council to investigate and report on the realization of this right<sup>12</sup>—Olivier De Schutter defined the right as the having "physical and economic access at all times to sufficient, *adequate*, and culturally acceptable food that is produced and consumed sustainably, preserving access to food for future generations."<sup>13</sup> (emphasis added) Today's broad definition can thus be distilled into four basic tenets: availability, accessibility, adequacy, and sustainability.<sup>14</sup> Though the right to adequate food has broadened since the enactment of the UDHR over seventy years ago, the concept of adequacy is common to all of these definitions and indeed remains one of its core tenets today, illustrating the concept's centrality to the right. As the ensuing discussion will show, the concept of adequacy also inextricably links the right to adequate food to the right to health.

The presence of the modifier "adequate" is critical to the proper interpretation of the right to adequate food. It signals that the right is to a standard of nutritional quality and not just to a minimum quantity of calories.<sup>15</sup> Calorie intake alone reflects little about nutritional or health status.<sup>16</sup> Consensus within the right to food literature supports this interpretation. According to CESCR, for a diet to be adequate, it must "as a whole

contain a mix of nutrients for physical and mental growth, development and maintenance, and physical activity, that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation.”<sup>17</sup> The Right to Food Guidelines—a document developed by an Intergovernmental Working Group established by the Food and Agriculture Organization of the UN (FAO)—provides practical guidance to States on the realization of the right to food.<sup>18</sup> Guideline 10 is entirely devoted to incorporating nutrition into practical implementations of the right to adequate food. Guideline 10 advocates strengthening dietary diversity and healthy eating habits to prevent malnutrition, including overconsumption and unbalanced diets that lead to obesity and many noncommunicable diseases.<sup>19</sup> The FAO recently published a Working Paper on promoting nutrition in the right to adequate food, explicitly acknowledging that “nutrition constitutes an inherent element of adequacy that is at the core of the right to food” and that “the two themes cannot be separated.”<sup>20</sup> The Ten-Year Retrospective on the Right to Food Guidelines Working Paper also recognizes that nutritional well-being is “an integral part” of realizing the right to adequate food.<sup>21</sup> Importantly for this discussion, correctly framing the right to food as inherently including adequacy (and therefore nutrition) inextricably links this right to the right to health. Throughout the remainder of this article, references to “adequate food” should be read to encompass proper nutrition.

Adequacy’s inherency to the right to food admittedly makes it more difficult to realize than would a right to a mere quantity of calories. However, there also lies a potential benefit to this difficulty. By centralizing nutrition, adequacy moves the right to food beyond subsistence and into the realm of promoting a healthful existence, making the right more compelling and easier to advocate and strengthening the right in its own right. Incorporating adequacy also extrinsically strengthens this right by linking it conceptually with the right to health. The right to health—officially the right to the “highest attainable standard of physical and mental health”—necessarily includes a healthy diet.<sup>22</sup> The two rights thus share a common core component in nutrition; this shared component fortifies both rights and increases their potential basis for rights advocacy and also widens the pool of potential advocates.

In addition, to categorize a right to food as a right to sufficient calories would devalue the marginalized populations most in need of the right’s protection. This narrow interpretation would mean an entitlement not to the nutrition that adequacy affords but only to the survival that sufficient calories would provide. It would institutionalize the notion that the poor are entitled only to survival and not to nutrition and health, which are reserved only for those who can afford them, undermining the realization of the right to health for deprived populations. Making this distinction between nutrition and survival is a key component to reducing the nutritional and health inequalities—the “inequitable distributions of disease and early death between the rich and poor”—that “represent perhaps the most enduring and consequential global health challenge” today.<sup>23</sup> Accounting for the needs of the most deprived is another way that adequacy helps to conceptually deepen and legitimize the right to food and ties the right to food more robustly to the right to health.

Thus far, the analysis of adequacy—again, meaning a standard of nutritional quality—in the right to food has squared closely with the interpretations in the ICESCR and FAO literature. This section expands on traditional interpretations of adequacy,

extending the analysis to the over-nutrition and obesity context. The meaning of adequacy in the right to food does not, or should not, apply exclusively under-nutrition; it must also apply to obesity and over-nutrition.<sup>24</sup> Although movement has begun in this direction—for example the FAO now defines “malnutrition” broadly to include under-nutrition, micronutrient deficiencies, and overweight and obesity<sup>25</sup>—this area remains underdeveloped.

Perhaps puzzlingly, the current global food system simultaneously fosters both over-nutrition and under-nutrition, enabling obesity and hunger to co-exist in almost equal numbers. Macro-level policies, especially in trade and agriculture, create an obesogenic (that is, obesity-producing) environment while at the same time reinforcing the distribution, availability and accessibility problems that lead to under-nutrition.<sup>26</sup> A sufficient number of calories is produced to feed the world’s population on a daily basis. The problem lies in the policies and practices that determine which food is grown (i.e. nutritional concerns) and how it is distributed. Furthermore, similar to under-nutrition, obesity and poor diet disproportionately affect the poorest and most marginalized members of society.<sup>27</sup> Although there are certainly other factors at play, one logical conclusion is that the food available and accessible to the poorest in society is either largely non-existent (leading to under-nutrition) or untenably unhealthy (leading to over-nutrition and its attendant negative health outcomes, which are many and varied).<sup>28</sup> These two problems—over- and under-nutrition—are two sides of the same coin: they are manifestations of an inequitable food system that takes its toll in the form of large-scale poor nutrition and negative health outcomes. To recognize the significance of adequacy to the right to food vis-à-vis under-nutrition without also extending it to obesity would miss the other half of the issue and exacerbate already growing social inequalities. Ignoring the importance of nutritional quality to over-nutrition could simply result in solving one problem (hunger and under-nutrition) by replacing it with another (obesity and over-nutrition).

Reframing the right to adequate food to apply in both the under-nutrition and over-nutrition contexts also highlights the inextricable relationship between the food system, diet, and health outcomes, which further strengthens the link between the right to adequate food and the right to health. It helps illuminate why obesity now frequently exists alongside under-nutrition among the poorest populations in most if not all countries<sup>29</sup> and it begins to illustrate why realizing the right to adequate food means in many ways also realizing the right to health and vice versa.

## **THE RIGHT TO ADEQUATE FOOD AS SUBSTANTIVE CONDITION OF THE RIGHT TO HEALTH**

It is well established in scientific, social scientific, and human rights literature that food and nutrition are both instrumental *and* vital to achieving full physical and cognitive health.<sup>30</sup> According to the Lancet global burden of disease reports, poor diet is now responsible for more disease than physical inactivity, smoking, and alcohol combined.<sup>31</sup> Fewer children are dying each year now than twenty years ago, but more young and middle-aged adults are dying and suffering from noncommunicable diseases such as cancers and cardiovascular disease, which have been linked to poor diet.<sup>32</sup> In fact, noncommunicable diseases are now the leading cause of death, accounting for sixty-three percent of all deaths worldwide.<sup>33</sup> Noncommunicable diseases also contribute to

growing disability rates: although life expectancy for both men and women has increased slightly more than ten years overall since 1970, more of these years are now spent living with injury and illness, many diet-related.<sup>34</sup> In addition to the impact on physical health, over-nutrition and obesity frequently negatively impact mental health and wellbeing,<sup>35</sup> further threatening the realization of the right to health from a cognitive perspective. Improving dietary behavior is critical to improving these mental and physical health outcomes and to reducing the growing rates of noncommunicable disease, disabilities, and death.

For many vulnerable populations, adequate food is acutely important. For example, there is growing consensus among regulatory, practitioner, and academic circles that for the chronically and acutely ill, food is medicine.<sup>36</sup> For pregnant women and children in the first two years of life, the long-term, often irreversible, negative impact of both under- and over-nutrition—and conversely the long-term benefits of adequate food—are well-documented across low-, middle- and high-income countries.<sup>37</sup> According to the FAO, child and maternal malnutrition “impose by far the largest nutrition-related health burden at the global level.”<sup>38</sup> For these populations, adequate food is especially important to improving health and reducing socioeconomic inequalities because of the long-term effects of inadequate nutrition at these life stages, which include physical and cognitive deficiencies, lower earnings over the life course, greater likelihood of living below the poverty line, worse school performance, and greater likelihood of childhood and lifelong obesity.<sup>39</sup> In contrast, having access to healthy food over the life course can entirely prevent certain incapacitating illnesses and other serious health conditions.<sup>40</sup> Given the link between healthy diets and positive health outcomes, laws, policies, and public health interventions must be enacted to ensure the physical and economic availability of nutritious food for all with special attention to the least advantaged populations, which are disproportionately affected.<sup>41</sup>

The WHO conservatively estimates that twenty to forty percent of the world’s “health spending is consumed in ways that do little to improve people’s health.”<sup>42</sup> Without detracting from the considerable progress that has been made in global health over the past several decades,<sup>43</sup> these figures suggest the need for new, more efficient approaches. A key problem in the approaches to date is the gap that exists between commitments and realities.<sup>44</sup> Although diet has long been recognized as vital to health, and although it is frequently mentioned alongside health in scientific, social scientific, and human rights literature, in many ways this recognition has yet to be put into practice concretely. The right to health movement must move beyond recognizing diet to integrate and then operationalize the right to adequate food. Doing so will appropriately centralize the role adequate food must play in achieving the right to health globally and help provide pathways to implementation.

It is important to note that the right to adequate food is both separate from and constituent of the right to health. Indeed, ICESCR actually codifies the right to adequate food as part of the right to an adequate standard of living. However, the unification of food and health is highly precedented in both human rights and health literature. UDHR, the founding UN human rights document from 1948, bundles food and health together within the right to an adequate standard of living.<sup>45</sup> CESCR calls for fusing the rights to adequate food and health, asserting in its interpretation of the right to health in General Comment 14 that this right extends beyond timely and appropriate healthcare, and also includes underlying determinants of health, including specifically food and



nutrition.<sup>46</sup> FAO working papers on the right to adequate food affirm nutrition's role in achieving full physical and cognitive health and stress the interdependence, indivisibility, and interrelation of food and health.<sup>47</sup> The FCGH movement echoes these interpretations. The Platform for a Framework Convention on Global Health (FCGH Platform), a document delineating the fundamental principles of the FCGH, already envisions incorporating nutrition and specifically enumerates nutritious food as one component of the "robust version of universal health coverage" it seeks to realize.<sup>48</sup> It reiterates that nutritious food is necessary to achieve equitable and effective health systems and asserts that the financing framework must provide for this.<sup>49</sup> FCGH proponents have further substantiated their recognition of food's special place in the FCGH by identifying the importance of agriculture to global governance for health.<sup>50</sup>

Yet despite recognizing the importance of food and nutrition to the right to health, the FCGH does not yet integrate these concepts as rights. Indeed, Gable and Meier have decried human rights' limited incorporation into the FCGH in general, advocating "moving beyond the mere mention of human rights toward the holistic incorporation of human rights as a basis for the development and implementation of the FCGH."<sup>51</sup> They point out that the limited incorporation of human rights hinders the ability of the FCGH to "provide the grand reform to global health that its proponents seek."<sup>52</sup> Shifting from recognition to rights-based integration of the right to adequate food would be one pathway toward this grand reform: it would better legitimize adequate food, appropriately centralize its role in the right to health, and begin to take steps to operationalize its fulfillment.

The FCGH aims to provide "the conditions essential for a healthy life," which are "a well-functioning health system, a full range of public health services, such as nutritious food; and broader economic and social conditions conducive to good health, such as employment, housing, income support, etc."<sup>53</sup> The FCGH recognizes the need for nutritious food to achieve health. However, the broader economic and social conditions it delineates are far too narrow. Chief among these conditions—but conspicuously absent here—is the unhealthy and inequitable food system. As discussed above, the modern food system is simultaneously obesogenic and under-nutritious, disproportionately affecting the least advantaged, largely as a result of macro-level legal and regulatory mechanisms including agriculture, trade, and corporate policies, among others.<sup>54</sup> It contributes to worse health outcomes and exacerbates health inequalities between rich and poor.<sup>55</sup> Integrating the right to adequate food will begin to address the problematic food system and its role in worsening health outcomes and, if targeted appropriately, help begin reducing socioeconomic health inequalities. In a world where obesity and under-nutrition exist side-by-side, predominantly in the most marginalized communities; where enough food is produced to feed all healthfully yet preventable health conditions and deaths continue to occur from both under- and over-nutrition; where sixty-three percent of all deaths stem from noncommunicable diseases, many if not most caused or exacerbated by poor diet; and where the poorest populations suffer disproportionately from these conditions, food, nutrition and the skewed food system must be systematically addressed. Including the right to adequate food in the right to health and the FCGH will draw these issues to the center of global health discourse, highlighting their importance to health and health inequalities in an unprecedented but critical way. It can help direct focus at enacting structural change to the food system to effect population-level improvements in health.

One counter-argument to incorporating the right to adequate food into the right to health may be a concern that including an ancillary right could dilute or detract from the right to health. However, integrating the right to adequate food may actually help mutually strengthen both rights. In many ways the form of the claim of the right to adequate food remains “vague, if not unclear,” in spite of the fact that the right has now been enshrined in many domestic constitutions and legal frameworks, because few have actually then operationalized the right or translated it into specific legal obligations.<sup>56</sup> To a lesser extent, similar criticisms may be lodged at the right to health, particularly in light of the WHO estimate that twenty to forty percent of global health spending does little to improve people’s health.<sup>57</sup> This ineffective spending suggests that past approaches to realize this right have fallen short. However, bundling the right to adequate food with the right to health will provide a new paradigm for the right to health. It will provide an additional concrete pathway to implementing the right to health and will simultaneously help address each right’s operational vagueness.

### **THE RIGHT TO ADEQUATE FOOD AND FCGH LEGITIMACY AND EFFICIENCY**

Thus far, the analysis has focused on the substantive importance of the right to adequate food to realizing the right to health. The right to adequate food is also important to the FCGH for legitimacy and efficiency reasons: it will help the FCGH maintain internal consistency and may also represent a cost effective way of realizing the right to health.

The right to adequate food should be incorporated into the FCGH to help ensure the Framework’s coherence. The right to health can be thought of as consisting of a bundle of constituent rights, each of which must be met in order for the umbrella right to health to be realized. A threshold step when devising the FCGH is to identify and codify these constituent rights. Because the right to adequate food is a necessary condition for realizing the right to health, any rights-based approach to health must include a right to adequate food to remain consistent.<sup>58</sup> It should be noted that this process does not detract from the right to food’s separate status as a significant standalone right; it is to point out that in addition to being its own discrete right, the right to food is also a constituent of the right to health. The breadth and depth of consensus on the importance of adequate food to health indicates it is a constituent right and warrants its explicit incorporation.<sup>59</sup> At present, the Platform on FCGH acknowledges nutrition’s indispensability to achieving the right to health but does not explicitly mention (let alone incorporate) the right to adequate food.<sup>60</sup> It is logically incoherent to acknowledge nutrition’s indispensability to health, but not incorporate it as a right—that is, to assert individuals are entitled to an overall state of being (i.e. health), but not to the elements essential to achieving and maintaining that state of being (e.g. nutritious food). Conditions essential to achieving the right to health must also be integrated as rights or their absence will undermine the FCGH. Integrating the right to adequate food strengthens FCGH consistency and its commitment to its mission to achieve the highest attainable standard of health by formally recognizing that these two rights are indivisible.

Even more specifically, the right to adequate food is important to FCGH legitimacy vis-à-vis its special concern for marginalized populations. In virtually all countries, marginalized populations suffer disproportionately from worse diet quality, including both under- and over-nutrition, and from worse health outcomes in general,

including diet-related noncommunicable diseases such as type 2 diabetes and cardiovascular disease.<sup>61</sup> These populations also often include the critically and chronically ill, for whom food is a particularly important component of health and medical care, as evidenced by the previously mentioned growing consensus that for these groups food is medicine.<sup>62</sup> Other vulnerable populations such as pregnant women and children in the first two years of life are also particularly susceptible to inadequate nutrition. Because adequate food is so important for improving the health of marginalized populations, as discussed in greater detail in Section III, in order for the FCGH to remain consistent with its claims for its special concerns in this area, it should incorporate the right to adequate food.

Finally, the right to adequate food may also represent a more efficient and cost effective pathway to achieve the right to health. Financing the FCGH is a key consideration, commanding an entire section in the FCGH Platform.<sup>63</sup> The success or failure of a FCGH seeking large-scale realization of the right to health will hinge on an adequate financing framework. Modern healthcare systems face the difficult task of improving health outcomes while simultaneously reducing the cost of care. Going forward, cost effective innovations and novel approaches to health will become increasingly important as the cost of care reaches unsustainable levels.<sup>64</sup> For example, in 2013 U.S. spending on healthcare totaled \$2.7 trillion or seventeen percent of gross domestic product.<sup>65</sup> The bulk of this cost (\$936.9 billion) was attributable to hospital care, a figure which grows about five percent each year.<sup>66</sup> Properly targeted preventive medicine has been shown to significantly lower these costs and also has been shown to have other added values, including improved patient mental health and avoided lost earnings and productivity.<sup>67</sup> Because adequate food results in improved health outcomes and is a key component of preventive medicine, incorporating the right to adequate food into FCGH could help ease the significant financial constraints of realizing the right to health globally. Furthermore, looking beyond preventive care, the combined global social and economic costs of malnutrition and over-nutrition are staggering, resulting in hundreds of millions of disability-adjusted life years lost and costing up to an estimated five percent of global gross domestic product (or \$3.5 trillion) yearly.<sup>68</sup> Integrating the right to adequate food could also help alleviate some of these costs.

The financial benefits of integrating the right to adequate food are particularly relevant for high-cost care groups, for many vulnerable population groups, and for preventing chronic disease. These three groups often overlap. For high-risk, high-need, and frequently high-cost patient populations, food and nutrition interventions “have been proven to dramatically reduce monthly and overall healthcare costs,”<sup>69</sup> to lower frequency and length of hospital stays, and to improve the likelihood that patients will be discharged to their homes rather than to acute care facilities.<sup>70</sup> Malnourished patients with chronic or acute illnesses are twice as likely to be readmitted to the hospital within fifteen days of discharge, have a significantly higher risk of death, respond worse to medication, and have decreased recovery rates compared to their well-nourished counterparts.<sup>71</sup> Given that the bulk of healthcare spending, at least in the U.S., is attributable to hospital care, reducing hospital stays for high-cost care groups could have significant financial benefits. As discussed above, adequate food is critical for child and maternal health, with these populations particularly vulnerable to inadequate nutrition and the potential lifelong consequences thereof both in the under-nutrition and the over-nutrition contexts. Even the private sector has recognized the significance,

cost effectiveness, and major growth opportunity in creating a new role for nutrition in disease management and prevention to help relieve the significant cost burden of chronic disease.<sup>72</sup> Because it results in lower ameliorative healthcare costs and better overall health outcomes with progressive benefits for the most marginalized populations, adequate food embodies the elusive modern health goal of improving outcomes while reducing expenses. For these legitimacy and efficiency reasons the right to adequate food should be integrated into the FCGH.

## **OPERATIONALIZING THE RIGHT TO ADEQUATE FOOD**

Formally enshrining the right to adequate food is critical, but FCGH will also need to provide some guidance on operationalizing this right and implementing it in practice. There are several steps to be taken at the international, national, state, and local levels, in conjunction with the private and academic sectors, to begin to realize the right to adequate food as part of the right to health.

First and foremost, the importance of adequate food to health should be formally recognized in health legislation at every level of government. Relatedly, governments must align policies across sectors with food and health goals, adopting a “food-and-health-in-all-policies” approach, which the FCGH already advocates.<sup>73</sup> Many seemingly unrelated policies significantly impact dietary behaviors and health outcomes, whether directly or indirectly. These include for example agriculture, trade, labor, business, and environmental policies, to name only a few. However, these policies tend to be siloed and do not account for, or even acknowledge, their impact on dietary behaviors and health outcomes. There should be full and meaningful health impact assessments for these seemingly non-health-related policies, perhaps beginning with agriculture because of its position at the top of the production chain and because it commands a massive budget in both the U.S. and Europe. Health impact assessments are challenging tasks to undertake, but successful examples of integrating health into policy in other sectors (for example, integrating health into transport decision-making) suggest they are achievable in the long-term.

Governments can also implement measures to improve the health of the food supply and encourage healthier consumption as a means of operationalizing this right. One important measure is to invest in agricultural research and development of healthier crops. It is estimated that over one-third of all food in the world is lost or wasted on a yearly basis, highlighting among other things the profound need for improving harvest, transport, and storage technologies, particularly for the most perishable foods, which often happen to be among the healthiest.<sup>74</sup> Improving the yields and the postharvest technologies for the healthiest crops can improve their market availability and pricing, which could help boost consumption. Governments may also consider requiring reformulations of processed products to improve their nutrient profiles, either by law or by taxing products which are below a certain quantitative nutrient profile threshold. In addition, they could legislate fortifying certain foods with under-consumed vitamins and minerals, as many countries do already.

Healthier diets have consistently been shown to be costlier than less healthy foods. This cost gap continues to widen, in many cases making health outcomes contingent on the ability to pay for healthier foods.<sup>75</sup> However, a small but growing body of research suggests the potential effectiveness of healthy food financial incentives

including discounts, vouchers, and other individual-level subsidies to increase healthy food purchasing for middle and lower socioeconomic groups alike.<sup>76</sup> Subsidizing healthy purchases in various ways could thus help to realize the right to adequate food. One option, for example, is the creation of healthy food savings accounts. These accounts, which would be akin to health savings accounts (HSAs) in the US, would enable individuals to spend pre-tax dollars on a set list of healthy foods meeting a certain nutrient profile threshold. Governments could also subsidize fruit and vegetable purchasing, particularly for the poor, through social and food assistance programs as some cities have already begun to do with positive effect.<sup>77</sup>

In order to enact these policies, it is important that governments maintain and enhance their monitoring of food prices, diet, and health to understand the policies' effects on the cost and availability of foods, the different types of foods in the food supply, and the impact on diet and health, particularly among different socioeconomic groups. Only through comprehensive data collection and analysis can we more adequately understand the effects different, seemingly unrelated policies have on diet, health, and socioeconomic inequalities. In addition, these data can and should inform policy responses to ensure measures are appropriately and effectively targeted. It is recognized that one challenge to this recommendation is the costliness and time-intensiveness of in-depth surveillance. To help mitigate this challenge, in countries where these or similar data are already collected for another purpose, there could be additional collaboration to determine whether the collection process can be altered to also accommodate health analysis (without impeding the original purpose for collection).

Finally, education is an important element of realizing the rights to adequate food and health. Improving knowledge and attitudes toward healthy diets is an important (though not sufficient) factor in improving nutrition.<sup>78</sup> Studies have advocated for increased nutrition education in schools, though they have also expressed efficacy concerns and doubt at the marginal benefit of additional investment into nutrition education in its current form.<sup>79</sup> One challenge to implementing education, then, is that it will first require additional investment to improve its efficacy, followed by wider dissemination in primary, secondary, and tertiary schools. This research is necessarily somewhat time- and resource-intensive as the data will likely vary across countries and localities. However, the fact that a platform and impetus for nutrition education already exists highlights this recommendation's potential feasibility. Countries may also consider integrating nutrition education into existing social assistance programs as some US programs currently do. For example, the US federally funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) mandates nutrition education as a prerequisite to enrollment.<sup>80</sup> Assessments of the program have found it to be cost effective at improving nutritional and health outcomes among deprived and vulnerable populations.<sup>81</sup> Given these positive results, governments should consider incorporating nutrition education programs into existing similar social assistance programs (such as, for example, the UK Healthy Start Program)<sup>82</sup> or launching separate nutrition education programs targeting the populations most in need of nutritional interventions according to dietary surveillance data. As with nutrition education in schools, these programs will need to be locally tailored and extensively researched to optimize effectiveness.

## CONCLUSION

FCGH claims to be “committed to the highest attainable standard of physical and mental health as a universal human right.”<sup>83</sup> Any commitment to the highest attainable standard of physical health must incorporate adequate food. It is first important to establish the meaning and centrality of the concept of adequacy to the right to adequate food. “Adequacy” denotes a standard of nutritional quality and not a minimum quantity of calories. It should be broadly construed to apply in both the under-nutrition context, as traditionally conceived, and the over-nutrition context, which encompasses a more novel approach. Construing adequacy in this way centers health in the food discourse (and vice versa) and highlights the inextricability of food and health and their accompanying rights. It recognizes the vital role of adequate food in achieving good health in all contexts. In addition, this conception of adequacy places appropriate focus on the fact that the least advantaged populations are disproportionately both under- and over-nourished and consequently also suffer disproportionately from the serious health outcomes of each. Finally, properly conceptualizing adequacy and the right to adequate food lays the foundation for conceiving of this right as both constituent *and* partner of the right to health.<sup>84</sup>

It is important when devising the FCGH to question how this Framework—yet another binding international treaty—can help where countless international treaties, institutions, constitutions, framework laws and sectoral legislations have thus far failed to realize the right to health globally. Critics have expressed concern over the FCGH potential to be just another source of superfluous, or possibly even detrimental, international law in health.<sup>85</sup> This critique highlights the importance to the FCGH of building on and meaningfully diverging from past approaches if it is to succeed where its predecessors have not. The FCGH must not duplicate previously unsuccessful efforts and must thoughtfully consider the novelty and the added value of its approach.

With an eye toward meaningful divergence, there are several necessary conditions for the FCGH to succeed in achieving the right to health globally. For one, several commentators and the Platform itself have repeatedly stressed the importance of comprehensiveness.<sup>86</sup> The Framework must also be credible and consistent in order to remain legitimate. It must prioritize efficiency, particularly fiscal, if it is to achieve the right to health on such a large scale. And it must identify and formally incorporate the constituent rights that are necessary conditions for achieving the right to health. That is, in the same spirit as the “health-in-all-policies” approach that the FCGH champions,<sup>87</sup> but conversely to that approach, the Framework should adopt an “all-policies-in-health” approach to help ensure it is comprehensive, legitimate, efficient, and effective. Integrating the right to adequate food, appropriately conceptualized, helps to meet these conditions. It addresses in part the need for comprehensiveness and it reinforces Framework legitimacy and efficiency. Perhaps most importantly, however, this right is an indispensable substantive condition of achieving the right to health. Incorporating a broadly conceived right to adequate food into the FCGH acknowledges and formally takes steps to address nutrition’s critical role in realizing the right to health, particularly for the most marginalized populations. The right to adequate food will deeply strengthen the FCGH and its chances of success.

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<sup>1</sup> Food and Agriculture Organization of the United Nations, “The State of Food and Agriculture: Food Systems for Better Nutrition” (2013): 3, accessed September 7, 2014, <http://www.fao.org/docrep/018/i3300e/i3300e.pdf>.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.*; D.L. Pelletier et al., “The Effects of Malnutrition on Child Mortality in Developing Countries,” *Bulletin of the World Health Organization* 73 (1995): 443, accessed September 7, 2014, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2486780/pdf/bullwho00408-0029.pdf>.

<sup>4</sup> Universal Declaration of Human Rights art. 25, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).

<sup>5</sup> International Covenant on Economic, Social and Cultural Rights [hereinafter ICESCR] arts. 1, 6–15, Dec. 16, 1966, 993 U.N.T.S. 3; United Nations Treaty Collection, “Chapter 4: Human Rights, 3. International Covenant on Economic, Social and Cultural Rights,” (2015), accessed April 21, 2015, [https://treaties.un.org/pages/viewdetails.aspx?chapter=4&lang=en&mtsg\\_no=iv-3&src=treaty](https://treaties.un.org/pages/viewdetails.aspx?chapter=4&lang=en&mtsg_no=iv-3&src=treaty)

<sup>6</sup> *Ibid.* art. 11.

<sup>7</sup> ICESCR Arts. 1, 16–7.

<sup>8</sup> American Convention on Human Rights, art. 62, Nov. 22, 1969, 1144 UNTS 123. It should be noted that the Inter-American Court of Human Rights enforces the American Convention on Human Rights (ACHR), and not the ICESCR, but that the ACHR also contains a provision protecting economic, social, and cultural rights.

<sup>9</sup> *Ibid.* Art. 21.

<sup>10</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 12: The Right to Adequate Food (Art. 11)*, ¶¶ 6–7, U.N. Doc. E/C.12/1999/5 (Dec. 5, 1999).

<sup>11</sup> CESCR, General Comment 12, ¶ 7.

<sup>12</sup> Office of the High Commissioner for Human Rights, “Special Rapporteur on the Right to Food,” (2015), accessed April 21, 2015, [www.ohchr.org/EN/Issues/Food/Pages/FoodIndex.aspx](http://www.ohchr.org/EN/Issues/Food/Pages/FoodIndex.aspx).

<sup>13</sup> Human Rights Council, *Report of the Special Rapporteur on the right to food, Final report: The transformative potential of the right to food* [hereinafter *Final Report*], U.N. Doc. A/HRC/25/57 (Jan. 24, 2014) (by Olivier De Schutter), 3 (citing CESCR, General Comment 12, ¶ 6) (emphasis added).

<sup>14</sup> *Ibid.*

<sup>15</sup> Serena Pepino, “Nutrition, Education and Awareness Raising for the Right to Adequate Food Thematic Study 6,” [hereinafter FAO, “Nutrition, Education and Awareness Raising”], *FAO Right to Food Team, Agricultural Development Economics Division* (2014): 1, 4, accessed April 22, 2015, <http://www.fao.org/3/a-i3895e.pdf>.

<sup>16</sup> De Schutter, *Final report*, 4.

<sup>17</sup> CESCR, General Comment 12, ¶ 9.

<sup>18</sup> Food and Agriculture Organization of the United Nations, *Voluntary Guidelines to Support the Progressive Realization of the Right to Adequate Food*, 127<sup>th</sup> Session of the FAO Council (November 2004): iii.

<sup>19</sup> *Ibid.*, p. 21; FAO, “Nutrition, Education and Awareness Raising,” 1–2.

<sup>20</sup> FAO, “Nutrition, Education and Awareness Raising,” 3.

<sup>21</sup> Food and Agriculture Organization of the United Nations, “The Right to Food: Past commitment, current obligation, further action for the future. A Ten-Year Retrospective on the Right to Food Guidelines” (2014): 13, accessed September 8, 2014, [http://www.fao.org/fsnforum/sites/default/files/files/106\\_RightToFood/RTF\\_Synthesis\\_Report.pdf](http://www.fao.org/fsnforum/sites/default/files/files/106_RightToFood/RTF_Synthesis_Report.pdf).

<sup>22</sup> ICESCR Arts. 12.

- <sup>23</sup> Lawrence O. Gostin, "A Framework Convention on Global Health: Health for All, Justice for All," *Journal of the American Medical Association* 307 (2012): 2087, accessed September 7, 2014, <http://ssrn.com/abstract=2072457>.
- <sup>24</sup> See Krista Nadakavukaren Schefer, "The International Law of Overweight and Obesity," *Asian Journal of WTO & International Health Law and Policy* 9 (2014): 33-34, accessed September 7, 2014, <http://ssrn.com/abstract=2434994>. 33-34.
- <sup>25</sup> FAO, "The State of Food and Agriculture," 3.
- <sup>26</sup> See generally, Emilie Aguirre, "Sickeningly Sweet: Analysis and Solutions for the Adverse Dietary Consequences of European Agricultural Law," *Journal of Food Law and Policy* 11 (2015) (in press). ).
- <sup>27</sup> See, e.g., Charles L. Baum II and Christopher J. Ruhm, "Age, Socioeconomic Status and Obesity Growth," *National Bureau of Economic Research Working Paper Series*, Working Paper 13289 (2007): 2, 3, accessed April 22, 2015, <http://www.nber.org/papers/w13289.pdf>; "Health Survey for England 2011 Vol. 1: Health, Social Care and Lifestyles," *NHS*, (2011): Chapters 2, 4, 10, accessed April 22, 2015, <http://www.hscic.gov.uk/catalogue/PUB09300/HSE2011-All-Chapters.pdf>; Eva R. Maguire & Pablo Monsivais, "Socio-economic Dietary Inequalities in UK Adults: An Updated Picture of Key Food Groups and Nutrients from National Surveillance Data," *British Journal of Nutrition* 113(2015): 181; FAO, "The State of Food and Agriculture," 3.
- <sup>28</sup> FAO, "The State of Food and Agriculture," 8-10.
- <sup>29</sup> For example, Mexico just surpassed the United States as the world's most obese country. Obesity rates are rapidly rising in many developing countries that have traditionally had high malnutrition rates. FAO, "The State of Food and Agriculture," 18, 73-79. See also Schefer, "The International Law of Overweight and Obesity," 8. Likewise, food insecurity and under-nutrition occur in rich, industrialized countries. Elizabeth A. Dowler and Deirdre O'Connor, "Rights-based Approaches to Addressing Food Poverty and Food Insecurity in Ireland and UK," *Social Science and Medicine* 74 (2012): 44, accessed September 7, 2014 doi:10.1016/j.socscimed.2011.08.036.
- <sup>30</sup> Dowler and O'Connor, "Rights-Based Approaches," 44; Malinda Ellwood et al., "Food is Medicine: Opportunities in Public and Private Health Care for Supporting Nutritional Counseling and Medically-Tailored, Home-Delivered Meals," Center for Health Law and Policy Innovation, Harvard Law School (2014): 1, accessed September 8, 2014, <http://www.chlpi.org/wp-content/uploads/2013/12/6.5.2014-Food-is-Medicine-Report-FINAL.pdf>; FAO, "Nutrition, Education and Awareness Raising," 1.
- <sup>31</sup> A Malhotra, T Noakes, S Phinney, "It is time to bust the myth of physical inactivity and obesity: you cannot outrun a bad diet," *British Journal of Sports Medicine* (2015).
- <sup>32</sup> Executive Summary, "Global Burden of Disease Study 2010," *The Lancet* 380 (2012).
- <sup>33</sup> Gostin, "A Framework Convention on Global Health," 2090 (citing World Health Organization, *Global Status Report on Noncommunicable Diseases 2010* (2011)).
- <sup>34</sup> *Ibid.*
- <sup>35</sup> See Anna Kirkland, *Fat Rights: Dilemmas of Difference and Personhood* (2008); Schefer, "The International Law of Overweight and Obesity," 9-10;
- <sup>36</sup> Ellwood et al., "Food is Medicine," 3 (asserting that food is medicine for the critically and chronically ill because, for example, it improves response rates to medication, contributes to maintaining and gaining strength, and improves recovery chances). For example, in the United States, the federal Ryan White HIV/AIDS program has long recognized and funded "Medical Nutrition Therapy" as a core medical service.
- <sup>37</sup> De Schutter, *Final report*, 4; Pelletier et al., "The Effects of Malnutrition," 443.
- <sup>38</sup> FAO, "The State of Food and Agriculture," ix.
- <sup>39</sup> Douglas Bereuter and Dan Glickman, "Healthy Food for a Healthy World: Leveraging Agriculture and Food to Improve Global Nutrition," *The Chicago Council on Global Affairs* (2015): 31, accessed April 27, 2015, [http://www.thechicagocouncil.org/sites/default/files/GlobalAg-HealthyFood\\_FINAL.pdf](http://www.thechicagocouncil.org/sites/default/files/GlobalAg-HealthyFood_FINAL.pdf); Siân M Robinson et al, "Modifiable early-life risk factors for childhood adiposity and overweight: an analysis of their combined impact and potential for prevention," *American Journal of Clinical Nutrition* 101 (2015), doi: 10.3945/ajcn.114.094268.
- <sup>40</sup> Ellwood et al., "Food is Medicine," 5.
- <sup>41</sup> Gostin, "A Framework Convention on Global Health," 2090.
- <sup>42</sup> Eric A. Friedman and Lawrence O. Gostin, "Pillars for Progress on the Right to Health: Harnessing the Potential of Human Rights Through a Framework Convention on Global Health," *Health and Human Rights Journal* 14 (2012): 7, accessed September 8, 2014, <http://ssrn.com/abstract=2086456> (citing World Health Organization, "The World Health Report – Health Systems Financing: The Path to



Universal Coverage" (2010): 71-72, accessed September 7, 2014, <http://www.who.int/whr/2010/en/index.html>.

<sup>43</sup> FAO, "The State of Food and Agriculture," 73-79.

<sup>44</sup> "Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health," (2014): 4, accessed September 8, 2014, <http://www.globalhealthtreaty.org/docs/platform-for-an-fcgh-full.pdf>.

<sup>45</sup> Ellwood et al., "Food is Medicine," 2.

<sup>46</sup> Universal Declaration of Human Rights, Art. 25 ("the right to a standard of living adequate for the health and well-being of himself and of his family, including food...and medical care," among other factors).

<sup>47</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, ¶ 4, U.N. Doc. E/C.12/2000/4 (2000). See also ¶ 11.

<sup>48</sup> See, e.g. FAO, "Nutrition, Education and Awareness Raising," 1.

<sup>49</sup> "Platform for a Framework Convention," 2, 4.

<sup>50</sup> *Ibid.*

<sup>51</sup> Gostin, "A Framework Convention on Global Health," 2090.

<sup>52</sup> Lance Gable and Benjamin Mason Meier, "Global Health Rights: Employing Human Rights to Develop and Implement the Framework Convention on Global Health," *Health and Human Rights* 15 (2013): 23, 27, accessed September 7, 2014, <http://ssrn.com/abstract=2263421>.

<sup>53</sup> Gable and Meier, "Global Health Rights," 23.

<sup>54</sup> Gostin et al., "Towards a Framework convention on global health," *Bulletin of the World Health Organization* 91 (2013): 790-93, accessed September 7, 2014, doi: <http://dx.doi.org/10.2471/BLT.12.114447>.

<sup>55</sup> Christopher Birt, "A CAP on Health? The Impact of the EU Common Agricultural Policy on Public Health," A report by the Faculty of Public Health (2007), accessed September 7, 2014, [http://www.fph.org.uk/uploads/r\\_CAP.pdf](http://www.fph.org.uk/uploads/r_CAP.pdf).

<sup>56</sup> Dowler and O'Connor, "Rights-Based Approaches," 44, 45.

<sup>57</sup> Raghav Gaiha, "Does the Right to Food Matter?," *Economic and Political Weekly* 38 (2003): 4270, 4273 accessed September 7, 2014, <http://www.jstor.org/stable/4414110>.

<sup>58</sup> Friedman and Gostin, "Pillars for Progress on the Right to Health," 7, (citing WHO, "The World Health Report," 71-72).

<sup>59</sup> See CESCR, General Comment 14; FAO, "Nutrition, Education and Awareness Raising," 1.

<sup>60</sup> See e.g. Gable and Meier, "Global Health Rights," 24 (citing Lawrence O. Gostin, "Meeting basic survival needs of the world's least healthy people: Toward a framework convention on global health," *Georgetown Law Journal* 96 (2008): 331-392); Friedman and Gostin, "Pillars for Progress," 10; Gostin, "A Framework Convention on Global Health." It is important to note that although the right to adequate food is certainly a constituent of the right to health, it is also a separate, independent, partner right. To call it a constituent is not to take away from its significant standalone status or to subordinate it to the right to health; it is simply to recognize the two rights' inextricability. See e.g. Dowler and O'Connor, "Rights-Based Approaches"; ICESCR art. 11.

<sup>61</sup> See "Platform for a Framework Convention"; see also Gable and Meier, "Global Health Rights," 23.

<sup>62</sup> See Baum and Ruhm, "Age, Socioeconomic Status and Obesity Growth," 2, 3; "Health Survey for England 2011 Vol. 1: Health, Social Care and Lifestyles," *NHS* (2011): Chapters 2, 4, 10, accessed April 24, 2015, <http://www.hscic.gov.uk/catalogue/PUB09300/HSE2011-All-Chapters.pdf>; Eva R. Maguire and Pablo Monsivais, "Socio-economic Dietary Inequalities in UK Adults: An Updated Picture of Key Food Groups and Nutrients from National Surveillance Data," *British Journal of Nutrition* 113 (2015): 181.

<sup>63</sup> Ellwood et al., "Food is Medicine," 3, 39. Indeed, the US federal government agrees and, for example, has long recognized and funded nutritious meals as a core medical service for those with HIV/AIDS.

<sup>64</sup> "Platform for a Framework Convention," 38.

<sup>65</sup> Ellwood et al., "Food is Medicine," 38.

<sup>66</sup> "National Health Expenditures 2013 Highlights," *Centers for Medicare and Medicaid Services* (2013): 1, accessed April 24, 2015, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.

<sup>67</sup> *Ibid.*

<sup>68</sup> See PL Yong, RS Saunders, and LA Olsen, eds., "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," *National Academies Press* (2010), accessed April 24, 2015, <http://www.ncbi.nlm.nih.gov/books/NBK53914/>.

<sup>68</sup> FAO, “The State of Food and Agriculture,” ix, 15-16.

<sup>69</sup> Ellwood et al., “Food is Medicine,” 3; Jill Gurvey et al., “Examining Health Care Costs Among MANNA Clients and a Comparison Group,” *Journal of Primary Care & Community Health* 4 (2013): 4-5, accessed September 7, 2014, doi: 10.1177/2150131913490737).

<sup>70</sup> *Ibid.*

<sup>71</sup> *Ibid.*, p. 3,4; Su Lin Kim et al., “Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality,” *Clinical Nutrition* 31 (2012): 345-50, accessed September 7, 2014, doi:10.1016/j.clnu.2011.11.001).

<sup>72</sup> “About Us,” Nestlé Health Science, accessed September 6, 2014, <https://www.nestlehealthscience.com/about>.

<sup>73</sup> See Gostin, “A Framework Convention on Global Health,” 2090; see generally “Platform for a Framework Convention.”

<sup>74</sup> These include, for example, fruits and vegetables.

<sup>75</sup> See Nicholas R.V. Jones et al., “The Growing Price Gap Between More and Less Healthy Foods: Analysis of a Novel Longitudinal UK Dataset,” *PLoS One* 9 (2014).

<sup>76</sup> See, e.g., Ruopeng An, “Effectiveness of Subsidies in Promoting Healthy Food Purchases and Consumption: A Review of Field Experiments,” *Public Health Nutrition* 16 (2012); Candace R. Young et al., “Improving Fruit and Vegetable Consumption Among Low-Income Customers at Farmers Markets: Philly Food Bucks, Philadelphia, Pennsylvania, 2011,” *Preventing Chronic Disease* 10:120356 (2013); Wilma E. Waterlander et al., “Price Discounts Significantly Enhance Fruit and Vegetable Purchases when Combined with Nutrition Education: A Randomized Controlled Supermarket Trial,” *American Journal of Clinical Nutrition* 97 (2013); Cliona Ni Mhurchu et al., “Effects of Price Discounts and Tailored Nutrition Education on Supermarket Purchases: A Randomized Controlled Trial,” *American Journal of Clinical Nutrition* 91 (2010); Roland Sturm et al., “A Cash-Back Rebate Program for Healthy Food Purchases in South Africa,” *American Journal of Preventive Medicine* 44 (2013).

<sup>77</sup> Young et al., “Improving Fruit and Vegetable Consumption Among Low-Income Customers at Farmers Markets;”

<sup>78</sup> See Wardle et al., “Nutrition Knowledge and Food Intake,” *Appetite* 34 (2000); McKinnon et al., “The Contribution of Three Components of Nutrition Knowledge to Socio-Economic Differences in Food Purchasing Choices,” *Public Health Nutrition* 17 (2014); Aggarwal et al., “Positive Attitude toward Healthy Eating Predicts Higher Diet Quality at All Cost Levels of Supermarkets,” *Journal of Academy of Nutrition and Dietetics* 114 (2014).

<sup>79</sup> “Effectiveness of Policy Interventions to Promote Healthy Eating and Recommendations for Future Action: Evidence from the EATWELL Project,” *EATWELL Project* (2013): 27-29, accessed April 28, 2015, [http://eatwellproject.eu/en/upload/Reports/Deliverable%205\\_1.pdf](http://eatwellproject.eu/en/upload/Reports/Deliverable%205_1.pdf).

<sup>80</sup> 42 U.S.C. § 1786 (b)(7), (f)(1)(C)(x), 17(j) (2010). “Women, Infants, and Children (WIC),” *Food and Nutrition Service, United States Department of Agriculture*, accessed April 9, 2015, <http://www.fns.usda.gov/wic/women-infants-and-children-wic>; WIC provides federal funding to states to support nutrition among low-income nutritionally at-risk pregnant and postpartum women and their children up to age five.

<sup>81</sup> See “EATWELL Project,” 43.

<sup>82</sup> “Healthy Start,” *NHS*, accessed April 28, 2015, <https://www.healthystart.nhs.uk/>.

<sup>83</sup> “Platform for a Framework Convention,” 1.

<sup>84</sup> Dowler and O’Connor, “Rights-Based Approaches,” 50.

<sup>85</sup> See Steven J. Hoffman and John-Arne Røttingen, “Dark Sides of the Proposed Framework Convention on Global Health’s Many Virtues: A Systematic Review and Critical Analysis,” *Health and Human Rights* 15 (2013): 117-134, accessed September 7, 2014, <http://www.hhrjournal.org/wp-content/uploads/sites/13/2013/06/Hoffman.pdf>.

<sup>86</sup> Friedman and Gostin, “Pillars for Progress,” 15.

<sup>87</sup> See Gostin, “A Framework Convention on Global Health,” 2090; see generally “Platform for a Framework Convention.”