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Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health

Lawrence O. Gostin¹

Introduction

This chapter searches for solutions to the most perplexing problems in global health – problems so important that they affect the fate of millions of people, with economic, political and security ramifications for the world's population. No State, acting alone, can insulate itself from major health hazards. The determinants of health (e.g. pathogens, air, food, water, even lifestyle choices) do not originate solely within national borders. Health threats inexorably spread to neighbouring countries, regions and even continents. It is for this reason that safeguarding the world's population requires cooperation and global governance.

If I am correct that ameliorating the most common causes of disease, disability and premature death require global solutions, then the future is demoralizing. The States that bear the disproportionate burden of disease have the least capacity to do anything about it. And the States that have the wherewithal are deeply resistant to expending the political capital and economic resources necessary to truly make a difference to improve health outside their borders. When rich countries do act, it is often more out of narrow self-interest or humanitarian instinct than a full sense of ethical or legal obligation. The result

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is a spiraling deterioration of health in the poorest regions, with manifest global consequences for cross-border disease transmission and systemic effects on trade, international relations and security.

This chapter first inquires why global health is a shared responsibility – for the Global South and North – and then reconceptualizes the global health enterprise. Second, I examine the compelling issue of global health equity, and ask whether it is fair that people in poor countries suffer such a disproportionate burden of illness and death. Here, I briefly explore what I call a ‘theory of human functioning’ to support a more robust understanding of the transcending value of health. Third, I describe how the international community focuses on a few high profile, heart-rending, issues while largely ignoring deeper, systemic problems in global health. By focusing on what I call ‘basic survival needs’, the international community could fundamentally improve prospects for the world’s population. Finally, I explore the value of international law itself, and propose an innovative mechanism for global health reform – a Framework Convention on Global Health (FCGH).²

A global coalition of civil society and academics recently launched the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI). Following international stakeholder meetings in Oslo, Berlin, Johannesburg, Delhi and Bellagio, JALI is developing a post-Millennium Development Goal (MDG) framework for global health. JALI’s goal is a Framework Convention on Global Health.³ In March 2011, the UN General Secretary endorsed the FCGH, calling on the United Nations to adopt it.⁴ Moreover, the World Health Organization Director-General Margaret Chan proposed a ‘framework’ for global health as part of the Organization’s major reform agenda.⁵

- 2 Lawrence O. Gostin, ‘The Unconscionable Health Gap: A Global Plan for Justice’, *The Lancet*, 2010, 375: 1504–5; Lawrence O. Gostin, ‘Redressing the Unconscionable Health Gap: A Global Plan for Justice’, *Harvard Law & Policy Review*, 2010, 4: 271–94. For an explanation of the progression from a Joint Learning Initiative for National and Global Responsibilities for Health, to a Global Plan for Justice, through to a Framework Convention on Global Health, see www.acslaw.org/node/16479.
- 3 Lawrence O. Gostin, Eric A. Friedman, Gorik Ooms, Thomas Gebauer, Narendra Gupta, Devi Sridhar, Wang Chenguang, John-Arne Røttingen and David Sanders, ‘The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health’, *PLOS Medicine*, 2011, 8(5): www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001031.
- 4 UN Secretary-General, *Uniting for Universal Access: Towards Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths: Report of the Secretary-General*, U.N. Doc A/65/979 (New York: United Nations, 2011), para. 73, www.unaids.org/en/media/unaids/contentassets/documents/document/2011/A-65-797_English.pdf.
- 5 WHO, *Reform for a Healthy Future: An Overview* (Geneva: WHO, 2011) proposing a charter or framework for global health governance as a key output; WHO, *Reforms for a Healthy Future: Report by the Director-General*, Doc. EBSS/2/2 (Geneva: WHO, 2011): http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_2-en.pdf, proposing a framework, code or charter to guide all global health stakeholders, with agreed targets and indicators or rights and responsibilities.

My proposal for a Framework Convention in a nutshell is 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 unconscionable inequalities in global health.

Reconceptualizing ‘Health Aid’: From ‘Aid’ to global justice

Global health means different things to different people. Often, it is used as shorthand for the aggregate of health assistance provided by the affluent to the poor in a donor–recipient relationship as a form of charity, together with the volume and the modalities of this assistance – a concept I refer to as ‘Health Aid’.

Framing the global health endeavour as Health Aid provided by the affluent to the poor is fundamentally flawed. This suggests that the world is divided between donors and countries in need. This is too simplistic. Collaboration among countries, both as neighbours and across continents, is also about responding to health risks together and building capacity collaboratively – whether it is through South–South partnerships, gaining access to essential vaccines and medicines, or demanding fair distribution of scarce life-saving technologies.

Likewise, the concept of ‘aid’ both presupposes and imposes an inherently unequal relationship where one side is a benefactor and the other a dependent. This leads affluent states and other donors to believe that they are giving ‘charity’, which means that financial contributions and programs are largely at their discretion. It also means that donors make decisions about how much to give and for what health-related goods and services. The level of financial assistance, therefore, is not predictable, scalable to needs, or sustainable in the long term. These features of Health Aid could, in turn, mean that host countries might not accept full responsibility for their inhabitants’ health, as they can blame the poor state of health on the shortcomings of aid, rather than their own failures.

Conceptualizing international assistance as ‘aid’ masks the greater truth that human health is a globally shared responsibility reflecting common risks and vulnerabilities – an obligation of health justice that demands a fair contribution from everyone – North and South, rich and poor. Global governance for health must be seen as a partnership, with financial and technical assistance understood as an integral component of the common goal of improving global health and reducing health inequalities.

The framework of mutual responsibilities should prove attractive to both the Global South and North, creating incentives to develop a far-reaching global health agreement. Southern countries would benefit from increased respect for their strategies, greater and more predictable funding from more coordinated and accountable development partners, reform of politics that harm health,

such as those in trade and agriculture and, most importantly, better health for their populations. Countries of the North will benefit from increased confidence that development assistance is spent effectively and the prospect of reduced financing needs over time as host countries increase their health spending and build sustainable health systems. All will benefit from lessons on shared health challenges, from economic and educational gains that will come with improved global health, and from increased protection from global public health threats – and from mutual goodwill derived from participating in an historic venture to make unprecedented progress towards global health equity.

Are profound health inequalities fair?

Perhaps it does not, or should not, matter if global health serves the interests of the richest countries. After all, there are powerful humanitarian reasons to help the world's least healthy people. But even ethical arguments have failed to capture the full attention of political leaders and the public.

It is well known that the poor suffer, and suffer more than the rich. Unfortunately, this is also true with respect to global health. What is less often known is the degree to which the poor suffer unnecessarily. The global burden of disease is not just shouldered by the poor, but disproportionately so, such that health disparities across continents render a person's likelihood of survival drastically different based on where she is born. These inequalities have become so extreme and the resultant effects on the poor so dire, that health disparities have become an issue no less important than global warming or the other defining problems of our time.

Over a decade into the twenty-first century, billions of people have yet to benefit from the health advances of the twentieth century. Average life expectancy in Africa is nearly 30 years less than in the Americas or Europe⁶ – only two years higher than in the United States a century ago,⁷ and 27 years lower than in high-income countries today. Life expectancy in Sierra Leone or Zimbabwe is half that in Japan;⁸ a child born in Angola is 65 times more likely to die in the first few years of life than a child born in Norway;⁹ and a woman giving birth in sub-Saharan Africa is 100 times more likely to die in labour than a woman in a rich country.¹⁰ The most basic human needs continue to elude

6 WHO, *World Health Statistics* (Geneva: WHO, 2009), www.who.int/whosis/whostat/EN_WHS09_Table1.pdf reporting that average life expectancy at birth in Africa is 52 years compared with 76 years in the Americas. The gap between rich and poor is still higher when measured by the number of years of healthy life (i.e. life without significant illness or disability).

7 Elizabeth Arias, 'United States Life Tables 2006', *National Vital Statistics Reports*, 2010, 58(21): 1–40, available at www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_21.pdf.

8 Ibid.

9 UNICEF, *The State of the World's Children 2007* (New York: UNICEF, 2006): www.unicef.org/sowc07/docs/sowc07.pdf.

10 UNICEF, *Progress for Children: A Report Card on Maternal Mortality* (New York: UNICEF, 2008): www.childinfo.org/files/progress_for_children_maternalmortality.pdf.

the world's poorest people. In 2010, approximately 925 million people were suffering from chronic hunger,¹¹ 884 million people lacked access to clean water and 2.6 billion people were without access to proper sanitation facilities.¹²

While life expectancy in the developed world has consistently increased throughout the twentieth and early twenty-first centuries, it actually has been decreasing in the least-developed countries and in transitional states such as Russia.¹³ Infectious disease epidemics, particularly HIV/AIDS (which kills 4,000 Africans, but only 63 North Americans, each day),¹⁴ and increased chronic disease erased hard-won gains in life expectancy that took decades to achieve.¹⁵

As little as one concrete example offers a sense of perspective on the global health gap between the rich and the poor. The World Bank reports that in one year alone, 14 million of the poorest people in the world died, while only 4 million would have died if this population had the same death rate as the global rich.¹⁶

The yawning health gap cannot be fully understood by using the over-simplified division of the world into the global rich (the North) and the global poor (the South). In fact, 20 percent of the largest fortunes in the world are in so-called poor countries. Even within countries, dramatic health differences exist that are closely linked with degrees of social disadvantage. The poorest people in Europe and North America often have life expectancies equal to those in the least-developed countries.

A great deal of the variation in health outcomes within countries and among population subgroups can be explained by where people live (urban/rural), their wealth and their education.¹⁷ The differences can sometimes be striking. For example, in Calton, Glasgow, life expectancy at birth for men is 54 years, while in Lenzie, a few kilometres away, it is 82.¹⁸ And in Baltimore, Maryland, a

- 11 Food and Agricultural Organization, *925 Million in Chronic Hunger Worldwide* (Rome: FAO, 2010): www.fao.org/news/story/en/item/45210/icode/.
- 12 United Nations General Assembly, *The Human Right to Water and Sanitation*, U.N. Doc. A/Res/64/292 (New York: UN, 2010): www.un.org/en/ga/64/resolutions.shtml.
- 13 WHO, *World Health Statistics* (Geneva: WHO, 2009): www.who.int/whosis/whostat/EN_WHS09_Full.pdf.
- 14 UNAIDS, *Global Facts and Figures: Report on the Global AIDS Epidemic 2008* (Geneva: UNAIDS, 2008) (last modified August 2008): http://data.unaids.org/pub/GlobalReport/2008/20080715_fs_global_En.pdf.
- 15 UNAIDS, *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2008): www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/default.asp; Economic and Social Research Council, *Global Health Disparities Fact Sheet*, available at www.esrcsocietytoday.ac.uk/ESRCInfoCentre/facts/health.aspx.
- 16 Davidson R. Gawtkin and Michel Guillot, *The Burden of Disease among the Global Poor: Current Situation, Future Trends, and Implications for Strategy* (Washington: World Bank, 2000), 19–20.
- 17 World Health Organization, *World Health Statistics 2009: Table 8 Health Inequities* (Geneva: WHO, 2009): www.who.int/whosis/whostat/EN_WHS09_Table8.pdf.
- 18 WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva: WHO, 2008): http://whqlibdoc.who.int/publications/2008/9789241563703_Eng.pdf.

black unemployed youth has a lifespan 32 years shorter than a white corporate professional.¹⁹

The world's 400 million indigenous people have remarkably low standards of health compared with non-indigenous populations. The gap in life expectancy is estimated to be 19–21 years in Australia, 8 years in New Zealand, 5–7 years in Canada and 4–5 years in the United States.²⁰ This poor health is associated with poverty, malnutrition, poor hygiene, environmental contamination and prevalent infections. Some indigenous groups, as they move from traditional to transitional and modern lifestyles, are rapidly acquiring lifestyle diseases such as cardiovascular disease, diabetes, mental illness and dependency on drugs and alcohol.²¹

As vividly enunciated by Vicente Navarro, 'It is not the North versus the South, it is not globalization, it is not the scarcity of resources – it is the power differentials between and among classes in these countries and their influence over the state that are at the root of the poverty [and health] problem.'²²

The diseases of poverty are endemic in the world's poorest regions, but barely get noticed among the wealthy. Diseases such as elephantiasis, guinea worm, malaria, river blindness, schistosomiasis and trachoma are common in poor countries, but are largely unheard of in rich countries. Beyond morbidity and premature mortality, the diseases of poverty cause physical and mental anguish, for example, when a two-foot-long guinea worm parasite emerges from the genitals, breasts, extremities and torso with excruciating pain; or filarial worms cause disfiguring enlargement of the arms, legs, breasts and genitals; or river blindness leads to unbearable itching and loss of eyesight.

Human instinct tells us that it is unjust for large populations to have such poor prospects for good health and long life simply by happenstance of where they live. Although almost everyone believes it is unfair that the poor live miserable and short lives, there is little consensus about whether there is an ethical, let alone legal, obligation to help the downtrodden. What do wealthier societies owe as a matter of *justice* to the poor in other parts of the world?

Perhaps the strongest claim that health disparities are unethical is based on what I call a theory of human functioning. Health has special meaning and importance to individuals and the community as a whole. Health is necessary for much of the joy, creativity and productivity that a person

19 Vicente Navarro, 'What We Mean by Social Determinants of Health', *International Journal of Health Services*, 2009, 39(3): 423–41.

20 Editorial, 'The Health Status of Indigenous Peoples and Others,' *British Medical Journal*, 2003, 327: 404–5.

21 Michael Gracey and Malcolm King, 'Indigenous Health Part 1: Determinants and Disease Patterns', *The Lancet*, 2009, 374(9683): 65–75; Malcolm King, Alexandra Smith and Michael Gracey, 'Indigenous Health Part 2: The Underlying Causes of The Health Gap', *The Lancet*, 2009, 374(9683): 76–85.

22 Navarro, 'What We Mean by Social Determinants of Health', 430.

derives from life. Individuals with physical and mental health recreate, socialize, work and engage in family and social activities that bring meaning and happiness to their lives. Perhaps not as obvious, health also is essential for the functioning of populations. Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art and provide for the common security.

Amartya Sen famously theorized that the capability to avoid starvation, preventable morbidity and early mortality is a substantive freedom that enriches human life.²³ Depriving people of this capability strips them of their freedom to be who they want to be and ‘to do things that a person has reason to value’.²⁴ Other ethicists have expanded on this theory, claiming that health, specifically, is important to the ability to live a life one values – one cannot function who is barely alive.²⁵ Under a theory of human functioning, health deprivations are unethical because they unnecessarily reduce one’s ability to function and the capacity for human agency. Health, among all the other forms of disadvantage, is special and foundational, in that its effects on human capacities impact one’s opportunities in the world and, therefore, health must be preserved to ensure equality of opportunity.²⁶

But Sen’s theory does not answer the harder question about who has the corresponding obligation to do something about global inequalities. Even liberal egalitarians who believe in just distribution, such as Nagel,²⁷ Rawls²⁸ and Walzer,²⁹ frame their claims narrowly and rarely extend them to international obligations of justice. Their theories of justice are ‘relational’ and apply to a fundamental social structure that people share. States may owe their citizens

23 See generally Amartya Sen, *Development as Freedom* (Oxford: Oxford University Press, 1999).

24 Ibid.; see also Jennifer Ruger, ‘Ethics and Governance of Global Health Inequalities’, *Journal of Epidemiology & Community Health*, 2006, 60: 998–9; Amartya Sen, ‘Equality of What?’, *Tanner Lecture on Human Values at Stanford University*, 1979: www.tannerlectures.utah.edu/lectures/sen80.pdf.

25 See Ruger, ‘Ethics and Governance of Global Health Inequalities’. See also Jennifer Ruger, ‘Rethinking Equal Access: Agency, Quality, and Norms’, *Global Public Health*, 2007, 2(1): 84; Martha C. Nussbaum, ‘Human Functioning and Social Justice: In Defense of Aristotelian Essentialism’, *Political Theory*, 1992, 20(2): 202–46. See also, John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge: Cambridge University Press, 2012), chapter 8.

26 See Norman Daniels, ‘Justice, Health, and Healthcare’, *American Journal of Bioethics*, 2001, 1(2): 2–16. See also Sridhar Venkatapuram, *Health Justice* (Malden, MA: Polity Press, 2011).

27 See generally Thomas Nagel, ‘The Problem of Global Justice’, *Philosophy & Public Affairs*, 2005, 33(2): 113–47.

28 See generally John Rawls, *The Law of Peoples* (Cambridge, MA: Harvard University Press, 1999).

29 See generally Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983).

basic health protection by reason of a social compact.³⁰ But positing such a relationship among different countries and regions is much more difficult.

Basic survival needs: Ameliorating suffering and early death

Suppose that States were convinced that amelioration of global health hazards was in their national interests or that they otherwise accepted the claim that they have an ethical responsibility to act. Would the consequent funding and efforts make a difference? If past history is any guide, the answer is no. Most development assistance is driven by high-profile events that evoke public sympathy, such as a natural disaster in the form of a hurricane, tsunami, draught or famine; or an enduring catastrophe such as AIDS; or politicians may lurch from one frightening disease to the next, irrespective of the level of risk ranging from anthrax and smallpox to SARS, novel influenza (H5N1 and H1N1) and bioterrorism.

What is truly needed, and which richer countries instinctively (although not always adequately) do for their own citizens, is to meet what I call 'basic survival needs'. By focusing on the major determinants of health, the international community could dramatically improve prospects for good health. Basic survival needs include sanitation and sewage, pest control, clean air and water, tobacco reduction, diet and nutrition, essential medicines and vaccines and well-functioning health systems. Meeting everyday survival needs may lack the glamour of high-technology medicine or dramatic rescue, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disabilities across the globe. Mobilizing the public and private sectors to meet basic survival needs, comparable to a Marshall Plan, could radically transform prospects for good health among the world's poorest populations.

Meeting basic survival needs can be disarmingly simple and inexpensive, if only it could rise on the agendas of the world's most powerful countries. It does not take advanced biomedical research, huge financial investments or complex programs. Consider what human benefits would accrue from highly cost-effective interventions such as vaccines, essential medicines, sanitation and pest abatements. Vaccine-preventable diseases are virtually extinct in developed countries, but still kill millions of children and adults annually in poorer regions. A single annual dose of ivermectin (Mectizan®) and albendazole (Albenza®) costing a couple of dollars rids the body of intestinal worms and the itching symptoms of river blindness, prevents blindness and revives sex drive, so it

30 See generally Thomas Hobbes, *Leviathan*, (Touchstone, 1997 [1651]). See also Michael O. Hardimon, 'Role Obligations', *The Journal of Philosophy*, 1994, 91(7): 333–63; Robin West, 'Unenumerated Duties', *University of Pennsylvania Journal of Constitutional Law*, 2006, 9: 221–61.

helps regenerate populations in decline.³¹ Basic sanitation and water systems would vastly improve global health at minimal cost, such as clean water kits costing as little as \$3. An insecticide-treated bednet, which costs roughly \$5 and provides protection for up to five years, is highly effective in reducing malaria, river blindness, elephantiasis and other insect-borne diseases among children.³² But only about one in seven children in Africa sleep under a net, and only 3 per cent of children use a net impregnated with insecticide.³³

Consequently, what poor countries need is not foreign aid workers parachuting in to rescue them. Nor do they need foreign-run state-of-the-art facilities. Rather, they need to gain the capacity to provide basic health services themselves.

Global governance for health: A proposal for a Framework Convention on Global Health

If meeting basic survival needs can truly make a difference for the world's population, and if this solution is preferable to other paths, then can international law structure legal obligations accordingly? The answer is that extant health governance has been lamentably deficient, and a fresh approach is badly needed.

If law is to play a constructive role, innovative models are essential and here I make the case for a Framework Convention on Global Health. I am proposing a global governance for health scheme incorporating a bottom-up strategy that strives to: build health-system capacity; set priorities to meet basic survival needs; engage stakeholders to bring to bear their resources and expertise; harmonize the activities among the proliferating number of actors operating around the world; and evaluate and monitor progress so that goals are met and promises kept.

The framework convention approach is becoming an essential strategy of powerful transnational social movements to safeguard health and the

- 31 World Health Organization, 'Lymphatic Filariasis', *Weekly Epidemiological Record*, 2001, 76: 149–54; see also Eric A. Ottesen, B.O. Duke, M. Karam and K. Behbehani, 'Strategies and Tools for the Control/Elimination of Lymphatic Filariasis', *Bulletin of WHO*, 1997, 75: 491–503.
- 32 David Molyneux and Vinad Nantulya, 'Linking Disease Control Programmes in Rural Africa: A Pro-Poor Strategy to Reach Abuja Targets and Millenium Development Goals', *British Medical Journal*, 2004, 75: 1129–32; see also C. Lengeler, 'Insecticide-Treated Bed Nets and Curtains for Preventing Malaria', *Cochrane Database of Systematic Reviews*, 2004, 2: CD000363; Donald G. McNeil, Jr, 'Beyond Swollen Limbs, a Disease's Hidden Agony', *New York Times*, 9 April 2006.
- 33 World Health Organization, *Africa Malaria Report 2003* (Geneva: WHO, 2003): www.rbm.who.int/amr2003/amr2003/amr_toc.htm; John M. Miller, Eline L. Korenromp, Bernard L. Nahlen and Richard W. Steketee, 'Estimating the Number of Insecticide-Treated Nets Required by African Households to Reach Continent-Wide Malaria Coverage Targets', *Journal of the American Medical Association*, 2007, 297: 2241.

environment.³⁴ A series of international environmental treaties serve as models for global health governance, including the Barcelona Convention for Protection of the Mediterranean Sea Against Pollution (1976),³⁵ the Convention on Long-Range Transboundary Air Pollution (1979),³⁶ and the Vienna Convention for the Protection of the Ozone Layer (1985)³⁷ (leading to the Montreal Protocol on Substances that Deplete the Ozone Layer in 1987).³⁸

The UN Framework Convention on Climate Change (UNFCCC) (1992), the most prominent international environmental treaty, is designed to stabilize greenhouse gas concentrations in the atmosphere.³⁹ The 1997 Kyoto protocol required ratifying States to reduce their total greenhouse gas emissions, with specific quantitative levels assigned to each country.⁴⁰ Although the United States failed to ratify,⁴¹ and highly polluting transitional States such as China and India are largely exempt, the Kyoto Protocol represents a nascent attempt at global cooperative governance to reduce global climate change.⁴² But even this approach can be painstakingly difficult, as the stalled climate change negotiations make clear.

These framework conventions recognize that the world's atmosphere and bodies of water are shared resources, and that a collective effort is necessary to mitigate the threat that humans pose to the global environment. Although far from perfect, international environmental treaties offer innovative approaches to global governance. The Montreal protocol, for example, adopted a 'common but differentiated responsibility', with disparate legal obligations on developing and developed countries; created a multilateral implementation fund administered by the World Bank to provide technical and financial assistance to developing countries;⁴³ and utilized trade sanctions for enforcement.⁴⁴

34 Ibid.

35 Convention for Protection of the Mediterranean Sea against Pollution 1976 and Protocols 1980 and 1982 (12 February 1978): <http://eelink.net/~asilwildlife/barcelona.html>.

36 Convention on Long-Range Transboundary Air Pollution 1979 (establishing a broad agreement between European and North American countries to address the problem of emissions that cross borders, causing regional environmental and health effects).

37 Vienna Convention for the Protection of the Ozone Layer 1985.

38 Montreal Protocol on Substances that Deplete the Ozone Layer 1987.

39 United Nations Framework Convention on Climate Change 1992.

40 Kyoto Protocol to the United Nations Framework Convention on Climate Change 1998 [hereinafter Kyoto Protocol]; see David Dreisen, 'Free Lunch or Cheap Fix: The Emissions Trading Idea and the Climate Change Convention', *Boston College Environmental Affairs Law Review*, 1998, 26: 5.

41 Kyoto Protocol: Status of Ratification: http://unfccc.int/files/kyoto_protocol/background/status_of_ratification/application/pdf/kp_rat_131206.pdf.

42 United Nations, *United Nations Framework Convention on Climate Change: The First Ten Years* (New York: United Nations, 2004): http://unfccc.int/resource/docs/publications/first_ten_years_En.pdf.

43 World Bank, *The Multilateral Fund for Implementation of the Montreal Protocol* (Washington: World Bank, 2004).

44 World Bank, *The World Bank and the Montreal Protocol: Reducing Health Risks by Restoring the Ozone Layer* (Washington: World Bank, 2003): <http://web.worldbank.org/servlets/ECR?contentMDK=20489383&sitePK=407352>.

The Framework Convention on Tobacco Control, one of only two treaties negotiated under the WHO's constitutional authority, was modelled on environmental framework conventions, notably the UNFCCC.⁴⁵ It too has inventive governance approaches to tobacco control that include: *demand reduction* – price and tax measures, as well as non-price measures; *supply reduction* – control of illicit trade and sales to minors, as well as creation of economically viable alternatives to tobacco production; and, most controversially, *tort litigation* – international cooperation on tort actions and criminal prosecutions, such as information exchange and legal assistance.

The key modalities of an FCGH

An FCGH would represent an historical shift in global health, with a broadly imagined global governance regime. The initial framework would establish the key modalities, with a strategy for subsequent protocols on each of the most important governance parameters. It is not necessary, or perhaps even wise, to specify in detail the substance of an initial FCGH, but it may be helpful to state the broad principles:

- *FCGH mission* – Convention Parties seek innovative solutions for the most pressing health problems facing the world in partnership with non-state actors and civil society, with particular emphasis on the most disadvantaged populations.
- *FCGH objectives* – 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.
- *Engagement and coordination* – finding common purposes and process among a wide variety of State and non-state actors, setting priorities and coordinating activities to achieve the mission of the FCGH.
- *State Party and other stakeholder obligations* – incentives, forms of assistance (e.g. financial aid, debt relief, technical support, subsidies, tradable credits) and levels of assistance, with differentiated responsibility for developed, developing and least-developed countries.
- *Institutional structures* – conference of Parties, secretariat, technical advisory body and financing mechanism, with integral involvement of non-state actors and civil society.

45 Ruth Roemer, Allyn Taylor and Jean Lariviere, 'Origins of the WHO Framework Convention on Tobacco Control', *American Journal of Public Health*, 2005, 95: 936–8; Allyn Taylor and Douglas Bettcher, 'WHO Framework Convention on Tobacco Control: A Global "Good" for Public Health', *Bulletin of WHO*, 2000, 78: 920–9.

- *Empirical monitoring* – data gathering, benchmarks and leading health indicators, such as maternal, infant and child survival.
- *Enforcement mechanisms* – inducements, sanctions, mediation and dispute resolution.
- *Ongoing scientific analysis* – processes for ongoing scientific research and evaluation on cost-effective health interventions, such as the creation of an Intergovernmental Panel on Global Health, comprised of prominent medical and public health experts.
- *Guidance for subsequent law-making process* – content, methods and timetables to meet framework convention goals.

Strengths of the framework convention-protocol approach

Facilitating global consensus

The framework convention-protocol approach has a number of advantages resulting from the incremental nature of the process, and its ability to evolve over a longer time horizon. The framework agreement allows for the initial codification of normative parameters, with the expectation of building detailed standards in the future. The incremental nature of the governance strategy allows the international community to focus on a problem in a stepwise manner, avoiding potential political bottlenecks over contentious elements. A comprehensive international governance regime can emerge from a long-term negotiation process as political will develops.⁴⁶ Although the graduated nature of framework conventions can frustrate those desiring rapid results, it can offer the only realistic strategy for finding global consensus.

Facilitating a shared humanitarian instinct

The creation of international norms and institutions provides an ongoing and structured forum for States and stakeholders to develop a shared humanitarian instinct on global health. A high-profile forum for normative discussion can help educate and persuade Parties, and influence public opinion, in favour of decisive action. And it can create internal pressure for governments and others to actively participate in the framework dialogue. The creation of such a normative community, therefore, may be an essential element of building an international consensus.⁴⁷ The imperatives of global health have to be framed

46 Allyn Taylor, 'An International Regulatory Strategy for Global Tobacco Control', *Yale Journal of International Law*, 1996, 12: 257–304.

47 Marc Levy, 'Improving the Effectiveness of International Environmental Institutions', in Peter Haas, Rober O. Keohane and Marc A. Levy (eds), *Institutions for the Earth* (Cambridge, MA and London, England: MIT, 1993).

not just as a series of isolated problems in far-off places, but as a common concern of humankind.

Building factual and scientific consensus

The framework convention-protocol approach can be used to build international consensus about the essential facts of global health, such as the causes of extremely poor health and stark disparities, as well as the most cost-effective solutions. Just as the normative process can shape values, it can also serve as a forum for experts and policy-makers to collect and analyse health data and scientific evidence. The FCTC process, for example, facilitated discussion about the harms of tobacco and role of the industry, which was vital to the adoption of the treaty. At the same time, the incremental approach of a Framework Convention allows for normative development to accommodate evolving scientific evidence.

Transcending shifts in political will

An ongoing diplomatic forum can also help to transcend the inevitable ebbs and flows of interest in international cooperation around global health. As political environments change, governments can become more or less interested in creating new international obligations, or complying with existing obligations. One of the strengths of an FCGH is that it can serve as a lasting entity that is resistant to temporary shifts in political will.

Engaging multiple actors and stakeholders

The really interesting and vital aspect of a FCGH is not merely how it governs inter-State responsibilities. The critical challenge is how to make it do the really hard work of mobilizing the diverse drivers of health, including NGOs, private industry, foundations, public/private hybrids, researchers and the media. It is essential to harness the ingenuity and resources of these non-state actors. The FCGH, therefore, should actively engage major stakeholders in the process of negotiation, debate and information exchange, as well as reducing barriers for them to actively engage in capacity-building.

Political difficulties of a Framework Convention on Global Health

An FCGH offers an intriguing approach, potentially creating a process and structure for an innovative international mechanism for ameliorating complex problems in global health. It will not, however, be a panacea, and there are multiple social, political and economic barriers to the creation of such a framework convention. The framework convention-protocol approach cannot easily circumvent many of the seemingly intractable problems of global health governance: the domination of the most economically and politically powerful countries; the deep resistance to creating obligations to expend, or

transfer, wealth; the lack of confidence in international legal regimes and trust in international organizations; and the vocal concerns about the integrity and competency of governments in many of the poorest countries.

Although the framework convention-protocol approach can help create the political, scientific and normative space for agreement to be reached, it does not ensure consensus on contentious issues. In fact, this approach has a number of structural problems that could hinder the creation of a universal, cooperative solution to global health problems. Loss of momentum is one potential barrier. The extended, incremental process can be seen as detrimentally long and drawn out.⁴⁸ After an initial framework convention, if years pass without an agreement on subsequent protocols, there is a risk that political momentum will wane. Furthermore, the long timeframe can be used to derail the imposition of binding obligations. Parties that were initially reluctant to engage in negotiations about an issue, can take advantage of the political capital achieved by signing a framework convention, then subtly disengage from, or even subvert, the subsequent protocol creation process.

But given the dismal nature of extant global health governance, an FCGH is a risk worth taking. It will, at a minimum, identify the truly important problems in global health. Solutions will not be found solely in increased resources, although that is important. Rather, an FCGH can demonstrate the imperative of targeting the major determinants of health, prioritizing and coordinating currently fragmented activities, and engaging a broad range of stakeholders. It also will provide a needed forum to raise visibility of one of the most pressing problems facing humankind. An FCGH would represent an historical shift in global health, with a broadly imagined global governance regime.

A tipping point

I have sought to demonstrate why politically and economically powerful countries should care about the world's least healthy people. It may be a matter of national interest for the Global South and North so that helping the poor makes everyone safer and more secure. Or global health assistance simply may be ethically the right thing to do to avert an unfolding humanitarian catastrophe. Or there may be a growing sense of legal obligation, whether through WHO treaties and regulations or the international right to health. Although no single argument may be definitive in itself, the cumulative weight of the evidence is now overwhelmingly persuasive. Whatever the reasons, perhaps we are coming to a tipping point where the status quo is no longer acceptable and it is time to take bold action. Global health, like global climate change, may soon become

48 Lawrence Susskind, 'The Weaknesses of the Existing Environmental Treaty-Making System', in Lawrence Susskind (ed.), *Environmental Diplomacy: Negotiating More Effective Global Agreements* (New York: Oxford University Press, 1993), 11–39.

a matter so important to the world's future that it demands international attention, and no State can escape the responsibility to act.

If that were the case, States would need an innovative international mechanism to bind themselves, and others, to take an effective course of action. Amelioration of the enduring and complex problems of global health is virtually impossible without a collective response. No State or stakeholder, acting alone, can avert the ubiquitous threats of pathogens as they rapidly migrate and change forms. If all States and stakeholders voluntarily accepted fair terms of cooperation through an FCGH, then it could dramatically improve life prospects for millions of people. But it would do more than that. Cooperative action for global health, like global warming, benefits everyone by diminishing our collective vulnerabilities.

The alternative to fair terms of cooperation through a Framework Convention is that everyone would be worse off, particularly those who suffer compounding disadvantages. Absent a binding commitment to help, rich States might find it politically or economically easier to withhold their fair share of global health assistance, hoping that others will take up the slack. Major outbreaks of infectious disease, including extensively drug-resistant forms, would become increasingly more likely. Even if the economically and politically powerful escaped major health hazards, they would still have to avert their eyes from the mounting suffering among the poor. And they would have to live with their consciences knowing that much of this physical and mental anguish is preventable.

What is most important is that if the global community does not accept fair terms of cooperation on global health soon, there is every reason to believe that affluent States, philanthropists and celebrities simply will move on to another cause. And when they do, the vicious cycle of poverty and endemic disease among the world's least healthy people will continue unabated. That is a consequence that none of us should be willing to tolerate.