Article

Global health justice: A perspective from the global South on a Framework Convention on Global Health*

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A global coalition of civil society and academics recently launched the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI), which is developing a post-Millennium Development Goal (MDG) framework for global health. The Framework Convention proposes establishing fair terms of international co-operation, with agreed-upon mutually binding obligations to create enduring health system capacities, meet basic survival needs, and reduce unconscionable inequalities in global health. States that bear a disproportionate burden of disease have the least capacity to do anything about it. The richer states are deeply resistant to expending the political capital and economic resources. When they 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 is a spiralling deterioration of health in the poorest regions, with manifest global consequences and systemic effects on trade, international relations, and security.

S Afr J BL 2012;5(1):33-37.

This paper 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. Health threats inexorably spread to neighbouring countries, regions, and even continents. It is for this reason that safeguarding the world's population requires co-operation and global governance.

If ameliorating the most common causes of disease, disability, and premature death require global solutions, then the future is demoralising. The states that bear the disproportionate burden of disease have the least capacity to do anything about it. The States that have the wherewithal are deeply resistant to expending the political capital and economic resources. 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 is a spiralling deterioration of health in the poorest regions, with manifest global consequences and systemic effects on trade, international relations, and security.

This article first inquires why global health is a shared responsibility – for the global South and North – and then reconceptualises the global health enterprise. Second, we 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, we will briefly explore what we call a 'theory of human functioning', to support a more robust understanding of the transcending value of health. Third, we 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 'basic survival needs', the international community could fundamentally improve prospects for the world's population. Finally, we explore the value of international law itself, and propose an innovative mechanism for global health reform – a Framework Convention on Global Health (FCGH).[1-3]

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.[4] In March 2011, the UN General Secretary endorsed the FCGH, calling on the United Nations to adopt it.[5] Moreover, the World Health Organization Director-General, Margaret Chan, proposed a 'framework' for global health as part of the major reform agenda of the WHO.[6]

*An expanded version of this paper was published in the *Georgetown Law Journal* in 2008.[1]

Our proposal for a Framework Convention, in a nutshell, is to establish fair terms of international co-operation, with agreed-upon mutually binding obligations to create enduring health system capacities, meet basic survival needs, and reduce unconscionable inequalities in global health.

Reconceptualising '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 we will 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 dependant. This leads affluent states and other donors to believe that they are giving 'charity', which means that financial contributions and programmes 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 on their own failures.

Conceptualising 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 co-ordinated 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, 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.

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 he or 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.

A decade into the 21st century, billions of people have yet to benefit from the health advances of the 20th century. Average life expectancy in Africa is nearly 30 years less than in the Americas or Europe[7] – only 2 years higher than in the USA a century ago,[8] 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 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% 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.

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.'[11]

Ethical underpinnings for global health justice

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 we 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 derives from life. Individuals with physical and mental health recreate, socialise, 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 theorised that the capability to avoid starvation, preventable morbidity, and early mortality is a substantive freedom that enriches human life. 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'.[12] 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. 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.[13]

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

Basic survival needs: ameliorating suffering and early death

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, drought, 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 strains (H5N1 and H1N1), and bioterrorism.

What is truly needed, and what richer countries instinctively (although not always adequately) do for their own citizens, is to meet what we 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. Mobilising the public and private sectors to meet basic survival needs 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 programmes. 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 law is to play a constructive role, innovative models are essential, and here we make the case for a Framework Convention on Global Health. We are 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
- harmonise the activities among the proliferating number of actors operating around the world
- 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 environment. A series of international environmental treaties serve as models for global health governance, culminating in the 1997 Kyoto Protocol to the UN Framework Convention on Climate Change. Although the United States failed to ratify, and highly polluting transitional states such as China and India are largely exempt, the Kyoto Protocol represents a nascent attempt at global co-operative governance to reduce global climate change. But even this approach can be painstakingly difficult, as the stalled climate change negotiations make clear.

The Framework Convention on Tobacco Control, one of only two treaties negotiated under the WHO's constitutional authority, was modelled on environmental framework conventions, nota-

bly the UNFCCC. 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 co-operation 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 co-operation, with agreed-upon mutually binding obligations to create enduring health system capacities, meet basic survival needs, and reduce global health disparities.
- **Engagement and co-ordination** – finding common purposes and process among a wide variety of State and non-State actors, setting priorities, and co-ordinating 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, taxation, 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.
- **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 can galvanise a global consensus as states and stakeholders negotiate the treaty. 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.

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 imperatives of global health have to be framed 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. The FCTC process, for example, facilitated discussion about the harm of tobacco and role of the industry, which was vital to the treaty's adoption.

Transcending shifts in political will. An ongoing diplomatic forum can also help to transcend the inevitable ebbs and flows of interest in international co-operation 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 an FCGH is not merely how it governs inter-state responsibilities. The critical challenge is how to make it do the really hard work of mobilising the divers 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.

A FCGH offers an intriguing approach, but faces enormous social, political, and economic barriers. 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, prioritising and co-ordinating currently fragmented activities, and engaging a broad range of stakeholders. It will also 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

We have sought to demonstrate why politically and economically powerful countries should care about the world's least healthy people. Although no single argument may be definitive in itself, the

cumulative weight of the evidence is now overwhelmingly persuasive. 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 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. If all states and stakeholders voluntarily accepted fair terms of co-operation, then it could dramatically improve life prospects for millions of people. But it would do more than that. Co-operative action for global health, like global warming, benefits everyone by diminishing our collective vulnerabilities.

The alternative to fair terms of co-operation is that everyone would be worse off, particularly those who suffer compounding disadvantages. 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 co-operation 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.

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