Examining the Global Health Arena: Strengths and Weaknesses of a Convention Approach to Global Health Challenges

Report from Kunnskapssenteret (Norwegian Knowledge Centre for the Health Services)
No 12–2010
Global health governance analysis paper

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Background: In June 2009 the Norwegian Directorate of Health commissioned the Norwegian Knowledge Centre for the Health Services with compiling and analyzing available international research material on the strengths and weaknesses of a convention approach to global health challenges. The following report is a response to this commission. • The purpose of the report is to contribute towards resolving the challenges related to poor health amongst the world's poorest and least healthy population. As such, it represents an initiative from the Norwegian public administration towards informing national and international governmental bodies of strengths and weaknesses of a global health convention approach to structure the international work on global health. **Key messages:** • Increasing global interdependence makes the health of the world's poorest and most marginalized people a pressing issue for all nations of the world. • There are observable weaknesses in the current international frameworks to improve health for the world's most marginalized people, including shortcomings in the human rights approach to health. • A global health convention could

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(continued from page one) provide an appropriate instrument to deal with some of the intractable problems of global health, especially: - clearly define what are basic survival needs, - setting principles for cooperation, accountability, and allocation of resources between stakeholders, - structuring and coordinating the financing of global health investments, - granting rules for access to health services, including setting demands for national priorities with respect to the provision of health services. • Challenges might be to muster international support for supranational health regulations, negotiate compromises between existing stakeholders in the global health arena, and to gain WHO's support as a convener of the parties and as a facilitator of the adoption process.

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Norwegian Knowledge Centre for the Health Services
Oslo, June 2010

Key messages

In June 2009 the Norwegian Directorate of Health commissioned the Norwegian Knowledge Centre for the Health Services with compiling and analyzing available international research material on the strengths and weaknesses of a convention approach to global health challenges. The following report is a response to this commission.

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Key messages of the report:

- Increasing global interdependence makes the health of the world's poorest and most marginalized people a pressing issue for all nations of the world.
- There are observable weaknesses in the current international frameworks to improve health for the world's most marginalized people, including shortcomings in the human rights approach to health.
- A global health convention could provide an appropriate instrument to deal with some of the intractable problems of global health, especially:
  - Clearly define what are basic survival needs
  - setting principles for cooperation, accountability, and allocation of resources between stakeholders
  - structuring and coordinating the financing of global health investments
  - granting rules for access to health services, including setting demands for national priorities with respect to the provision of health services.
- Challenges might be to muster international support for supra-national health regulations, negotiate compromises between existing stakeholders in the global health arena, and to gain WHO's support as a convener of the parties and as a facilitator of the adoption process.

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Executive summary

The article comprises a conceptual framework to analyse the strengths and weaknesses of a global health convention approach to some of the intractable problems of the global health arena. The analyses are inspired by Georgetown Law Professor Lawrence Gostin's suggested Framework Convention on Global Health. The analytical model takes a starting-point in events tentatively following a logic sequence: Input (global health funding), Processes (coordination, cooperation, accountability, allocation of aid), Output (definition of basic survival needs), Outcome (access to health services), and Impact (health for all). It then examines to what degree binding international regulations can create order in such a sequence of events.

The report also examines the most important rights based instruments within the global health arena, especially health as a human right, and assesses the impact these instruments have on global health disparities.

The report finds that there are observable weaknesses in the human rights approach to health, however that there are good reasons to continue developing and improving global health along the rights based avenue. It also concludes that a global health convention could be an appropriate instrument to deal with some of the problems of global health. Thus, the report argues that some of the tasks preceding a convention approach might be to muster international support for supra-national health regulations, negotiate compromises between existing stakeholders in the global health arena, and to utilize WHO as a platform for further discussions on a global health convention. Also, it shows that sustainable and coordinated funding for health is crucial to better utilize resources both internationally and on country-level, as well as to achieving long-term goals, like the establishment of a stable health work-force in developing countries.

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Preface

In 2009 the Norwegian Directorate of Health commissioned the Norwegian Knowledge Centre for the Health Services with compiling and analyzing available international research material on the strengths and weaknesses of a convention approach to global health challenges. The following report is a response to this commission. It will thus serve as part of the background documentation for national priorities within global health governance policies, as well as a means to take the international debate on global health challenges a little step further.

The project team is comprised of:

- Just Balstad, Project Coordinator and Medical Student at the University of Oslo. He holds a Master of Conflict Resolution degree from La Trobe University in Melbourne, Australia (2005), and a Law Degree from University of Oslo (2001).
- John-Arne Røttingen, Chief Executive of the Norwegian Knowledge Centre for the Health Services, and Adjunct Professor in Health Policy at the Department of Health Management and Health Economics, Institute of Health and Society, Faculty of Medicine, University of Oslo. He holds an MD and a PhD from the University of Oslo and an MSc from University of Oxford.

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Objective

The report gathers information on all relevant initiatives to create internationally binding regulations with the aim of promoting health as a global public good. It includes both legal and policy documents, and in addition refers to the most prominent private initiatives. A specific aim is to identify some of the concerns which make a global health convention desirable, and also to identify and evaluate the most important obstacles to such a convention, whether they are of an economic, political or practical nature.

Another objective of the report is to contribute with a pilot study to clarify the many major global health initiatives that have been embarked on over the last decade, to review them, examine the role of the most important international players in all this, and possibly, again, define basic survival needs and rights.

Background

Whatever one thinks about the existing initiatives for improving the health of the world's poorest peoples, it cannot be argued that enough is already done. Despite the vast amounts of money that goes into the global health field, there is a growing concern that international health aid is ineffective, or even counter-productive. And as a great number of the countries that we used to regard as poor over the last forty years have undergone a transition to aspiring growth, and often at amazing speed there is still a group of countries at the bottom that are falling behind, and often falling apart. The countries at the bottom coexist with the twenty-first century, but the reality they face is that of the fourteenth century: civil war, plague, ignorance(1). It is no longer justifiable to regard them as islands of chaos in an otherwise orderly world. Indeed, our economic interdependence is fragile. The safety and comforts we enjoy in our enlightened societies are already vulnerable to increasingly unpleasant interactions with our poor neighbours. And as the gap between those two worlds increase, integration will become harder, not easier.

This report is one attempt to contribute towards resolving the challenges related to poor health in developing countries. As such it represents an initiative from the Norwegian public administration towards informing national and international governmental bodies of strengths and weaknesses of a global health convention approach to structure the international work on global health.

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Method

Everybody taking part in the work on this report have contributed with their full experience and knowledge of the global health arena. They have also included their network of contacts and colleagues in the search for relevant proposals, ideas and comments on the concept of a FCGH. In addition, multiple purpose-oriented searches of journals, grey literature and web sites have been carried out to identify international legislation, official documents, and literature relevant for the concept of a FCGH. An annotated bibliography has been made based on these findings. The report has also been peer-reviewed by several distinguished national and international experts on global health issues. The findings of the report have also been discussed and commented on throughout a one-day workshop at the Norwegian Directorate of Health, comprising more than 30 national and international experts on global health.

The report is mainly a result of cross-disciplinary thinking, and draws upon methodology particularly from international (health) law, international public health (global health), and from the realm of international politics.

Discussion

"I am not unfamiliar with the fact that many have been, and still are, of the opinion that the affairs of the world are governed by Fortuna, and by God, in such manner that human beings, in all their wisdom, cannot control their course -yes, even that they are completely helpless in that respect. Thus, one could argue that one should not struggle much with anything, but rather let oneself be ruled by fate. [However,] an Emperor that relies too fully on Fortuna, will tumble down when his luck fails. I also believe that a person will have success whose actions are such that they agree with the spirit of that particular time."

Niccoló Machiavelli. Il Principe.

It is easy to agree with Machiavelli that there is a right time to act when it comes to issues of great complexity, and involving the immediate well-being of fellow human beings. The challenge of bringing a minimum level of health to the world's poorest and most marginalized populations is such an issue, and the time to act is now.

Introduction

Global health is a concept which in recent years has evoked a lot of interest from both academics, politicians, celebrities, and the media. The term "global health" implies a globally shared responsibility to provide health as a public good through an expansive number of initiatives. This emerging era of consciousness about our international interdependence, regardless of a problem's geographic location or type of disease, may be a good moment for exploring the strengths and weaknesses of an international law approach to global health challenges: a global health convention.

The most prominent global health initiatives are the Millennium Development Goals (MDGs)(2), the 2005 Paris Declaration Process on Aid Effectiveness on need for alignment and coordination (PDP)(3), and the 2008 Accra High Level Forum on Aid Effectiveness (AHLF)(4). These instruments have yet to prove their value(5), and the funds annually disbursed, approximately $25 billion in 2009(6), could have

better effect if the negotiated principles from the PDP and the AHLF were followed. However, these agreements are not legally binding. They also can also be perceived as solutions that have been negotiated in a top-down manner, and thus only seem to be respected as long as they are suited to a particular problem. Thus, there are several barriers to advancing global health that could be addressed with a unified and coordinated legal instrument, such as:

- funding problems (prioritization of resources)
- coordination of stakeholders
- access to health services (strengthening of country health systems)
- allocation of aid (cost of delivery, corruption)
- accountability of stakeholders
- enforcement of binding international health regulations

Our analysis is inspired by Lawrence Gostin's proposal for a Framework Convention on Global Health (FCGH)(7). In this article we use the acronym FCGH when commenting on Gostin's proposal, in other cases we use the more generic terms 'global health convention', 'convention', or 'binding regulations'.

The Proposal for a Framework Convention on Global Health

Gostin proposed a global health convention in his article Meeting Basic Survival Needs of the World's Least Healthy People Toward a Framework Convention on Global Health, published in 2007(7). In short, he argues that a FCGH:

"…could powerfully improve global health governance […] by committing States to a set of targets, both economic and logistic, and dismantle barriers to constructive engagement by the private and charitable sectors."

The framework convention-protocol approach refers to a process of incremental regime development where states could commit in a step by step manner. Specific protocols would be developed to achieve the objectives that are stated in a previously agreed upon framework of principles. The aim of a FCGH would be to ameliorate the most common causes of disease, disability, and premature death in the developing world, and thus to grant a majority of the world's poorest and most marginalized people a legal framework on which they could base their rightful claims for basic health care services(7).

According to Gostin a FCGH should include the following:

- Mission and objectives –establish fair terms of international cooperation;

- Engagement and coordination –find common purposes and process, set priorities, and coordinate activities;
- Stakeholder obligations –e.g. incentives, forms and levels of assistance;
- Institutional structures –e.g. secretariat, technical advisory body, and financing mechanisms;
- Empirical monitoring –data gathering, benchmarks, and health indicators;
- Enforcement mechanisms –inducements, sanctions, and dispute resolution;
- Ongoing scientific analysis –processes for ongoing scientific research and evaluation on cost effective health interventions;
- Guidance for subsequent law-making process –content, methods, and timetables to meet framework convention goals by developing subsequent protocols.

These suggested principles do not in themselves represent any novelty in the global health arena. Each is already, either fully or in part, integrated in the priorities of a number of global health stakeholders. What is new is Gostin's suggestion to create a unified and coordinated legal framework for all these concepts.

Inherent Issues in an International Law Approach to Global Health Challenges

Incremental Regime Development

According to the sovereignty principle states reign supreme in any question that regards global or transnational issues. Thus, states formally have absolute power to commit or oblige. However, most states have surrendered some of their sovereignty, and abide by the most important legal instruments that promote the sake of humanity, e.g. the Geneva Conventions. Understandably, such transfer of national power to international governing bodies does not come without controversy. Some of the problems pertaining to globally binding regulations are: How to create international legal regimes? How to assure compliance? How to grant them with legitimacy and timeliness?

In order to address the latter, Gostin proposes a "framework convention-protocol approach"; a mechanism capable of setting key objectives, defining means, methods and interventions, as well as ensuring compliance. The approach refers to a process of incremental regime development where stakeholders agree to negotiate broad principles for global health governance. Subsequent stages facilitate development of protocols including detailed legal norms, structures, and processes to achieve the objectives in the original framework(7). The strength of this gradual approach is that nation states' binding to more controversial obligations can happen progressively as actors try out any new positions, and as consequences are better explored. A weak-

ness is that some states will be sceptical because of the uncertainty inherent in this approach.

Gostin's proposes that the protocol approach constitutes a bottom-up strategy. Supporting the claim is that the idea renders possible empowerment of stakeholders behind grass-roots initiatives. However, the proposal assumes that a convention should set priorities, coordinate activities, and evaluate and monitor progress(7). Such activities undoubtedly involve elements of top-down governance, or will at least easily be perceived as such by traditional recipient-states. In a true bottom-up regime, should not stakeholders themselves set priorities? And could not coordination be seen as self-organization between grassroots enterprises? Indeed, there is still a danger that many recipient-countries will still perceive such regulation as a troublesome top-down initiative.

Compliance with International Regulations

Will a global health convention make a difference? The same question with regards to human rights treaties was addressed in a large-scale quantitative analysis of the relationship between ratification of such treaties and countries' human rights practices. The analysis showed that noncompliance with treaty obligations is common, and that treaty ratification appears to be associated with worse practices than otherwise expected(8). Such findings can be explained in part by the dual nature of treaties as both instrumental and expressive instruments; treaties not only create binding law, but also declare or express the position of countries that ratify them. Because human rights treaties tend to be weakly monitored and enforced (see below), countries that ratify may enjoy the benefits of this expression –including, perhaps, reduced pressure for improvements in practices– without bearing significant costs.

However, despite what one would believe, sanctions and threats are not considered the main success factors for ensuring compliance with international binding regulations. Treaty compliance(9) is sometimes considered to arise from reciprocity (mutual advantages)(10), transparency(11), legitimacy(12), social learning(13), mobilization (through the crafting of the agreement), and internalization (integration of treaty rules into states' legal systems and bureaucracies)(14). Accordingly, analyses of previous international agreements served as patterns when adopting the Framework Convention for Tobacco Control (FCTC). Among the features that were highlighted in terms of what could make the FCTC more effective in achieving its goals were: clear, precise rules; financial support where states lack the capacity to comply; and regular meetings among member states for information exchange and ongoing negotiation(15).

Another problem somewhat in relation to compliance is the conflict between national and global responsibilities for health. Such conflicts could easily occur if one sets out to design a legal framework which is fit to blur that border. Indeed, for some

the idea of a legal framework for global health could even be perceived to challenge the sovereignty principle and undermine national responsibilities. At the far end of such perceptions lie some dire consequences, namely that a global health convention could lead to circumstances where:

- Global responsibility would displace national responsibility, thereby extinguishing any domestic initiatives that work towards e.g. increasing tax revenues for subsequent health spending
- International assistance, by providing default funding to government budgets, would undermine community initiatives towards self-help financial arrangements, like the grassroots promotion of community health insurance.
- A nonexistent distinction between the national and global sphere where the world's total tax revenues allocated to health, in principle, should be spread evenly across the world. Thus, public health budget per capita per annum in Burundi, for example, would increase from US$0.7 to US$639, and in Norway would decrease from US$4,508 to US$639(16).

Indeed, if any of these arguments were true, neither donors nor recipients would feel very tempted to comply by global standards. However, as for human rights, there seems to be a global consensus that the primary responsibility for health lies with each country's government. Only if the government of a country is willing, but unable to achieve the minimum standards necessary for the enjoyment of the right to health, an obligation for other governments to provide international assistance sets in. Of course, potential donor countries can always argue that such international assistance is too costly on the grounds that they have an obligation towards their own inhabitants to achieve their highest attainable level of health. If such an argument is to be heard, one would have to disregard the fact that, according to The UN Committee on Economic, Social and Cultural Rights' (CESCR) General Comment 14(17), any core obligations to assist those that have nothing must be given priority over other rights. However, if countries do not disregard the core rights in General Comment 14, this is again an argument for a supra-national regime to which it is hard to obtain compliance.

On the other side, if one should accept the high-cost argument above, the right to health would in fact be a privilege and not a right. Thus, the recourse to human rights arguments inevitably leads to a "Catch 22-situation" where core obligations are not possible to realize without a supra-national governance regime. By analogy, a similar comprehension would have to be maintained for a global health convention; any rights that guarantee basic survival needs will by nature have to be supranational. Alas, the problem of compliance with supra-national versus national regulations is still real, and a conundrum that must be solved before embarking on a new global health governance scheme.

Assessment of Rule-Making Processes

In global health there seems to be a drive towards adopting legally binding instruments, and the examples of recent international regulations are numerous (e.g. 2006 United Nations Convention on Disabilities, 2005 International Health Regulations (IHR), 2003 WHO Framework Convention on Tobacco Control, Medical Research and Development Treaty (current proposal being discussed as a follow up of the Commission on Intellectual Property Rights, Innovation and Public Health), United Nations Framework Convention on Climate Change, and further back 1990 Convention of the Rights of the Child, 1979 United Nations Convention on the Elimination of All Forms of Discrimination Against Women). Thus, there already is quite substantial experience in establishing instruments based on the rule of law. Questions could be raised, however, as to whether the implementation of voluntary guidelines would be just as effective as binding legislation. Hence, one could ask what are the strengths and weaknesses of the rule-adoption-processes in formal rights-based processes compared to "soft law" processes.

Indeed, when analyzing the adoption of a supra-national legal instrument, it is clear that a chosen procedure can be more or less in harmony with different countries legal traditions and negotiations cultures. In international legislative negotiations parties regularly attend with increased vigilance in the face of committing to wide-ranging responsibilities, and countries' legal traditions often clash as country-specific legislative strategies surface. Indeed, some nations have traditions of dynamic legislative processes where new rules are regularly set into action as a result of ongoing political processes. Consequently, it becomes impossible to treat all regulatory initiatives with the same vigilance. In other countries, legal commitments are generally of a non-declaratory nature, and legislators thus display a more conservative attitude during adoption processes.

Such differences undeniably would play a part in the negotiations foregoing a global health convention, and need to be addressed before settling on a final approach. Whether Gostin's FCGH proposal encompasses mostly informal or formal procedures is not clear at the moment. However, we will briefly examine one prominent global health regulatory initiative, the Framework Convention on Tobacco Control (FCTC), and by this assess the main drivers and obstacles to its adoption processes. Other regulations that would have deserved attention are the IHR, the United Nations Framework Convention on Climate, and the Convention on the Rights of the Child.

It is regularly perceived that the major public health challenge that the use of tobacco causes was the carrying force of the process. It is also speculated that momentum was gained by fact that the countries of the world, in the face of tobacco related disease, could confront one common enemy that had no justifiable cause for its ultimately harmful actions. Thus, WHO could, without much controversy, take on the whole tobacco industry, its products, and its business strategies.

In the case of global health, no common enemy can be identified, and there are already numerous stakeholders combating disease and poverty, all defending their established turfs. Comprehensive regulations for the global health field thus challenge the legitimacy and justification of existing global health initiatives, fostering political discord.

Observing that previous important advances in the global arena have emerged as mainly rights-based initiatives, it appears that the most viable strategy for supporters of a global health convention would be to aim for the creation of clear, concise and easily verifiable rules that have been negotiated in integrative and empowering processes. To avoid controversy, supporters should early on propose principles that all parties can agree on, and if possible, highlight areas of relative value. This would contribute both to establish healthy relations between stakeholders, and to expand the outlook towards possible gains. Such an approach appears to be concurrent with the process used by the WHO when adopting the FCTC, which is regularly perceived to have consisted of two main phases, namely:

- Initial brainstorming by a technical working group on the potential parties, principles, and contents of a convention
- Establishment of an intergovernmental negotiating body to draft and negotiate the proposed FCTC and possible related protocols(18)

Each phase presents procedural challenges, and convention facilitators would do wise in making sure there is in place a coherent framework for analysis of the whole negotiation system.

Health as a Human Right

Inspired by the atrocities of two world wars in just 30 years, the UN was founded as a protection against totalitarian rule, genocide and international aggression. In 1948 the General Assembly proclaimed the Universal Declaration of Human Rights(19) as a common standard of achievement that grants every human being a set of equal and inalienable social and political rights. Health is mentioned in Article 25 of the Declaration, and is thus considered a fundamental human right, indispensable from the enjoyment of multiple other human rights. The highest attainable standard of health as an objective was first put forward in the Constitution of the World Health Organization. It has since been reaffirmed in several other international declarations.(20;21)

Also, under the very diverse international treaty-based system, which works on the assumption that national states' ratification of international treaties will lead to

domestic implementation of the corresponding binding legal obligation as national law, a large number of states have ratified the key human right treaties, including the UN initiated International Covenant on Economic Social and Cultural Rights (ICESCR)(22). The ICESCR contains a provision on the highest attainable standard of health in article 12, which states that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The CESCR has interpreted article 12, and in 2000 adopted General Comment No. 14, which in great detail outlines the various dimensions of the highest attainable right to health(17).

Article 12 thus contains both a definition of the right to health, and some illustrative, non-exhaustive examples of states' obligations, but it does by no means guarantee a right to be healthy. However, the right to health contains some crucial freedoms and entitlements. The freedoms include the right to control one's health and body, and to be free from any interference that threatens the integrity of the individual, and the entitlements include the right to a health system of health protection which provides equality of opportunity for everyone to enjoy their highest attainable standard of health. The Committee further interprets the right to health to include:

"...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. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels."

In addition to this, the CESCR regards the right to health to encompass four interrelated concepts which depend on the prevailing conditions, Availability, Accessibility, Acceptability, and Quality. Availability involves functioning public health and health-care facilities, goods and services. It includes the underlying determinants of

health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related institutions, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs. Accessibility means that health facilities, goods and services should be physically and economically accessible to everyone without discrimination. Accessibility also includes the right to information concerning health issues. Acceptability assumes that health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as being designed to respect confidentiality and improve the health status of those concerned. Quality implies that goods and services must be scientifically and medically appropriate and of good standard. This requires skilled medical personnel, scientifically approved and reliable drugs and hospital equipment, safe and potable water, and adequate sanitation.

The interpretations in General Comment No. 14 go far in expanding the wording of ICESCR article 12, and as such the international right to health in all its consequences must be considered to have a legal base, albeit fragile. Indeed, questions could be raised as to what kind of obligation the national states actually have agreed to take upon themselves at the time of ratification, and whether the assortment of goods and services that General Comment No. 14 requires states to provide is really part of that commitment.

The right to health is also subject to the principle of progressive realization to the maximum of available resources(22). Thus, assessing what constitutes violations in concrete situations may cause controversy as national states erroneously or deliberately confuse their factual obligations based on resource availability with the question of how far the international right to health actually reaches.

In addition to this, the ICESCR does not give rules for any institution through which it is possible to hold parties in breach of the commitments following article 12 accountable. However, as ratifying states according to article 16 and 17 are obliged to report the measures set into action to secure the right to health, some degree of control is possible. The reports are routinely reviewed by the CESCR, and general comments on how to interpret the ICESCR are given. Their legal status, as mentioned with respect to General Comment No. 14, remains uncertain (see figure).

Figure 1: The legal warranty of health as a human right grows weaker the more content is interpreted into it.

Notably, no system within the framework of the covenant allows for individuals to bring forth complaints if they consider their right to health infringed by a ratifying national state. As a result, the ICESCR does little to secure a common framework under which it is possible to predict exactly what the international right to health constitutes of. Consequently, it also becomes difficult to outline national states' exact obligations. Given the fact that no effective accountability mechanisms exist, and that there is no possibility for persons to complain about a nation's practice, the right to health, especially seen from an individual point of view, undoubtedly becomes illusory and hollow. As one expert puts it:

"One would be hard pressed to find a more controversial or nebulous human right than the right to health - a right that stems primarily, although not exclusively, from Article 12 of the International Covenant on Economic, Social and Cultural Rights."(23)

In General Comment No. 14, the CESCR has made it clear that despite the relatively extensive elaborations previously made on the right to health, there exists a small number of essential obligations that all states, whether rich or poor, should be able to meet in any circumstance, because they are only to a limited degree dependent on resources. However, as we will see below, the CESCR has acknowledged an awareness of the fact that for some of those countries left most behind, even the fulfilment of such essential obligations represents too much of a challenge. The core obligations include to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, to provide access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone, to provide essential drugs, to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, and to ensure equitable distribution of all health facilities, goods and services(17). In addition, there are other obligations of comparable importance, namely reproductive, maternal and child health care, immunization against communicable disease, information access, and appropriate training for medical personnel.

These core rights represent a “minimum package” or an “existential minimum” with which it is possible for every person in need to survive and to lead a life in dignity. However, regardless of their importance, the enforcement of these rights suffers from the same lack of accountability mechanisms that the wider right-to-health issues do. And even if they are closer to the scope of the wording in ICESCR article 12, they cannot be perceived to have a solid legal base. One also could argue that if such essential obligations are not unconditionally guaranteed by the international community, the rights from which they are derived would have to be regarded as purposeless. Indeed, they are no longer basic rights; they are in reality privileges. For example, if the international community were to accept as inevitable that certain populations in the poorest and least developed regions of the world must manage without essential medicines against life-threatening diseases, health cannot any more be perceived as a universal human right. Rather, health would have to be deemed a privilege for the populations in countries that can afford such medicines. This problem came to the surface as the CESCR worked to clearly define the core obligations arising from the right to health. The committee could not help but notice that some countries, irrespective of their willingness to comply, were unable to do so. Therefore, at a May 2000 CESCR session drafting the general comment on health, Paul Hunt, at that time a member of the CESCR and later the Special Rapporteur on the Right to Health, remarked:

“…if the Committee decided to approve the list of core obligations, it would be unfair not to insist also that richer countries fulfil their obligations relating to international cooperation under article 2, paragraph 1, of the Covenant. The two sets of obligations should be seen as two halves of a package.”(24)

The CESCR decided to follow this recommendation, and included paragraph 45 in the final general comment on the right to health:

“For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide “international assistance and cooperation, especially economic and technical” which enable developing countries to fulfil their core and other obligations…”(17)

Interestingly, the commitment to assist both economically and technically is thus confirmed as an essential part of the right to health. Without it the right to health does not exist; it is a privilege. Indeed, coming to terms with this obligation to provide international assistance to facilitate the fulfilment of the right to health in countries left behind, also means to acknowledge the need for a uniform framework of rules to initiate and coordinate the burden-sharing on the donor side, as well as the development of functioning institutions on the recipient side. Such an instrument of harmonization of rights and duties amongst donors and recipients is currently not to

be found within the human rights instruments. However, as mentioned above, it is one of the tenets of Gostin's suggested FCGH approach.

Despite the rather pessimistic outlook on the effectiveness of human rights demonstrated above, there are ways of perceiving the human rights instruments that illustrate their aptitude in promulgating certain kinds of health outcomes. Such recognition can even contribute towards consolidating the idea of a Global Health Convention within the existing international legal framework.

First, by their universal nature and their formal status, human rights implicitly recognize and address the multi-sectoral challenges of the global health arena in a uniform and holistic way. If we, for example, acknowledge that building a resilient health work force is crucial to strengthening health systems, such an approach assumes interaction and cooperation on multiple levels; between civil societies, governments, and international organizations; and between stakeholders in different sectors such as education, health, and finance. Also, a human rights approach to reforming global health assistance (GHA) could instigate positive synergies through interaction in areas where challenges are not thematically associated. For example, introducing a free lunch-meal at schools in impoverished regions would not only improve the health and nutritional status of school children. It would also serve as an incentive for impoverished parents to send their offspring, including females, to school where they can be properly fed. Further, the long-term societal impact of increased rates of female education is multifaceted, and includes better health for their children through breast feeding that goes up, or immunization rates that rise(25). Thus, in addition to health and human rights acting in a mutually reinforcing manner, a human rights approach renders possible an integration of health challenges emanating from areas as diverse as politics, economics, social and cultural affairs, and civil rights.

In the case of GHA, a human rights approach, and especially a right to health approach, can also lead to a more integrative understanding of global health financing: The human rights approach to health more often than not assumes the support of civil society in developing services, and the current GHA more often than not supposes a top-down process where funds are granted after an exclusionary scrutiny by donors. Thus, adopting the human rights mindset in the thinking about challenges to developing robust and sustainable GHA strategies can greatly improve outcomes of investments. Indeed, a Global Health Convention that continues to develop the more integrative human rights mindset will not only represent a consolidation of an existing human rights framework, but also a crucial amendment to global health law. On this background, it also becomes interesting to examine to what degree a convention could contribute towards setting new standards in adjoining areas, e.g. when it comes to establishing accountability structures, reducing cost of delivery, improving access to health care facilities, and the instigation of an enforcement regime. We will return to these issues below.

Conceptualizing the Complexity of the Global Health Arena

In this article, we attempt to conceptualize the convention approach to the global health arena by introducing a simplistic model. The model illustrates a tentatively logical sequence of events, and how a global health convention could impose order on such a system (see figure). However, we also acknowledge the underlying complexity of the global health arena, with self-organizing, tightly intertwined, ever changing, and both linear and nonlinear elements.

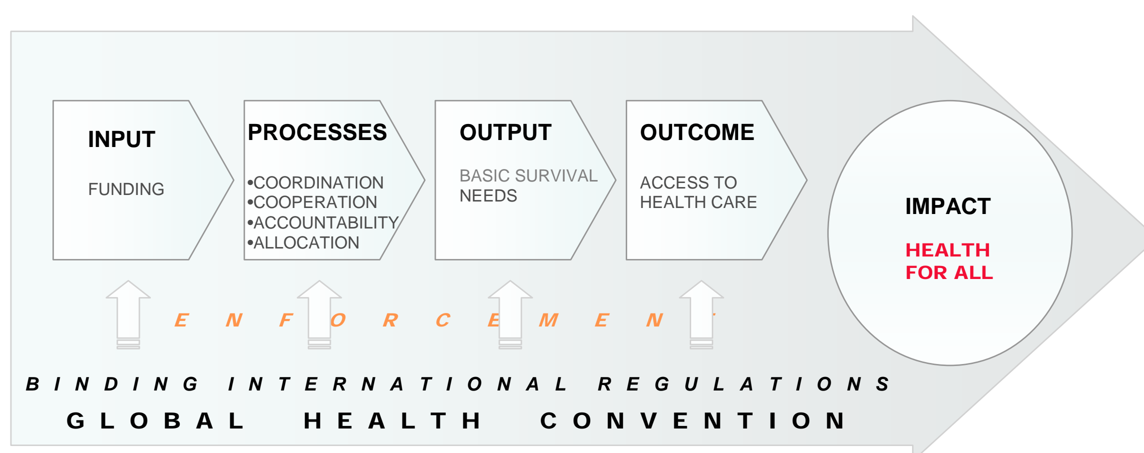


Figure 2: Binding international regulations, i.e. a global health convention, can contribute to structuring processes/elements of the global health arena towards achieving the ultimate goal of health for all.

Thus, the sections below will analyze the following issues in sequence:

- Input –funding for global health
- Processes –coordination, cooperation, accountability, allocation of aid
- Output –basic survival needs
- Outcome –access to health services
- Impact –health for all
- Enforcement

The analysis does not discuss what would be the intended impact of a convention. The impact, health for all, preferably manifest as a general improvement in public health or population health amongst the world's poorest and least healthy people, is rather regarded as a possible emergent quality once binding regulations are in place.

Input

Funding

One of the main conundrums in global health is how to assure sufficient, sustainable and adequate funding for necessary and essential global health investments. Another problem is how to administer the vast sums of money that are already channelled into global health every year. Also, a challenge especially in relation to a global health convention is to obtain enough funds to create, implement and enforce a comprehensive regulatory regime. Mainly the two first problems will be examined in this article.

Global funding for health has increased in the recent years. According to commentators, private and public institutions' combined development assistance for health (DAH) grew from US$5.6 billion in 1990 to almost US$21.8 billion in 2007(6). This increase is mainly comprised of public development assistance which soared from US$4.15 billion in 1990 to just over US$14 billion in 2007(6). In addition, there has been a substantial increase in private funding for global health, which is now regarded to constitute a fourth of all development aid for health(26).

Although there is evidence of increased funding, McCoy at al. argue that there is insufficient evidence to describe the precise volume of expenditures, the sources of this funding, and importantly; how it is managed and spent(26). There is thus still a need for a detailed account of global health funding mechanisms to improve the efficiency, accountability, performance, and equity impact of the many actors that populate the global health arena. Some researchers have even argued that there is a need for a single Global Health Fund to increase and coordinate available resources for health aid; according to Ooms, such a fund could be based on the design of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)(27). Ooms gives ten reasons why a single global health fund would be practical, most importantly that it would:

- simplify bilateral aid relationships and harmonize global health initiatives
- help align health aid with national priorities
- improve long-term reliability of international health aid
- create a “fiscal space” for health
- avoid conditionality as part of obligation for recipient countries
- fight corruption and misuse of funding(27)

In addition, a sustainable funding mechanism could contribute towards this goal through preparing the grounds for sustainable health workforce development(28).

As is evident from this list of advantages, a comprehensive financing mechanism could contribute substantially towards uniform management of global funding for health. Subsequently, such efforts could even spark the development of a more coordinated global health regime that guarantees basic survival needs to the world's least healthy people. It could also be a key factor in coordinating the constructive cooperation of nation states, intergovernmental organizations (IGOs) and non-governmental organizations (NGOs) towards such a legally binding global health initiative. However, a single global fund for health would necessarily have to build on a multitude of already established structures, and would thus represent a major challenge with respect to the cooperation, coordination and final merger of a number of large organizations. Questions could also be raised as to who should govern the fund, how one intends to assure accountability, and how to enforce any binding regulations. From a free market perspective a concern would moreover be the extinction of healthy competition between stakeholders, which could consequently lead to stagnation in innovation and business development. Such issues would need to be analyzed in detail before a final merger could come in place.

It is worth noting that African civil society activists are using the Abuja Declaration as a lobbying tool by pressing for governments to be held accountable to their commitment to spend 15% of their GDP on the health sector(29). Also, the grassroots people's organization People's Health Movement in its 2005 Cuenca Declaration has called upon governments to implement universal health care financing mechanisms, corresponding to at least 15% of the total budget, in all African countries(30). In the north, and especially in Europe, civil society groups with widely differing global health priorities call upon the EU and member states to ensure funding for health official development assistance (ODA) through the allocation of 0.1% of GDP in the case of donor countries, and through a 15% offset from national budgets in the case of recipient countries(31). In the USA, civil society groups call upon significantly expanded investments by doubling U.S. aid for global health to approximately $16 billion per year in 2011(32), a number which, coincidentally or not, represents 1.0 % of U.S. GDP.

According to Gostin, the suggested FCGH could contribute towards financing global health reform by setting attainable goals for global health spending as a proportion of GNP(7). As such, it could come to provide an arena that both facilitates and legitimizes the creation of innovative financial instruments towards global health strengthening, as well as procuring agreed upon principles for sound financial governance. Interestingly, the proposal for a single global fund is rooted in the same idea: creating a common framework for sustainable global health spending. Thus, the idea of a global health convention would be supported by the advent of a single fund and vice versa. The two ideas have different starting points: the need for binding commitments regarding financing versus the need for coordinated investments when funding is secured.

Processes

Coordination

Global health challenges cannot be solved unilaterally by governments, private parties, NGOs, or supra-national conglomerations. In some way or another, at all levels, parties must find ways to cooperate constructively and purposefully. However, existing cooperation within the global health arena is regularly thought to be based on incomplete information, or even withstanding competing interests and goals. It is on this basis that global health can be perceived to be in demand of a powerful new strategy for resource utilization.

Since year 2000 the international society's main response to emerging health disparities caused by a few, but fatal diseases, has been several large global health initiatives (GHIs), e.g. the Global Alliance for Vaccines and Immunization (GAVI), the GFATM, the US President's Emergency Plan for AIDS Relief (PEPFAR), United Nations AIDS (UNAIDS), Polio Plus, World Bank Multi-Country AIDS Program (WBMAP). Such initiatives have rapidly established themselves within the existing international aid network, and have shown remarkable success in raising funds and driving the technical development towards more targeted health interventions. As a result of these disease specific interventions, there has been a continuous incentive towards the development of separate independent health service delivery systems to the detriment of the overall health system and other less well funded programs. Indeed, the issue of whether vertical health initiatives have a detrimental effect to horizontal, or system-wide, health system strengthening approaches is a much debated argument within the field of global health.

Indeed, difficulties with health system performance are perceived to be major causes for the delays in achieving key targets of the health-related MDGs(33). Related to this, Ooms and colleagues state that lacking support for the health work force could lead to a "Medicines without Doctors" situation, where medicines to fight serious diseases are available, but not the skilled health personnel to administer the medicines properly(28). As pointed out by Ooms and colleagues, the outlook towards establishing sustainable funding of much needed health force development looks grim if the GFATM persists to concentrate on three diseases rather than on a wider health systems strengthening approach(28).

Thus, attention should be directed towards efforts to integrate existing vertical initiatives in a horizontal approach, and what benefits this could lead to. In the words of Frenk and Sepúlveda, health is a social value for which all sectors are responsible and accountable, and one should go beyond the traditional stand-off be-

tween the vertical and horizontal approaches by extending the geometry metaphor to search for diagonal approaches:

"–strategies in which we use explicit intervention priorities to drive the required improvements into the health system, dealing with such generic issues as human resource development, financing, facility planning, drug supply, rational prescription, and quality assurance."(34)

Several studies show that the quality of interaction between vertical initiatives and non-targeted health services is crucial(35;36). The current multiplicity of disease-specific initiatives, combined with activities by traditional international organizations (which are a mix of disease-specific and system-wide interventions), carry high transaction costs for developing countries(37). Thus, striving to coordinate the efforts of all stakeholders could instantly benefit the overall health systems strengthening needed to cover basic survival needs. Also, as Hunt and Backman argue, by drawing off resources, vertical interventions can jeopardize progress towards the long-term goal of an effective health system. This problem is particularly manifest by the fact that disease–specific initiatives carry the risk of duplication and fragmentation(38).

Compatibility of existing global health initiatives could thus contribute to assure that aid remains coordinated and purposeful –which in turn would free up resources for further health strengthening. A problem is that most vertical initiatives do not have any immediate interest in coordinating their operations with other stakeholders. Harmonization of bureaucracies and infrastructure would not only eliminate costly duplication; it would also cut down the number of available positions and careers in the health development business. The United Nations Team in Senegal succinctly frames this paradox:

"Everybody wants to coordinate but nobody wants to be coordinated."(39)

On the issue of direct funding, it has been proposed that several of the leading vertical initiatives move towards becoming one Global Fund (see above). Cometto and colleagues suggest that the GFATM and GAVI, in their next board meeting, should expend the review of their architecture to provide increased funding to national health plans, including co-financing non-disease-specific human resources for health(40). The challenges to such a merger are substantial, and balance is difficult to define precisely when the knowledge base is thin and conflicting about how vertical programs may affect horizontal efforts(33). However, a global health convention could provide a tool for stakeholders to reach such a goal. Thus, this issue would be one of the most important, and perhaps difficult, to address under a convention protocol approach.

Cooperation

A fairly common strategy amongst the world's developed nations is to include an element of self-interest when rolling out programs for humanitarian aid and/or health assistance. For governments such interest based approaches represents a systematic way to advance that society's security, political values, and welfare arrangements. Thus, knowledge and consciousness about its own public interests is underpinning any predictable and purposeful foreign policy over time, and also represents a necessary point of reference for other countries when engaging in international negotiation or cooperation. A focus on interests is also crucial to strengthening the ability to prioritize between different needs, strategies and actions in foreign policy.

Advancing a global health convention does not in principle represent an obstacle to such interest-based foreign policy. On the contrary, purposeful and predictable regulations will most likely contribute to strengthening the relationship between countries, and work to alleviate suffering, which in its turn preserves international security, cooperation, and trade. However, when suggesting a legal instrument with the potential to settle international relations, and especially donor-recipient connections, in the global health arena for decades to come, one would be wise to pay particular interest to balancing the interests of the donor and recipient countries.

In the literature, donor countries are often criticized for funding politically popular projects, rather than what is most likely to make an impact on the recipient countries' health status(41). This leads experts to conclude that funding is skewed towards what people in the rich countries want to deliver(42), and in particular towards specific diseases or treatments that give quick and measurable results, rather than on broad bottom-up health systems strengthening(41). And in a desperate attempt to keep the aid flow lines open, at all times and at any cost, host governments in poor countries often simply adopt these policies without paying proper attention to strengthening their existing dysfunctional health systems.

Some authors even go so far as to characterize the impact of aid in Africa as essentially counter-productive:

"What is […] becoming increasingly clear, is that dependency on aid from foreign donors has undermined the development of the basic institutions needed to govern and the vital link between state and citizen."(43)

Consequentially, poor countries that want to improve population health must take ultimate responsibility for the quality of their health systems. This implies that recipient countries should manufacture their own health plans, and thus not accept aid initiatives not fitting into their strategy. By doing so, they could ensure that available resources were used in a coordinated and purposeful manner, while at the same time ensuring that domestic bottom-up initiatives are not displaced or suppressed by ambitious narrow-sector donor programs.

Indeed, Gostin's proposal seems to include the idea of establishing such rules of engagement between donor and recipient countries. One of the key modalities is described as to:

"…establish fair terms of international cooperation, with agreed-upon mutually binding obligations to create enduring health system capacities."(7)

There is no detail on how such fair terms should be established. However, the convention-protocol approach suggests that a bottom-up initiative can help create the political, scientific, and normative space for agreement to be reached(7). Such an approach does not depend on more funds to be injected into deteriorating health systems. It rather grants support to an incremental regime development mobilizing the diverse drivers of health.

Accountability

Establishing globally binding regulations on contentious health issues requires a coherent approach which, in addition to agreeing on basic policy questions and creating innovative finance mechanisms, also includes the establishment of firm accountability structures suitable to guarantee adequate aid effectiveness. As stated in the Paris Declaration on Aid Effectiveness, one of the main issues of scaling up for more effective aid is assured by:

"Enhancing donors' and partner countries' respective accountability to their citizens and parliaments for their development policies, strategies and performance."(3)

Indeed, the notion of accountability covers a variety of concepts:

- donor accountability (towards recipient states, bi- and multilateral institutions in the global health arena)
- recipient accountability (towards donors, and their own citizens)
- country accountability (towards other countries –whether they are donors, recipients or none– as well as NGOs/IGOs, and towards the international society as a whole).

In addition, in civil society there are multiple layers of accountability that run parallel to those purely international responsibilities: society representatives' accountability towards their constituencies at community level(44), national states' accountability towards their individual citizens (and non-citizens), and individuals' responsibilities towards their governments. Not all these aspects of accountability can be touched upon in this article. However, they are important to bear in mind as a successful global health convention initiative would most likely need to establish or confirm comprehensive accountability structures on all levels. We will instead highlight

some of the main principles that are crucial when establishing accountability mechanisms.

In the 2005 High-Level Forum on the Health MDGs best practice principles for global health partnership (GHP) activities at country level were discussed. With relation to accountability the main findings were that:

"As a matter of principle, in order to ensure public accountability, all GHPs should publish key documents on the Internet: annual plans, budgets and performance reports. [...] Funding GHPs should provide timely, clear and comprehensive information on GHP assistance, processes, and decisions [...] to partner countries..."(37)

Thus, two main principles seem to be important: transparency and clarity. This is understandable as they are the prerequisites of any kind of revision by external parties.

Also, a global health convention should gather support for institutions that can enforce accountability mechanisms. One could envision accountability measures to be carried into effect by judicial processes, quasi judicial processes, administrative/policy decisions, and social/ethical obligations, even through the media. A prerequisite for any judicial processes is that there must be a clear legal commitment as well as an instrument that can effectuate decisions. If not, the lack of binding rules will lead to an accountability vacuum. Without legal obligations there are only political processes left, and given this, the provision of aid will in principle be a matter of charity. Also, following the recommendations of Transparency International, the global coalition against corruption, a global convention could serve as a tool for donor and recipient countries to:

"...institutionalise joint and credible enforcement mechanisms that are able to address corruption-related complaints by beneficiaries, civil society and other concerned stakeholders."(45)

Indeed, a transparent and proactive public redress system can inspire citizens to support centralized anti-corruption measures. Thus, by implementing such recommended measures, a global health convention can contribute to reducing the potential for fraud.

Allocation

Yearly, there are vast sums of money channeled into global health; sums intended to redress the basic needs of the world's least healthy population. However, often substantial amounts are spent on administrative efforts in governments, NGOs, and other agencies. Also, large sums of money disappear in outright corruption(45). It is difficult to determine what is the "right" level of administrative spending, and it is also difficult to decide what necessary expenditures are. Indeed, the problems with

cost of delivery are specifically to ensure that the procurement of aid is efficient enough, and to warrant that a larger part of the money is used as intended. In the words of Piva and Dodd, allocation of aid sees:

"…significant imbalances […] which run counter to internationally recognized principles of "effective aid". Countries with comparable levels of poverty and health need receive remarkably different levels of aid. […] Aid is highly fragmented at country level, which entails high transaction costs, divergence from national policies and lack of coherence between development partners."(46)

One could argue that raising taxes, or even introducing new taxation systems where none is available, in developing world countries would contribute with tools to improve transparency in national economic affairs. However, a question is whether people in poor countries would at all find taxation acceptable. Often no social contract readily exists between the governments and the people in many developing world countries, which again make it impossible for a regulator to assert the necessary authority to collect tax money, or even to design the information systems needed to control this kind of activity. Whether a global health convention would be a suitable instrument to facilitate the introduction of reformed national tax regimes, or even grant legitimacy to governments in their efforts to collect tax revenues, is an open question. However, the suggested protocol approach under the suggested FCGH regime allows great flexibility, and also longevity with respect to reaching goals. It is therefore something that could be advantageously explored in the continued work towards a binding instrument.

Similarly, it may seem obvious that flows of aid should be recorded, so recipients can ensure citizen representation and oversight in planning, budget processes, and monitoring public health care delivery(47). But there is no evidence that this happens today.

The most substantial allocation problem, however, seems to be too many aid agencies(48). In practice, the best way of coping with the galloping cost of delivery for recipient countries is thus to lay down a set of national development priorities and ask donors to fit in with their plans. In consequence, recipient countries could decline offers of aid that do not fit into their domestic processes. As stated by The Economist, this hardly ever happens. Neither does the preparation of domestic plans for use of aid:

"The Paris target is for three-quarters of recipient governments to publish development programmes that aid agencies can use. Last year, according to a survey on monitoring the Paris declaration, only a fifth did. Unless that improves, aid is likely to remain badly fragmented."(48)

A global health convention could alleviate such allocation problems by creating an agreed upon aid management regime pertaining to both recipients and donors. Such

a regime could contain unambiguous rules on conditions and terms for the contribution and reception of aid funds.

Output

Basic Survival Needs

One important feature of a global health convention would be to clearly define what constitutes basic survival needs within the global health sphere. A mechanism under the framework convention approach could indeed be that all nations, by ratifying the instrument, were obliged to guarantee access to such basic health services to all individuals. In reality, such provision of basic survival needs implicitly would imply a global implementation of a horizontal health systems strengthening initiative.

Basic survival needs have been defined several times in the literature as well as in international legal instruments. The CESCR in General Comment No. 14 highlights certain core rights that represent a "minimum package" or an "existential minimum". These core obligations include access to health facilities, goods and services, access to the minimum essential foods, freedom from hunger, provision of essential drugs, access to basic shelter, housing and sanitation, and an adequate supply of potable water. Other obligations are reproductive, maternal and child health care, immunization against communicable disease, information access, and appropriate training for medical personnel.

The CESCR definition is supported by the United Nations Committee on Economic, Social and Cultural Rights (ECOSOC¬) which includes immunization, essential medicines, food, potable water, sanitation, disease prevention and treatment, primary health care, and health education as basic survival needs(17). The health related MDGs highlight provisions that reduces child mortality, increases maternal health, and diminishes the burden of infectious diseases(49).

A global health convention initiative would be best served by a focus on survival needs within the most basic areas of health care. As such, it would have to span areas like access to functioning health systems run by skilled medical personnel, vaccination, essential foods and medicines, maternal health care, provisions that reduce child mortality and provisions that diminish the burden of infectious disease. According to WHO, such a "minimum package" could be provided for a cost of $35-50 per person(16).

Outcome

Access to Health Services

In most high-income societies there exists an unwritten, however functioning, societal contract between the government and the people. The people expect the governments to grant a number of basic goods like security, public infrastructure, courts of justice, democratic electoral processes, education, health care, and so on. In response, the people accept the government's authority and power to raise taxes, or to police daily interactions. Thus, for most people living in rich countries access to health care is part of the societal contract. However, as stated by one commentator, no such relationship exists on a global scale(50). Thus, 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.

A tenet of a global health convention would be to provide access to basic health care services to all citizens and non-nationals, irrespective of their legal status, within a country's borders. Logically, a commitment would also be to guarantee international health care services in countries that cannot or will not provide for their own.

This challenges the sovereignty principle, which leaves every state responsible only towards its own citizens, and consequently does not grant states authority to provide services to other states' citizens. It also represents a foreign policy problem for activist states because a number of non-committing nation states likely will respond belligerently towards any foreign initiative within their borders. Questions could also be raised as to what should be national states' obligations towards their own citizens compared to other countries' peoples? And under what circumstances should such international obligations be activated? Also, provision of universal access will lead to a problem in relation to domestic immigration policies. There are already several dilemmas with respect to those who have been denied asylum or citizenship, and provision of health care is a major one. Finally, from a national viewpoint, one could ask what kind of funding would be available for strengthening health care systems abroad. Although most developed nation states are resourceful, it would be a question of domestic policy whether such money could be made available.

Enforcement

In order to be effective, a global health convention needs backing from a robust enforcement instrument. Such an instrument could be an International Court of

Health. Such a court could be specially designed to implement the global health convention and its protocols, thus contributing towards incremental regime creation. Interestingly, the European Convention on Human Rights(51) dictates the rules for an international Human Rights Court, which could serve as a model for an International Court of Health. However, an enforcement instrument within the framework of a global health convention would instantly create an array of problems of political, economic, and practical nature. What should be the mandate of the International Health Court? Where should the money come from? Would the Court's decisions be binding? How should one guarantee the execution of the judgments? Such issues need further discussion.

Convening Authority

We have now discussed the global health convention approach according to our model, and have identified strengths, weaknesses, and some issues that need to be resolved before real progress can be made.

Any regulatory initiative with features as comprehensive as a global health convention would need some kind of shepherding authority for it to come into existence. Both before and after the adoption of a binding regulatory instrument, it would also need a secretariat that harbors advisory capabilities on legal issues, negotiation challenges, and technical questions. In the international arena, sovereign entities like nation states, or federations of states, are obvious candidates to take on such a role. Indeed, the United States and the EU indisputably form the two most dominant players in the global health arena, and might well initiate a global health convention. However, such action would disregard established international procedures on the adoption of international regulatory instruments. It would also run the risk of disempowering countries in other regions of the world by disregarding their particular positions, needs and interests, as well as ignoring any constructive contributions.

Furthermore, there are several intergovernmental conglomerates that could act as conveners for the deliberations on a potential global health convention. Commentators especially emphasize the role of the G8, and conceivably the G20(33). They also argue that into this increasingly crowded area of global health has emerged a new informal and self-appointed entity known as the Health 8 or H8—comprised of WHO, the World Bank, GAVI, the GFATM, UNICEF, UNFPA, UNAIDS, and the Bill & Melinda Gates Foundation(33). Within the trade sector the WTO continues to be the most important agency dealing with international trade and as such. Indeed, trade liberalization will continue to overlap with and compound the protection of human rights and other vital interests, including those affecting labor and health and safety rights worldwide. Such organizations are loosely jointed, and often have

united to fend for interests considerably divergent from health. However, their role as supporting agencies in sector-relevant issues should not be overlooked,.

The World Bank is a considerable force within the health, nutrition and population sector in developing world countries. During the FCTC-process the Bank collaborated with WHO in establishing the evidence base on which the FCTC-regulations could be based(52). However, the Bank suffers criticism for its self-interest and undemocratic processes(53). This, and the organization's role and mandate, make it questionable whether the World Bank could act as a gathering force in facilitating discussions on a global health convention.

The most prominent vertical initiatives are GAVI, GFATM, and UNAIDS. Although operating within different developing countries, and with different objectives, these initiatives are often criticized for their narrow attention towards one specific disease or conglomerate of problems. They are also criticized for being bureaucratic, thus blocking local initiatives by channeling away scarce resources. One would have to expect that several vertical initiatives will have reason to contest the proposal of a global health convention on grounds that a systemic approach comes in the way of their interests. It is thus unlikely that any of them would act as convening authorities for a global health convention.

WHO is the directing and coordinating authority for health within the UN system. Hence, it is an agency within the world's most prominent international network of states. In addition, the World Health Assembly (WHA), where all 193 WHO member states meet to discuss upcoming issues, is the world's foremost health policy setting body, and a mechanism that allows for representation by every country's highest health authorities. This means that any WHO proposal that musters support in the WHA would represent a democratic and deeply founded global endeavour. It would thus be the natural starting point of a global health convention initiative. Indeed, WHO itself has emphasized three main areas of action(54): 1) produce global norms, 2) assist development of systems that impact on health, and 3) support health systems strengthening. Also, some commentators assess that WHO will play a critical role especially in treaty content, consensus building and member state ratification and implementation(55). Given the history of WHO, and including the hopes for the future or the organization, it is possibly the most likely candidate to initiate and coordinate a global health convention initiative. In reality, such a feat would be very difficult without WHO. At the moment it is unclear whether WHO has at all envisioned an instrument like a global health convention for the years to come. An important task for supporters of a convention would thus be to examine more closely the organization's positions and interests in this relation. In addition the proposal for a convention needs to be further elaborated before it is mature, but such an elaboration may also be linked up with WHO. In this respect, considerable support could be gained from academia, think tanks, etc.

Conclusion

The analyses above have shown that a global health convention could be an appropriate instrument to deal with some of the intractable problems of global health, namely to (co-)create a sustainable funding mechanism, coordinate stakeholders, control the allocation of aid, define basic survival needs, and provide access to health services. We have also shown that some of the most important problems preceding a convention approach might be to muster international support for supra-national health regulations and negotiate compromises between existing stakeholders in the global health arena. There are several remaining challenges and issues that need to be addresses and discussed before setting up a more formal process. It is reason to believe that WHO could take a coordinating role in these further discussions, and that this can be done without making any commitments to whether or not a convention approach should be realized. However, if the proposal for a global health convention should manage to obtain substantial international support, and particularly through the WHA, WHO would most likely be the natural convening authority for the formal initiation and coordination of the adoption processes.

Need for further Discussions

The report has supposed that nation states are the likely signatories to a global health convention. However, because of the immensity of the task, it has not analyzed the context specific circumstances that would make a global health convention desirable or not for candidate countries. Also, it has not discussed whether there are other subjects in the global health arena that could potentially commit to a convention text, e.g. private enterprises or non-governmental organizations. In addition, the report has assumed that the health sector is closest to promote the adoption of a convention. It could, however, be argued that other state/public sectors should play central roles, e.g. the foreign policy(56;57), educational, judicial, or trade sectors.

Analyzes have shown that WHO is the most likely candidate to act as a convening body for further discussions, and eventually the initiation and execution of a convention adoption process. A discussion paper analyzing what WHO has done so far regarding a global health convention should thus be developed. Such analysis could

concentrate on any resolutions and decisions pertaining to the idea of universal access to health made by WHO in the last decades. Also, a discussion paper analyzing the potential for constructive and efficient division of labor between other existing stakeholders should be included in this. Such a text should contain analytic tools to define who the relevant parties to a convention are, and which sectors of society should be included in future discussions. The discussion papers should be circulated between all interested parties so that a structuring of the process could be as high-quality and as agreed upon as possible. Input from future potential parties to a convention would be the most important, and is best secured by an open and inclusive environment.

For a subsequent negotiation phase on the adoption of a convention, the main challenge will most likely be to create the right balance between the positions, interests and needs of the parties involved. The interests of the developing world will be clearly set against those of the developed countries, the rich against the poor. Another easily identifiable conflict could be the turf wars between existing stakeholders, e.g. vertical global health initiatives. Thus, including parties in integrative and constructive discussions on principles and crucial issues during an integrative bottom-up process grants both time and place to the all important empowerment and mobilization that this process demands. A framework for such a negotiation process should thus set in place powerful mechanisms to explore parties' positions and interests, as well as timely inclusion of legal advice whenever there is need to explore whether any emergent issues could create legitimacy problems. It should also include a set of agreed upon impasse breakers, as well as incentives to reengage in negotiation if breakdowns occur. A negotiation phase could moreover be exploited to explore the issue of purpose and goal of a convention initiative. Consensus about purpose could soon prove to be the driving force that carries the process forward. In fact, initial informal negotiation on such issues could seamlessly be developed into more committing cooperation on the concrete contents of a framework convention text.

The financing of further steps towards the adoption of a binding instrument is a crucial point, and must be discussed by supporters of a global health convention. Investigations should be done into how an initial brainstorming process and the first gathering of potential convention parties to elect a formal secretariat could be financed. It cannot be assumed that any institution or state alone will be able to raise all the funds needed. Also, supporters should study experimental sources of funding for global health that have been developed during the recent years, and continue to develop credible models whilst considering how to finance a comprehensive system of binding international regulations.

One example of an innovative financing model is the UNITAID initiative on taxing of plane tickets. Through its implementing partners, UNITAID now channels its funds to purchasing tests and medicines of assured quality and ensuring fast deliv-

ery to the patients who most need them, especially those in low– and middle–income countries. Another example often referred to is the Tobin tax. The suggested tax on all trade of currency across borders is intended to put a penalty on short-term speculation in currencies. A third proposal for sustainable funding is to make WTO membership conditional of contributions towards global health investments(58).

Immediate Developments following the Report Initiative

In December 2009, after reading the first draft of this report during a peer-review process, Professor Lawrence Gostin at Georgetown Law invited the authors to publish the essential content of this report in a special symposium edition of the US *Journal of Law, Medicine and Ethics* (JLME) especially concerned with the idea of a global health convention. A peer-reviewed and updated article text was submitted to the editor of the JLME in March 2010, and will be published in July 2010.

In March 2010 the Norwegian Directorate of Health, in cooperation with the Knowledge Centre, held a one-day workshop on the issue of a global health convention. The workshop gathered more than 30 distinguished participants from several countries, comprising stakeholders from the government sector, IGOs, NGOs, and private enterprises. The aim of the workshop was to present and discuss the premises as well as the most important findings of the report, thus providing an arena for an extended peer-review process as well as experienced feedback.

One outcome of the workshop was a report on all the discussions throughout the meeting. Another important result was a concrete proposal for a global health governance project following up on some crucial areas of global health governance that had been touched upon in the report. Such a project was suggested to build on a broad consensus around six major themes that are separate, but interrelated (see Panel). Each should include a stakeholder representative process where governments, civil society, NGOs, and private business can take part. Particular challenges are of political, legal, economic, and social nature, and exist both interconnected and overlapping in the real world. Thus, they are all in need of a systemic approach. The proposed work streams will provide an opportunity to analyze the challenges from a variety of perspectives, both separate and in relation to each other.

Panel 1: Proposed work streams of a Global Health Governance Project

1. Health as a human right – Where has a human rights approach taken us, how far can we still go and what is there still to harvest? What are the limits of a human rights approach, and what could be done instead?

2. A core/essential health benefit package – What should a Minimum Essential Package contain for all individuals? How could it be expanded when resource levels are expanded? How should it be defined?

3. National obligations to health – What should countries provide to their own populations, and how should it be assessed? Are national obligations defined by resource level/financial contribution to health (input), the provision of a minimum set of health services (output), or the achievement of a certain population health status (outcome)?

4. International obligations to health – How can a "global social health insurance system" be conceptualized? How can we move beyond aid-concepts and capture the idea of redistribution, and structuring the global burden-sharing?

5. Coordination and leadership within the global health arena – What are the roles of the state, private actors, NGOs and other existing stakeholders?

6. Processes for establishing clearer Global Health Governance – How can these discussions be continued and elaborated? How can different stakeholders play a role?

It was concluded that it was reasonable to expect that the proposal would be supported by different organizations. Indeed, as next steps it was suggested to publish a Lancet Viewpoint article announcing the project, and subsequently to engage in an open process with WHO regarding analyses and recommendations with respect to the future.

At a Senior Strategy Meeting running from April 14-15 2010 the United Nations General Assembly (UNGA), including distinguished specialists on global health issues, discussed a Joint Action Plan: Delivering Maternal and Child Health: A Call to Action, A Decisive Move to Improve the Health of Women and Children. The action plan represents a direct effort to fulfill the MDGs 4 and 5, as well as 1c, 3, and 6, that are all related to women and child health. Thus, over the next six months this effort will most likely take centre stage in the global governance debate. Consequently, it should also necessarily be the centre of gravity for any emerging global health governance project arising from the discussions during the March workshop on global health in Oslo.

The parties present at the March meeting in Oslo are currently circulating a document describing more closely the title and content of the proposed global governance project. An underlying insight driving the initiative forward is that the process of developing new ideas and concepts within the framework might be just as important as reaching more or less mature conclusions; indeed important outcomes might, expected or not, result from the course of action currently on its way.

Appendix

Global Health Definition. A New Global Health Paradigm?

Global health is a concept which in the recent years has provoked a lot of interest from both academics, politicians, celebrities, and the media. But alongside its alluring qualities, and its frequent attention in both daily press and academic literature, comes that the term is slippery. Perhaps for this reason it is also rarely defined. In attempts to operationalize the global health concept, many stakeholders have benevolently offered their own definitions. WHO in its mandate offers a brief and simple definition(59):

"[...] health is a shared responsibility involving equitable access to essential care and collective defence against transnational threats".

The word global is not embedded in the definition, but a natural inference from the context in which the word health is used, clearly insinuates a global scope. Of course, such a brief and simple text cannot fully elucidate all the ramifications of the global health conception. Although it insinuates an international shared responsibility for access to essential health care goods, it does not contribute to clarifying potential differences in priorities, strategies, and objectives. Indeed, as argued by Koplan and colleagues(60):

"...global health can be thought of as a notion (the current state of global health), an objective (a world of healthy people, a condition of global health), or a mix of scholarship, research, and practice (with many questions, issues, skills and competencies)."

On this basis the call for a more comprehensive explication of the global health institute is clearly evident. Thus, Kopland and colleagues go on to explore the reasoning behind the definition of global health, as agreed by a panel of international multidisciplinary experts.

First, they explain and compare the traditional domains of public versus international health, which are both closely related to the term global health.
Accordingly, they point to a viable definition of public health that was suggested by Winslow almost a century ago(61). It mainly emphasizes the promotion of physi-

cal health through the prevention of disease as well as the prolonging of life through community efforts, including sanitation of the environment, control of infectious disease, education of the individual, and organization of medical and nursing services.

Their definition of international health, as cited from Brown and colleagues(62), seems to be somewhat more dynamic in that it has been used plainly to describe health work abroad, with a geographic focus on the developing countries, and especially on the management of infectious and tropical diseases, malnutrition, water and sanitation, and maternal and child health.

Global health, they further argue, has areas of overlap with both public and international health. All three entities share characteristics like: priority on a population-based and preventive focus; emphasis on poorer, vulnerable and underserved populations, multidisciplinary and cross-disciplinary approaches; focus on health as a public good and the importance of systems and structures; and the participation of several stakeholders.

In addition, they stress that the word global should relate to any health issue that concerns many countries, not regarding its current location. Therefore, like public health, and unlike international health, global health can focus on domestic as well as transnational health disparities. Global health also has to encompass the full spectrum of important health threats, and keeping in mind that burden of illness should be used as a criterion for global health priority setting. How the burden of illness is to be measured, is not made explicit, but from the context is seems probable that especially quantitative aspects are to be given priority (HIV, tobacco, malaria, tuberculosis, deaths due to motor vehicle accidents, under and over nutrition).

They note that the transition from international to global health has run parallel to a shift in attitude that allows for a real transnational partnership, and a two-way flow between developed and developing countries. Global health thus utilizes the resources, knowledge, and experience of diverse societies to address health challenges all over the world. Finally, in pointing out that global health is also a truly interdisciplinary field, encompassing the prevention, treatment and care, they offer the following definition:

"...global health is an area for study, research and practice that places a priority on improving health, and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care.

In practice, this definition implies a globally shared responsibility to provide health as a public good through an extended number of initiatives, especially study, research and practice. Important to all areas will be the pursuit of political and dip-

lomatic solutions to existing challenges with international collaboration, corruption, and health system strengthening.

But, as Ooms intervenes, the trans-national solidarity that exists to promote the health of all people is limited, and most often intended to be temporary –a fact that represents a rejection of the globally shared responsibility for the health of all people. On this basis, he claims that a new Global Health paradigm, if indeed it exists broadly accepted as a concept, it is still in its infancy(27).

However, it is within this emerging area of consciousness about our international interdependence, regardless of a problem's geographic location or type of disease, and bearing in mind the globally shared responsibility to provide health as a public good, that it becomes desirable to explore the potential of a global health convention. At the same time, by acknowledging that there has been a paradigm shift from the predominantly interest based and individualistic world of international health towards a more value based and integrative world of global health, this should give incentives to think creatively about health challenges. Global health thinking perhaps represents the centre of gravity towards any successful future health initiative should orient itself. In this respect, one important tool to carry global health care into effect might very well be a FCGH.

A Complex Systems Perspective on Global Health

Any initiative aiming to deal with systemic problems on a global scale will necessarily have to take into account the problem of uncertainty in complex systems. Uncertainty about consequences is not only an important feature of the global health landscape, it is a defining quality. So many variables are involved in the relationships that have contributed to forming that landscape, and to reforming it on a daily basis, that it is simply impossible to predict precisely the outcome of any actions.

According to a WHO Flagship Report, such complex adaptive systems, including health systems, have a number of features in common; they are sensitive to even the tiniest of influences, and profound change can occur as a result of these, they are thus non-linear in a way that output is not proportional to its input; they are also self-organizing in such a way that system dynamics arise spontaneously from internal structure; they are constantly changing in that they adjust and readjust at many interactive time scales; they are tightly linked, which means that change in one subsystem affects the others; and they are governed by feed back in a way that a response to an action may alter the intervention or expected effects(63).

From the world of economics, an illustrating opinion by Alan Greenspan, on the constantly evolving systems of macroeconomics, states that:

"Despite the extensive efforts to capture and quantify [...] key macroeconomic relationships, our knowledge about many of the important linkages is far from complete and in all likelihood will always remain so. Every model, no matter how detailed or how well designed conceptually and empirically, is a vastly simplified representation of the world that we experience with all its intricacies on a day-to-day basis. Consequently, even with large advances in computational capabilities and greater comprehension of economic linkages, our knowledge base is barely able to keep pace with the ever-increasing complexity of our global economy(64)."

As the financial melt-down in 2008 made abundantly clear, Greenspan was not even barely able to keep pace with the complexity issues of the global economy. Accordingly, it is apparent that any analytic models for the world of global health will display the same shortcomings in predicting results. No-one can expect global health systems to respond linearly, or predictably, to any initiative. As the editor of The Lancet puts it:

"At present the gestation of Global Health involves the chaotic tumbling, rumbling and knocking together of ideas and aspirations(50)."

Or even:

"Perfection might take some time [...] [within] [...] the broad, sprawling, undisciplined, irritable, fractious, chaotic, divided, competitive and sometimes maddening community that is global health[...].(50)"

The following analysis is thus an unreasonable approximation of how one can expect the global health field to behave given any small or big scale intervention. Natural systems have a tendency to change in a bottom up manner; all profound change is a result of many small fluctuations at ground level. As such, our task to analyze the facts surrounding a global health convention cannot be relied more upon than any macroeconomic analysis.

However, if this is indeed the time for a paradigm shift within the global health arena, a framework convention initiative could be just one of those key factors that have the potential to facilitate big scale change. In other words, if there is a new centre of gravity in global health, new and perhaps surprising solutions will eventually appear as a result of the joint efforts of the world.

The all-encompassing nature of a Global Health Convention would probably make it rival any other global convention in terms of complexity and in terms of the commitment it requires. Its global nature would also make it unique measured in impact on socio-economic development, health provisions, and global security. An operative convention on basic global health issues would thus have profound implications both for the people in need, and for the states that would eventually have to grant

the support. This work therefore truly requires global commitment and global solutions. As Gostin argues:

"...the solution is simple in concept, but extraordinarily complex in reality. It requires a stable commitment of resources over the long-term that is modest compared with existing commitments in other spheres. The resources committed, moreover, must be directed toward genuinely effective interventions to meet basic survival needs. All this requires setting priorities, coordinating efforts, fostering public/private partnerships, and helping poor countries take ownership of policies and programs in a competent and transparent manner(7)."

This report makes an attempt to reduce the complexity of adopting a Global Health Convention into a rather simplistic model where different events follow as a result of each other, and as a result of the underlying structure that is granted through binding international regulations.

The model represents a conceptual framework within it is possible to visualize and analyze some of the most important strengths, weaknesses, opportunities and threats related to the adoption of a Global Health Convention. It is not meant to serve as an example of a strictly logic design after which a regulatory initiative should be modelled, but rather as a chain of events where the different events are tightly intertwined, ever changing, and self-organizing, and containing both linear and non-linear elements.

Thus, the report analyzes the basic tenets of a Global Health Convention with the aim of defining more precisely the rights and obligations that should follow from such an initiative. The analysis starts with a view on the structural element itself, namely strengths and weaknesses of binding international regulations. It then goes through all the other issues, commencing with Input and ending with Compliance. Interestingly, our analysis does not discuss in detail what would be the intended impact of a regulatory initiative. The Impact, health for all, preferably manifest as a general improvement in public health or population health amongst the world's poorest and least healthy people, is rather regarded as a possible emergent quality once all, or some of the measures in the process are subsisting in collaborative and mutually reinforcing relationships. As such, a regulatory initiative following our conceptualized process would have an opposite starting point (preferably a bottom-up strategy) e.g. compared with the Human Rights regulations.

The Body of Global Health Law

The contending global right to health must be regarded as a result of the combined global health regulations which are already in existence. Thus, to examine some of the challenges which could be expected in the process of adopting a global

health convention, it is useful to analyse the some of the main binding regulatory instruments already existing in the global health arena. Also some other regulatory initiatives of current interest, most notably the adoption of a climate convention, can illustrate certain problems regarding international policy.

It is worth noting that the framework convention approach of recent has served as an essential strategy in a number of other international legislative initiatives, especially the recent WHO regulation on tobacco control. Although the Framework Convention on Tobacco Control (FCTC) was lauded as a milestone when it entered into force in February 2005, there is still a long way to go to achieve full implementation of the treaty, and an even longer way to do something about the problem itself, namely to reduce the prevalence of smoking(65).

The experiences made after the FCTC's entry into force show that many of the ratifying countries are trying hard to limit their obligations. Even the prospect of raising money for a permanent secretariat, that according to the convention should be an advisory organ on commencement matters as well as on funding challenges for poor countries, has tuned out to be a controversial issue(66). Thus, there exist understandable fears that the FCTC will not deliver what it promised. And in the face of such failure, the risk is that much will be lost within the field of global health. Worse than the bereavement of the ground breaking results achieved in the fight against tobacco related disease, would be the surrendering of belief in international health issues' cooperation, and a consequential deterioration of WHO's authority as a global legislator. If this was the case WHO would face great challenges if it were to serve as the legislative body for a global health convention. And any other organization trying to follow in its place would face the same concerns about accountability and enforcement.

The framework-protocol approach, notably, has also been used in issues pertaining to climate change. The Framework Convention on Climate Change, which aims to reduce greenhouse gas emissions to the atmosphere, is perhaps the most prominent example. Its 1997 Kyoto protocol sets binding targets for 37 industrialized countries and the European community for reducing greenhouse gas emissions. This protocol, however, has not been ratified by a highly polluting state like the USA. Even rapidly developing polluters like China and India are largely exempt from the core obligations. Interestingly, this development illustrates one of the main problems of international legislative cooperation; the issue of gaining support from states. And often, those who are most to blame for a negative development are the ones most reluctant to comply. In the case of a global health convention, questions could be raised whether influential states would find it acceptable to commit to binding rules which would commit them in terms of yearly spending over the health budget.

One other initiative where WHO has played an extensive role, however not explicitly utilizing the framework-protocol approach, has been the international regulations on public health risks (IHR). The purpose and scope of the IHR (2005) are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade(67).”

Notably, the updated and amended IHR (2007) bring about numerous innovations(68), most importantly: (a) an extended scope covering any illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans; (b) State Party obligations to develop certain minimum core public health capacities for surveillance and response; (c) obligations on States Parties to notify WHO of events that may constitute a public health emergency of international concern according to defined criteria .

As such, the IHR (2007) go a long way in confirming WHO’s status as an influential player on the global health scene. However, when assessing the organization’s status it is important to take into the account that most of the legislative work happened at a time when the SARS epidemic was regarded an overhanging threat to the health of all, as well as an obstacle to international trade and commerce. As Gostin argues, the IHR was never intended as a vehicle for improving health in poor countries. Its raison d'ê•tre is to control the international migration of diseases. And since most serious infectious diseases move from the Southern to the Northern Hemisphere, richer countries stand to benefit much from the regulations(7).

The participants in the area of workers’ rights has a long tradition of reverting to international legal instruments as a way to regulate relationships, and is thus, on the basis of this experience, also interesting for the global health field. The International Labour Organization (ILO) has since 1919 sought to define and guarantee labor rights and improve conditions for working people by building a system of international labor standards expressed in the form of conventions, recommendations and codes of practice. And the regulations, some even safeguarding workers’ human rights and health, have been relatively successful; the ILO has adopted more than 180 conventions and 190 recommendations covering all aspects of the world of work(69). The reason for this success cannot be clearly stated. One reason might be the tripartite structure of ILO, with employers, workers, and authorities present at the negotiation table. Another explanation could be an inherited belief in the rule-of-law as a protection for workers against the exploitation by employers. Some have also argued that the ILO can thank itself because of its willingness to learn successful strategies from other international organizations as well as from its own history(70).   However, although there have been a significant numbers of ratifications of some instruments, many ILO conventions have not attracted large numbers. Some of these include legislation that many would hold to be of great importance.

Most notable in relation to the issue of global health is the ILO Convention No. 102 which outlines set of minimum standards for the social security arena. Its article 10 grants the following benefits for prescribed employees and their next of kin in case of morbid condition; general practitioner care, including domiciliary visits; specialist care; pharmaceutical supplies; and where necessary, hospitalization. Also, in case of pregnancy, pre-natal, confinement, and post-natal care by medical practitioners or midwives is granted. According to the ILO, applying the convention avoids inequities in access to health services between formal and informal economy workers, and between the rich and the poor(71). However, the convention is only ratified by 45 countries, and a number of the important ones —in terms of economic strength and sizable working populations—continue to be non-ratifiers. As with a potential global health convention, important questions will apply to these non-ratifiers with relation to what they are actually committed to.

Emergent Global Health Developments

Introduction

The last twenty years have seen dramatic shifts in power between the stakeholders who share interests in international health issues. In the early1990s the development assistance for health was controlled by the UN system and bilateral development agencies in donor countries(72). Today, donor countries have kept their position. However, the efforts of the UN system seem diluted by effect of a multitude of new entrants into the global health arena. As formulated by Reich and Takemi:

"Policy making in global health has become a multi-stakeholder process, but without an explicit institutional process and with competition and confusion both globally and nationally(33)."

Alongside the established human rights instruments, which are discussed elsewhere in this appendix, the most prominent initiatives of the global health arena are the MDGs, the PDP, and the AHLF. The PDP is generally recognized as a significant juncture in the history of development assistance and cooperation(73). However, it has not worked in the intended way; there is still a serious gap between the rhetoric of ownership and practices on the ground. In many aid-receiving African states donors still have the last word in decisions regarding questions on how aid is spent, and the conditions that are attached to its release(74). Even the AHLF follow-up has proved of little value so far. Also the obligation to reach the health related MDGs by 2015 is off track(40). Maternal mortality has remained unchanged for two decades(75), child mortality is not declining to the rate intended(76), and HIV/AIDS still infects people faster than antiretroviral treatment can be disbursed(77).

Thus, in addition to a global health arena which seems over-crowded with good intent, there is too little coordination of efforts in aid-receiving countries. The funds that are annually disbursed, approximately $ 25 billion, could be spent to a lager effect given that the negotiated principles from the PDP and the AHLF were followed. It is on this basis it becomes interesting to explore what could be achieved through a coordinated, purposeful global health strengthening effort through binding regulations, and especially in the light of other current emergent initiatives in the global health arena. Indeed, a global health convention could provide a framework for the stepwise adoption of binding rules through protocols. By assuring reliable funding as well as fair and transparent processes throughout such protocol negotiations, a coordinated response to the world's health problems could be mounted. Before negotiations regarding a convention initiative can begin, it is however necessary to survey the prevailing trends within the global health arena, as well as institutions and existing regulations.

Social Determinants of Health

According to WHO, the social determinants of health are:

"…the conditions in which people are born, grow, live, work and age, including the health system(78)."

Indeed, these conditions are regularly influenced by the distribution of wealth, power, and distribution of resources at all levels of society. The latter factors are again shaped by the political, social, and economic forces under which people persist. When examining the distribution of health in any population, it becomes obvious that there exists a social gradient with respect to burden of disease: the higher the social position, the better the health(79). Accordingly, people in poor societies carry a disproportional burden of disease. A recent report by a WHO Commission, commencing on the proposition that differences in life expectancy are not biologically explained, calls for the health gap to be closed in a generation, a feat that would reflect that action –socially, politically, and economically- would lead to dramatic narrowing of the health differences between and within countries(80). Although these claims for improved social determinants of health by definition trancends the proposed FCGH's aim to provide basic survival needs for the worlds poorest, both initiatives ultimately have the same goal; improving life expectancy and quality of life where needed most. As such, efforts to achieve one of the above will reinforce the other. Stakeholders in both fields would thus do wisely in joining forces; which is again an argument for increasingly unified efforts, e.g. through the adoption of a global health convention.

Health Systems Strengthening

No consensus exists pertaining to what should be the operational definition of health systems strengthening. However, it is widely recognized in the international community that weak health systems present a critical barrier to the world wide provision of basic health services. Some commentators even consider difficulties with health system performance major causes for the delays in achieving key targets of the health-related MDGs(33). Indeed, weak health systems inevitably represent a liability for poor people; bad hygiene standards regularly lead to the spread of infectious diseases, lack of sterilizing equipment can facilitate the spread of blood-borne diseases like HIV/AIDS, and lack of funding or infrastructure can result in loss of skilled personnel to higher remunerated positions in the developed world. Strengthening health systems is thus a crucial in improving the health of the world's poorest. As stated by Gostin:

"There is little doubt that the single most important way to ensure population health is to build enduring health systems in all countries. [...] If the vast preponderance of international assistance went into helping poor States develop and maintain health systems, it would give them the tools to safeguard their own populations(7)."

Thus, the world wide strengthening of health systems in a bottom-up manner would be one of the main areas that a global health convention would have to deal with. The latter is confirmed by Gostin. He argues that one main objective of a FCGH would be to create:

"...agreed-upon mutually binding obligations to create enduring health system capacities(7)."

However, with increased interest in strengthening health systems, the world of recent has been confronted with a multitude of models, strategies, and approaches to improve activities. The question is how one should assess these different conceptual models, or even select an appropriate one. In line with what is the case for basic survival needs, no one method exists for strengthening health systems that can be applied to all countries(33).

WHO presents its updated approach to health-system strengthening in a report entitled Everybody's Business. However, this report does not provide a clear definition or boundary for a health system. Indeed, the report states

"There is no single set of best practices for health-system strengthening because health systems are highly context-specific(81)."

However, some of the lessons learnt about different nations' health systems' interaction with international health-aid initiatives, are summed up by The World Health Organization Maximizing Positive Synergies Collaborative Group in a report

assessing interactions between global health initiatives and country health systems(44).

The Group has identified five points of interaction between global health initiatives and country health systems; namely governance, finance, health workforce, health information systems, and supply management systems. An additional point of interaction has been deduced from the interaction between all those fields, and it has been categorized as the delivery of health services. The group ends up making five recommendations for international policy makers:

1) Infuse the health systems strengthening agenda with a sense of ambition and speed that has characterized the GHIs
2) Extend the targets of GHIs and agree indicators for health systems strengthening
3) Improve alignment of planning processes and resource allocations among GHIs, and between GHIs and country health systems
4) Generate more reliable data for the costs and benefits of strengthening health systems, and evidence to inform additional and complimentary investments to those of GHIs
5) Ensure a rise in national and global health financing, and in more predictable financing to support the sustainable and equitable growth of health systems

This strategy of learning from GHIs health strengthening initiatives, both their strengths and weaknesses, should be paid close attention to during the design of a Global Health Convention. It represents somewhat of a "best practice" example, and meets some of the challenges that the harmonization of vertical health initiatives within the framework of a global health convention most likely will offer.

Chen and colleagues argue that a cornerstone issue pertaining to health systems strengthening to alleviate the health crisis in the poorest countries in the world is the continued effort towards strengthening the health work force(82). According to the authors the health workforce in poor countries is continuously threatened by diseases like HIV/AIDS, out-migration, and insufficient investment. In this respect, Ooms and colleagues state that without support for the health work force this could lead to a "Medicines without Doctors" situation, where medicines to fight serious diseases are available, but not the skilled health personnel to administer the medicines properly(28). To invest in increased health worker training capacity, and the actual training, as well as increased health worker retaining incentives, a country has to maintain a certain level of financial viability. This is both to be able to carry through with long term projects (educating a physician takes 4-7 years), and to avoid subsequent "brain drain" as a result of not being able to guarantee competitive salaries. As pointed out by Ooms and colleagues, the outlook towards establishing sustainable funding of much needed health force development looks grim as the GFATM persists to concentrate on three diseases rather than on a wider health sys-

tems strengthening approach(28). Also, official GHA currently plays a subdued role in health workforce strengthening. The World Bank even admonishes countries using GHA to improve their health workforce that the:

"...volatility [of GHA] makes it an unreliable source of funding for permanent increases in recurrent expenditures(49)."

As stated by the World Bank, for increased health workforce expenditures to be sustainable there is a need for financing from both domestic and external fronts(49). It is at present an open question where such funds should come from, or even how they should be coordinated. However, given that one of the goals of a global health convention would be to contribute with a framework that works towards the long-term sustainability and coordination of official GHA, a very important premise for a comprehensive health systems strengthening would be in place.

The World Bank's own approach to health system strengthening is described in its 2007 strategy document on healthy development. The document recognises that the World Bank needs a collaborative division of labor with global partners(83). These include WHO, UNICEF, and UNFPA, which are viewed as providing technical expertise in areas such as disease control, human resource training, and service delivery. The World Bank considers its comparative advantages as broader systemic issues, especially health financing and health economics, as well as public–private partnerships, public-sector reform and governance, inter-sectoral collaboration for health, and macroeconomics and health.

A major challenge for the World Bank is thus to implement its strategy, at a time when the Bank's own financing is becoming a smaller proportion of global health funds. Especially, the often deep-pocketed GHIs tend to provide a full range of health services, often competing in those where the World Bank sees its areas of expertise.

In addition, some of the substantive challenges in global health regularly encompass more than what can be delivered through what the World Bank regards as its comparative advantage. For example, the Bank has little to offer when confronted with questions about the epidemiology of infectious disease, or the adequate training of medical personnel. Thus, one can understand that the Bank acknowledges its dependence of other stakeholders in global health. Importantly though, as the traditional focus is of the World Bank is on broader systemic issues, it would have the potential to offer very valuable advice on financing questions, private-public partnership, and health governance related to a global health convention. As such, it could reinforce its position as a major stakeholder in the global health arena.

Efforts by WHO and the World Bank represent just two approaches; other frameworks also exist. Drawing upon their experience, authors Hunt and Backman have

on the basis of ICESCR article 12 and relevant policy documents outlined the general approach to the right to the highest attainable standard of health towards the strengthening of health systems(38). They initially argue that there is always a risk that health systems become impersonal, "top-down" and dominated by experts. Accordingly, as a WHO publication concludes:

"...health care and health systems must embrace a more holistic, people-centred approach...(84)"

Hunt and Backman argue that the ICESCR Article 12 also has a health systems perspective. In their opinion, the right to health towards the strengthening of health care systems encompasses the following assets:

- The well being of individuals as well as communities and populations
- Not only outcomes, but also processes –not only what a system does, but how it does it
- Individual access to all necessary health information
- Participation in issues bearing upon the individual's health
- Equity, equality and non-discrimination
- Respect for cultural difference
- Medical care and the underlying determinants of health
- Progressive realization and resource constraints
- Quality –all health services must be of good quality, not only recycled from rich to poor
- A continuum of prevention or care with effective referrals –primary, secondary, tertiary
- Coordination of a range of public and private actors at national and interna tional level
- Monitoring and accountability

Again, such an extensive interpretation of ICESCR article 12 is legally dubious. And most likely such an understanding cannot be enforced by any court of law. However, the examples above might very well serve as a guideline to which topics should be discussed under a convention initiative.

Private/Public Partnerships

The Global Health challenges cannot be solved unilaterally by governments, private parties, NGOs, or supra-national conglomerations. In some way or another, at all levels, the parties mentioned must find ways to cooperate constructively and purposefully. Such cooperation is already a fact in a great number of instances, and this deliberation is thus not meant to represent the discovery of a new success criterion. However, the existing cooperation within the global health arena is regularly thought to be based on incomplete information, or even withstanding competing interests and goals. It is on this basis that global health can be perceived to be in de-

mand of a purposeful new strategy for constructive cooperation and better utilizing of resources. Thus, according to Gostin, one of the key modalities of a FCGH would be:

"...to stimulate creative public/private partnerships and actively engage civil society stakeholders(7)."

And, accordingly:

"It is not simply the amount of money spent that is important, but how those resources are invested and used. This requires a structured approach that sets priorities, ensures coordination, and monitors results(7)."

Gostin does not delve into what concretely a FCGH could contribute with in respect to ensuring constructive cooperation. However, according to WHO, in countries where external assistance contribute with an essential part of the health system's resources an important expansion of this approach to policy-making and implementation is represented by sector-wide approaches (SWAPs). The main function of SWAPs is that:

"...under government leadership, a partnership of funding agencies agrees to work together in support of a clear set of policy directions, often sharing many of the implementation procedures, such as supervision, monitoring, reporting, accounting, and purchasing. [...] Health planning thus shows signs of moving beyond investment programming and towards consensus statements on broad lines of policy and system development(85)."

Thus, a global health convention could contain procedural rules on how to achieve consensus-based statements within health systems strengthening and health policy development. It could also contain provisions on how governments are to work with private providers on public health related activities, such as the provision of basic survival needs.

However, as one author points out, improving public policy toward private health care providers in developing countries requires new and expanded analysis –to assess the current role of the private sector, and to evaluate the effectiveness of instruments for working with them(86). Indeed, dialogue with the private sector is critical, both to identify any obstacles or assets pertaining to the implementation a Global Health Convention. Therefore, any regulatory initiative must be based on a clear cooperation strategy for every key modality, and especially those meant to cover basic survival needs.

Global Health Funding

In the summery of his paper on global health politics, Fidler plays a sombre note with respect to expectations within the financial field:

"In 2008 global health's political revolution [...] ended when four global crises damaged global health and altered the political, diplomatic, and governance contexts in which global health activities operate. The climate change, energy, food, and economic crises revealed limitations in global health's ability to shape large-scale political, economic and environmental problems that adversely affect health or harm underlying determinants of health(87)."

The financial melt-down at one point seemed like the end of the world as we know it. But in hindsight of the tumults, it appears clear that most of the devastating consequences that pessimists feared did not happen. However, within the field of global health, it was once again made clear where the priorities of rich countries lie. As argued by Fidler, the above mentioned crises not only generated new health risks, but also exposed fragilities in the international standing of the global health field. Thus, the crises re-directed political, economic, and intellectual capital away from global health(87).

It is hard to quantify what the overall deteriorating effect of these crises could be. Most likely the development has had/will have a negative effect on progress towards achievement of the health-related MDGs and needed increases in foreign aid and development health assistance. Also, assertions that global health problems constitute threats to a nation's vital security and economic interests have a less persuasive texture in face of the experiences made through the crises(87).

On a more positive note, one could rather argue that the present global financial crises might also be an opportunity to push the global health agenda. As argued in the invitation to the Confederation of Indian Industry's invitation to the 4th Sustainability Summit in Asia 2009 (procured by the World Business Council), temporary periods of crisis can be opportune times. They provide opportunity to correct past mistakes, restructure institutions of governance, and transform human society. If nothing else, the financial crisis did a lot to underline the global financial interdependence, even if the exact same system allowed deregulation and overconfidence in one country to create a global crisis. The imminent consciousness of such a global vulnerability might just represent a chance for leaders to emphasize the globally shared responsibility for all human endeavours. As stated by Ooms, this might be the time to push the message that if the risk is global, the insurance against the consequences should be global as well(27).

Thus, several emerging ideas on how to finance the ever evolving global health initiatives are continuously discussed in global health forums worldwide. What seems to be a general conception is that any credible source of finance for the future global

health arena must be designed with a special focus on sustainability, and at least partly on the redistribution of domestic wealth so that also those countries on the recipient side are made partly responsible for the development.

Since one of the main conundrums related to the concept of a global health convention is how to assure sustainable and adequate funding to create, implement and enforce a comprehensive and well functioning global legal regime, this report will point to some interesting financial models designed to ensure the redistribution of funds from the haves to the have-nots in the world.

What has been ambiguously dubbed "innovative financing" was introduced into the international debate during the Monterrey summit in 2002. Since then the concept has taken shape thanks to increasing mobilization, and through new international commitments. Linked essentially initially to the IMF's possible issue of additional special drawing rights (SDR), it now refers to the mechanisms generating resources additional to traditional official development assistance (ODA) and featuring greater predictability.

One example of a financial model that fits under the concept is the UNITAID initiative on taxing of plane tickets. After the Paris Conference in February 2006, Norway, Chile, Brazil and France settled on the idea of channeling revenues from the taxation of plane tickets to an International Drug Purchase Facility (UNITAID)(88). Assured funds to the UNITAID on the basis of this suggested new form of taxation would warrant it a reliable and sustainable funding stream. Through its implementing partners, UNITAID now channels its funds to purchasing tests and medicines of assured quality and ensuring fast delivery to the patients who most need them, especially those in low– and middle–income countries.

Another example often referred to is the Tobin tax. The suggested tax on all trade of currency across borders is intended to put a penalty on short-term speculation in currencies. The original tax rate proposed was 1%, which was subsequently lowered to between 0.1% and 0.25%(89). Ramonet proposed to create an association for the introduction of this tax, which was named ATTAC(90). The tax thus represents a multilateral initiative which has the potential to generate hundreds of billions of revenue every year, which in its turn makes it possible to meet urgent global demands, such as sustainable funding for global health initiatives. The main obstacle to be overcome would be the political passage of such a tax, as well as the legitimate management and distribution of funds.

As explained below, a tenet in international law is the sovereignty principle which ideally makes states accountable only towards their own inhabitants. And since there is no (formal) global authority to police international transactions, states thus cannot be pressured by others to develop a social redistribution system, neither national nor international. Even the UN does not wield much power when it comes to

compelling member countries to comply with obligations. The only leverage the UN, or any international organization, can use to assure due contributions to a cause, is to make it a condition of membership. Interestingly, as suggested by some commentators(58), this conditionality can be utilized as leverage, thereby committing states to allocate funds to a cause. Most countries in the world, for obvious reasons, seem intent on remaining members of the World Trade Organisation. This organisation has already included considerations of public health, and respect for the environment, into its appreciation of fair competition in international trade. A next step could be to make membership conditional of a social protection scheme for workers, or even for all citizens in a member state. Countries not contributing their fair share would run the risk of being considered guilty of social dumping and unfair competition. Indeed, if they prove unwilling to contribute towards a social protection scheme, it would not be justifiable for them to reap the profits of globalisation. Given that such conditionality can be imposed on all WTO member countries, it could also be imposed on a supra-national level, compelling member countries to pay their share in a basic protection scheme for the global arena. Such an initiative would undoubtedly represent a crucial step towards fair trade in the world. Also, prospering countries could gain both a legal and a moral right to derive profits from international trade. One could in fact picture such a conditionality clause as a way of financing a global health convention. Such an arrangement would ensure that states took responsibility towards the financing of a legally binding global health regime. It would also psychologically prepare governments for the extensive task of implementing a novel global health system. For national states' internal affairs, the linking together of a social protection/health care scheme with trade policies would also serve to establish a tighter link between ministries of health, which in national politics are often considered weak or costly, and ministries of finance, which regularly exert a strong influence on national priorities.

Medical Research and Development

Within the field of medical research and development there are those who claim that the needs of the poorest have been almost entirely neglected when new medicines and technical medical procedures are generated. Some have called for a complete redesign of the research and development field, so that the health challenges of the poor could be more considered(91). Other commentators express a concern that global health programmes that emphasize the delivery of medical commodities and treatment allow multinational pharmaceutical companies to benefit considerably(26).

Under any circumstance, it must be clear that new thinking is needed to improve ability to deal with the IPR issues of the global health arena, such as ensuring sufficient long-term investment in health research and development, as well as the equitable distribution of durable medicines. Other issues that could be raised are who should contribute, and who should pay for development of new and affordable medicines, and especially how the dynamism and capacity of both public and private

sectors from north and south can be harnessed, without compromising the public sector's regulatory responsibilities(92). It is on this basis that WHO, through an Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property (IGWG), established at the May 2006 World Health Assembly, has decided to draft a Medical Research and Development Treaty (MRDT). The aim of this work is promote sustainable systems of medical innovation through a number of objectives, e.g. ensuring finance, allocating costs, identifying areas of new research, and promoting access to equitable medical technologies(93).

Another imperative within global health research and development is to highlight the crucial importance of national health systems as connectors of research and development with populations, and as guarantors of the successful and sustained delivery of health interventions to peoples and populations(92). Accordingly, it would be important to examine closer how the different health systems have evolved to integrate the research, development, and delivery of health interventions, indeed core functions of the system.

Continued discussions regarding a global health convention, and especially the issue of innovative funding mechanisms for such an idea, especially any proposals leading to mandatory and increased subsidies for GHA, could easily be regarded as coincidental creation of a deep pocket into which the pharmaceutical industry can bury its hands(94). Indeed, even if no such accusation is made, questions surrounding intellectual property rights in pharmaceutical innovation are complex and difficult issues that should not be omitted when setting out to draft fair and functioning principles and regulations for global health governance. Indeed, any solutions to controversial issues proposed in unison by the IGWG and those that set out to draft a global health convention could mutually reinforce each other, thus giving them more weight.

Global Health Institutions

Introduction

Much of the complexity of the global health arena can be attributed to the colossal number of stakeholders involved in sectors as diverse as human relief, trade, foreign policy, health systems strengthening, infrastructure construction, and development assistance. Arising from widely differing policy and business cultures all these sectors regularly assert narrowly focused positions and interests, and each employing distinctly dissimilar negotiation strategies. Although paved with good intent, such behavior only contributes to cement the confusion and lack of coordination evident in global health improvement.

The most influential stakeholders in the global health arena are nation states, international government organizations, non-governmental organizations, international companies and conglomerates, and even philanthropic organizations. Although most of these operate within a framework of international law and treaties, some are decidedly more dominant that others, and thus wield powers that can be harmful if left unchecked. For some stakeholders questions could also be raised as to what degree their transactions are transparent, and how they are accountable to democratic principles.

The United States and the EU indisputably form the two most dominant players in the global health arena. Both blocks consist of a multiplicity of actors, and internal decision-making procedures are so complex that once internal positions are agreed, they often have difficulty compromising on those positions in order to reach global consensus(95). The US government's most prominent initiative is the United States President's Emergency Plan for AIDS Relief (PEPFAR), which authorizes up to $48 billion over 5 years to combat global HIV/AIDS, tuberculosis, and malaria. The main European governmental actors can be illustrated as a triangle composed of the ministries responsible for health, development cooperation, and foreign affairs, including other ministries that also have authority and interest in particular areas of global health policy. Illustrating for this composition, the foreign policy platform has recently sprung the Foreign Policy and Global Health Initiative (FPGH)(56) that works to bridge the divide between global health efforts and the economic, political and national security context in which policy in this area is formulated and implemented

Among the intergovernmental organizations that influence the global health arena there is reason to emphasize the role of the G8, and perhaps also the G20. The advent of the G8 in health governance coincides with rapid changes in global health governance in the 21st century, especially the decreasing role of WHO as the sole international health agency. As stated by Reich and Takemi:

"...the G8 can play a major part in catalysing efforts to reframe the global health architecture in a more coherent direction(33)."

The same commentators also argue that into this increasingly crowded area of global health has emerged a new informal and self-appointed entity known as the Health 8 or H8—comprised of WHO, the World Bank, GAVI, the GFATM, UNICEF, UNFPA, UNAIDS, and the Bill & Melinda Gates Foundation.

Interestingly, the Bill & Melinda Gates Foundation may serve as the prime example of philanthropic organizations that has colonized the global health arena. According to commentators the foundation has done much, and it will be doing even more as its level of spending sets to increase(96). But there are problems with what is happening. The Foundation has been criticized for employing a non-transparent grant-program(96) which necessitates further independent research and assessment

to ensure that intentions are translated into the right and most cost-effective set of approaches, strategies, and investments for improving the health of the poor.

Within the trade sector the WTO continues to be the most important agency dealing with international trade and as such. As international trade is necessary for health developments, WTO-activities are crucial also for improving health services. Indeed, there is a growing critical literature on the WTO and its potential role in international health standards through the trading of health goods and services. As international trade continues to grow there is a need to understand the effects of trade laws and policies on health and safety. Indeed, trade liberalization will continue to overlap with and compound the protection of human rights and other vital interests, including those affecting labour and health and safety rights world-wide.

In order to analyze the strengths and weaknesses of a global health convention approach to solving the intractable problems of global health, it is in reality a need for a thorough assessment of the different sector policies that influence the global health arena, as well as the negotiation regimes that exist amongst stakeholders in each sector. Only in this way is it possible to decipher influencing policy and business cultures, including prevailing negotiation styles, thus enabling a potential legislator to prognosticate the most opportune content of any binding regulations for the global health arena. Such a task goes beyond the scope of this report.

Below is a fairly schematic account of the most prominent organizations and conglomerates that govern the global health arena.

World Health Organization

World Health Organization is the directing and coordinating authority for health within the UN system. The objective of the organization is stated in article no. 1 of its constitution as the:

"…attainment by all peoples of the highest possible level of health(59)."

Article no. 2 of the Constitution outlines numerous functions through which the WHO shall organize the international community in its struggles towards greater health. In addition to serving as a coordinating and advisory body on health research and technical issues pertaining to different aspects of international health, the organization sets out to:

"…assist governments, upon request, in strengthening health services" and to "promote conventions, agreements and regulations, and make recommendations with respect to international health matters."

With regards to strengthening national health services, WHO itself has emphasized three main areas of action(81). First, the organization commits to producing

global norms, standards and guidance on health systems concepts, methods and metrics, and building scenarios for the future. Second, WHO sets out to assist the development and shaping of international systems that impact on health, especially including systems and networks for identifying and responding to outbreaks and emergencies. Third, the organization seeks constructive collaboration with other international partners comprising their support for health systems strengthening. Such global health initiatives (GHIs) include relations with The Global Fund, GAVI, the World Bank, and the larger philanthropic organizations, as well as stakeholders in the non-government and corporate sector.

The first two areas cause little controversy as WHO relies mostly on the dissemination of research evidence, advisory texts and expert opinions. These are essentially non-committing in their form, and there are few, if any, sanctions if national states, or other stakeholders, choose not to oblige by them. The third point, however, holds ample potential for dissension. Any genuine initiative directed at a broad based, horizontal, health systems strengthening will inevitably collide with the interests of the vertically integrated global health initiatives. This can be stated as a logic inference without regards to whether the overall effect of vertical initiatives is desirable or not. It is simply a consequence of expanding the perspectives enough to see that, for instance, an exclusive focus on one disease, like AIDS or malaria, does not intentionally solve problems pertaining to unclean drinking water, or maternal health. The status of WHO's position in this respect, and especially when contrasted with the interests of the global health initiatives is not clear. There is, as always, reason to believe that influence follows the money around, and that WHO's efforts in strengthening global health systems sooner or later will meet opposition from very powerful global actors.

With regards to WHO's other main function we have, over the last couple of decades, in two areas seen an organization which has moved from its traditional expert/advisory function into a more legislative role.

The first WHO initiated legislature was a reality in 1969 as the International Health Regulations (IHR) saw the light of day. These regulations have since been reviewed and amended, and a second set of regulations was adopted by the World Health Assembly in 2005. They entered into force 15 June 2007, and are the subject of implementation in 194 countries across the globe. The second global health regime negotiated under WHO auspices is the Framework Convention on Tobacco Control (FCTC). The convention is designed to promote international cooperation as well as national action to control the growth and spread of the global tobacco epidemic. Adopted by WHO's well over 190 member states on May 21, 2003, the treaty has been signed by more than 160 states worldwide. As a result of the implementation process that it requires, the convention is now binding international law for around 60 states that have ratified it(97). Both of these initiatives will be examined in some more detail later in this report.

For the future of global health some commentators assess that WHO will play a critical role in:

"...agenda setting, treaty content, consensus building and ultimately member state ratification and implementation [...]. No other international organization has the normative or technical capacity or legitimacy to stewards the success of efforts to address distinctly global health issues such as finding treatments for neglected diseases...(55)"

Given the past history of WHO, and including the hopes for the future or the organization, it is possibly the most likely candidate to initiate and coordinate a Global Health Convention initiative, as well as adopting the binding document, and secure international ratifications.

However, as even early supporters of WHO discovered, the organization has three crucial weaknesses; first, it is inter-governmental –not supra-governmental, second, its budget and facilities are limited and third, its impact totally depends on the will of countries(50). Given these facts, it is obvious that although WHO will always play a part in any global health initiative, the organization will have to strive to assert its position as a leading agency in the future of global health.

The World Bank

Commencing its operations in 1946, The World Bank was established to finance the rebuilding of Europe after the Second World War. The bank today is a considerable force within the health, nutrition and population sector in third world countries. Formally, the bank consists of two development institutions which in conglomerate are owned by 186 member countries. Its aim is now to contribute with financial and technical assistance to developing countries around the world. Indeed, from having almost no presence within the field of global health, it has grown to become the world's largest financial contributor, committing more than $1 billion annually for new health, nutrition and population projects. It has also spent more than $1.6 on the fight against HIV/AIDS over the last years(52).

Recently, the bank undertook a revision of its strategic plans, and ended up with a new strategy for its efforts within the Health, Nutrition and Popluation sectors. Through the planning process the bank identified several important tasks where it wishes to expand its research and financing, some of which are: inter-sectoral country assistance, health-system strengthening, health financing, regulatory frameworks for the health sector, good governance, accountability, and transparency in the health sector(98).

In strengthening health systems, the plans highlighted numerous key issues, including: financing, a regulatory framework for private-public collaboration, insur-

ance, logistics, provider payment, well trained personnel, and basic infrastructure. They also emphasized the importance a shared international commitment, which can be accomplished by leaving eg. training of health resources, or technical aspects of disease control to organizations where they belong more naturally(98).

This approach to health systems strengthening is not very far away from what would be a natural starting point for thoughts around minimum health regulations in a global health convention. And interestingly, during the process of drawing up the FCTC, the World Bank collaborated with WHO in establishing the evidence base on which effective methods of curbing the prevalence and consumption of tobacco products could be based(52).

However, despite all these accomplishments, the World Bank suffers criticism for never having been a truly democratic organ. The amount of influence each member state wields within the organization is simply a result of the sum of money with which it contributes through the acquisition of shares. As such, the bank has been criticized for its self-interest based development focus, and some have even uttered concerns that the World Bank would be nothing but a tool to implement US foreign policy goals(99). Other critics have long complained about undemocratic processes like the unequal distribution of executive board votes, unclear decision making processes, and the absence of board accountability to elected officials and legislative bodies in the states that the bank targets its efforts. This criticism makes it questionable whether the World Bank could act as a gathering force in fronting a global health convention.

Global Health Initiatives

There are numerous so-called vertical health and development initiatives within the global health sphere, the most prominent being GAVI, GFATM, and UNAIDS. Although operating within different countries, and with different objectives, these initiatives all share certain traits that, for the purpose of analyzing the facts pertaining to a Global Health Convention, bear with them much of the same implications. We will therefore, as far as possible, describe their impact as a whole.

Most of the vertical initiatives are prosperous organizations with established sources of funding, and already in possession of considerable resources on the ground. And they are indeed making a world of difference for marginalized population groups in particularly vulnerable communities. However, often their narrow attention towards one specific disease or conglomerate of problems, act to block any attempts with the aim of strengthening whole health systems from the ground and up. All of the initiatives carry with them their own bureaucracies, which makes it difficult to adjust the provision of resources to receiving countries' existing health systems. They are also criticized for blocking local initiatives by channelling away scarce resources, e.g. competent health workers, and for bringing in their own infrastructure instead of developing local assets.

On the basis of previous experience, it is not unlikely that some, if not all, of these initiatives will contest the proposal of a global health convention on grounds that such a systemic approach will be perceived to come in the way of their interests There are good reasons in principle, however, for any initiative that sets out to create globally binding health regulations to include rules that contribute to coordinating vertical initiatives with local health systems. Director of WHO, Margaret Chan, expresses it this way:

"Weak health systems are almost certainly the greatest impediment to better health in the world today. They are the central obstacle that blunts the power of global health initiatives(100)."

Thus, the relationship also works the other way around; weak health systems work to the detriment of vertical initiatives. Undeniably of a complex character, the task of aligning health systems and global health initiatives seems to be a key issue that needs to be addressed under a convention initiative.

Ackronyms

ATTAC: Association for the Taxation of Financial Transactions for the Aid of Citizens
AHLF: Accra High Level Forum on Aid Effectiveness (2008)
CESCR: UN Committee on Economic, Social and Cultural Rights
DAH: Development Assistance for Health
EC: European Commission
ECOSOC: United Nations Committee on Economic, Social and Cultural Rights
EU: European Union
FCGH: Framework Convention on Global Health
FCTC: Framework Convention on Tobacco Control (2003)
FPGH: Foreign Policy and Global Health
G8: Group of Eight (wealthiest countries)
G20: Group of Twenty (wealthiest countries)
GAVI: Global Alliance for Vaccines and Immunization
GDP: Gross Domestic Product

GFATM: Global Fund to Fight AIDS, Tuberculosis, and Malaria
GHA: Global Health Assistance
GHI: Global Health Initiative
GHP: Global Health Partnership
GNP: Gross National Product
H8: Health Eight (comprised of WHO, the World Bank, GAVI, the GFATM, UNICEF, UNFPA, UNAIDS, and the Bill & Melinda Gates Foundation)
ICESCR: UN International Covenant on Economic Social and Cultural Rights
IGO: Intergovernmental Organization
IGWG: Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property
ILO: International Labour Organization
IHR: International Health Regulations (2005+2007)
LDCs: Least Developed Countries
MDGs: Millennium Development Goals
MRDT: Medical Research and Development Treaty
NGO: Non-governmental Organization
ODA: Official Development Assistance
OECD: Organization for Economic Co-operation and Development
PDP: Paris Declaration Process(2005)
PEPFAR: The US President's Emergency Plan for AIDS Relief (2003)
SDR: Special Drawing Rights
SWAPs: Sector Wide Approaches
UNAIDS: United Nations AIDS
UNCRC: United Nations Convention on the Rights of the Child
UNFCCC: United Nations Framework Convention on Climate Change
UNFPA: United Nations Population Fund
UNICEF: United Nations International Children's Emergency Fund
UNITAID: International facility for the purchase of drugs against HIV/AIDS, Malaria and Tuberculosis
UNSG: United Nations Secretary General
WBMAP: World Bank Multi-Country AIDS Program
WHA: World Health Assembly
WHO: World Health Organization

Hovedbudskap

I juni 2009 fikk Nasjonalt kunnskapssenter for helsetjenesten i oppdrag av Helsedirektoratet å sammenstille og analysere eksisterende litteratur som tar opp sterke og svake sider ved en global helsekonvensjon som svar på de globale helseutfordringer. Denne rapporten er et svar på dette oppdraget.

Formålet med rapporten er å bidra til å løse utfordringene knyttet til dårlig helse blant verdens fattigste befolkninger. Som sådan representerer den et initiativ fra norsk forvaltning for å informere nasjonale og internasjonale myndigheter om styrker og svakheter ved en global helsekonvensjon som tilnærming for å strukturere den internasjonale satsningen på global helse.

Rapportens hovedbudskap er:

Den økende gjensidigheten og avhengigheten i det globale samfunnet medfører at helse i verdens fattigste og mest marginaliserte befolkninger er et påtrengende problem for alle nasjoner i verden.

Det er klare svakheter i det eksisterende internasjonale rammeverk for å sikre helse i klodens mest marginaliserte befolkninger, inkludert mangler i den rettighetsbaserte tilnærming til helseutfordringer (særlig helse som en menneskerettighet).

En global helsekonvensjon vil kunne representere et egnet instrument for å håndtere noen av de mest fastlåste problemene innenfor global helse, særlig:

- definere hva som menes med grunnleggende overlevelsesbehov
- oppstille av prinsipper for samarbeid, ansvarlighet, og fordeling av ressurser mellom aktører
- strukturere og koordinere finansiering av globale helseinvesteringer
- gi regler for tilgang til helsetjenester, inkludert krav til nasjonale prioriteringer med hensyn til tilbudet av helsetjenester

De mest fremtredende utfordringene kan særlig dreie seg om å mønstre internasjonal støtte til et sett med overnasjonale helsereguleringer, fremfor-

Styrker og svakheter ved en global rammekonvensjon for helse. En gjennomgang av kritiske institusjoner, prosesser og utviklingstrekk i den globale helsearenaen

Hvem er målgruppen for denne rapporten?

Nasjonale og internasjonale myndigheter

Oppdatert:

Søk etter studier ble avsluttet mai 2010.

handle kompromisser mellom eksisterende aktører på den globale helsearena, samt å sikre WHOs støtte som samlingspunkt for relevante parter til en konvensjon, og som en tilrettelegger gjennom en eventuell vedtakelsesprosess.

Norsk sammendrag

Styrker og svakheter ved en global rammekonvensjon for helse. En gjennomgang av kritiske institusjoner, prosesser og utviklingstrekk i den globale helsearenaen

BAKGRUNN

Internasjonalt har man de siste år sett økende bekymring for at internasjonal helsebistand er ineffektiv. Enkelte vil endog hevde at den i visse tilfelle virker mot sin hensikt. Flere av de land vi tidligere betraktet som fattige har de siste førti årene gjennomgått en økonomisk og demografisk transisjon til økende vekst og velferd. Likevel er det fortsatt en gruppe av de aller fattigste land som fortsatt sakker etter i utviklingen, og som ofte er på randen av sammenbrudd. Det er ikke lenger forsvarlig å betrakte disse fattigste land som øyer med kaos i en ellers ryddig verden; vår globale økonomi er skjør, og den trygghet og de goder vi nyter i våre utviklede samfunn er utsatt for stadig mer ubehagelig samhandling med våre fattige naboer. Og etter hvert som gapet mellom disse to verdener blir større, vil integrasjon bli vanskeligere, ikke lettere.

Helsedirektoratet kontaktet i juni 2009 Nasjonalt kunnskapssenter for helsetjenesten med oppdrag å sammenstille og analysere tilgjengelige internasjonale forskningsmateriale, lovverk og offisielle dokumenter som tar for seg styrker og svakheter ved en internasjonal rammekonvensjon for helse som svar for globale helseutfordringer. Denne rapporten er et svar på dette oppdraget.

FORSLAGET TIL EN GLOBAL RAMMEKONVENSJON FOR HELSE

En rammekonvensjon for global helse ble først foreslått av Professor Lawrence Gostin ved Georgetown University i USA. Gostin hevder i artikkelen "Meeting Basic Survival Needs of the World's Least Healthy People Toward a Framework Convention on Global Health", publisert i 2007(Gostin, 2007 23 / id) at en global rammekonvensjon for helse vil kunne:

"...powerfully improve global health governance [...] by committing States to a set of targets, both economic and logistic, and dismantle barriers to constructive engagement by the private and charitable sectors."

Med ideen om en rammekonvensjon tar Gostin sikte på en prosess der stater blir enige om visse grunnleggende prinsipper for global helseutvikling. Spesifikke protokoller vil så bli utviklet for å nå mål som krever større grad av forhandling. På denne måten kan man sørge for at internasjonale aktører har mulighet for gradvis å påta seg forpliktelser etter en trinnvis prosess. Konkret vil målet med en rammekonvensjon være å bøte de vanligste årsakene til sykdom, funksjonshemming, og for tidlig død i utviklingsland, og dermed gi et flertall av verdens fattigste mennesker et juridisk rammeverk som de vil kunne basere sine rettmessige krav til grunnleggende helsetjenester på.

PROBLEMSTILLING

Denne rapporten tar for seg enkelte av grunntankene til Professor Lawrence Gostin, og representerer på denne måte nok et bidrag til å løse utfordringene knyttet til helse i utviklingsland. Rapporten representerer således et initiativ fra norsk forvaltning som tar sikte på å opplyse nasjonale og internasjonale myndighetsorganer, halvstatlige og private aktører, samt sivilsamfunnet generelt om styrker og svakheter ved en global helsekonvensjon.

Rapporten sammenstiller informasjon om alle relevante tiltak for å skape internasjonalt bindende regelverk med sikte på å fremme helse som et globalt fellesgode. Dette inkluderer både juridiske og politiske dokumenter. I tillegg refereres de mest prominente private initiativer. Målet er å identifisere noen av bekymringene som gjør en global helsekonvensjon ønskelig, og å identifisere og evaluere de viktigste hindringer for en slik konvensjon, enten de er av en økonomisk, politisk eller praktisk karakter.

Et annet mål er å bidra med en pilotstudie for å evaluere de mange store globale helsetiltak som har vært en del av global helsesatsning de siste tiår.

METODE

Alle som har deltatt i arbeidet med denne rapporten har så langt mulig bidratt med sin fulle kunnskap om globale helseutfordringer. Både Helsedirektoratet og Kunnskapssenteret har også involvert sitt nettverk av nasjonale og internasjonale eksperter og kolleger i søk etter relevante forslag, ideer og kommentarer som belyser ideen om en global rammekonvensjon for helse. I tillegg har det vært gjort flere målrettede søk i internasjonale tidsskrifter, politiske dokumenter og relevante nettsteder for å identifisere internasjonalt lovverk, avtaleverk, offisielle dokumentfremstillinger og

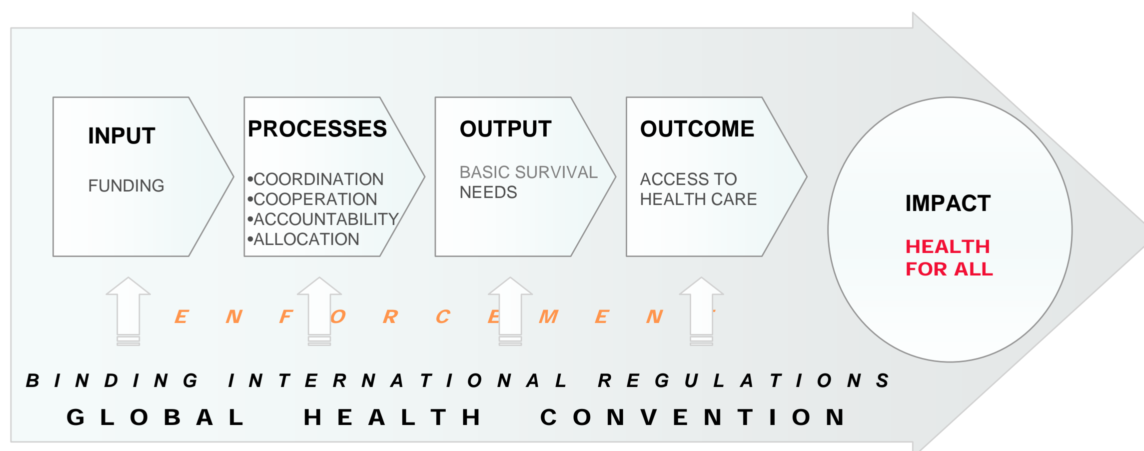
litteratur relevant for ideen om en global rammekonvensjon for helse. En omfattende bibliografi er utarbeidet basert på de funn som er gjort.

Rapporten har også vært undergitt to høringsrunder der fremstående nasjonale og internasjonale eksperter på globale helsespørsmål har uttalt seg. Funnene i rapporten er også drøftet og kommentert i en daglang arbeidssamling i regi av Helsedirektoratet der over 30 nasjonale og internasjonale eksperter på global helse deltok.

For øvrig er rapporten i hovedsak et resultat av tverrfaglig tenkning. Den drar i så måte nytte av metodikk fra den internasjonale rettslige tradisjonen, internasjonal folkehelse (global helse), og fra internasjonal politikk.

DISKUSJON

Rapporten tar sikte på å konseptualisere hvordan en global rammekonvensjon kan bidra til å strukturere prosesser/elementer som hører til i den globale helsearena. Den introduserer således en enkel modell som forsøksvis byr på en logisk sekvens av hendelser/prosesser, og som beskriver hvordan en global helsekonvensjon kan påvirke et slikt system (se figur). Imidlertid erkjenner vi at modellen ikke fullt ut tar høyde for den underliggende kompleksiteten som eksisterer i den globale helsearenaen, med selvorganiserende prosesser som er tett sammenvevd og stadig skiftende, og som inneholder både lineære og ikke-lineære elementer.



Figur 1: Bindende internasjonale reguleringer, dvs. en global rammekonvensjon for helse, kan bidra til strukturering av prosesser/elementer i den globale helsearenaen, og på den måte bidra til målet om helse for alle.

Rapporten analyserer følgende elementer i den gitte rekkefølge:

- Input (innsats): finansiering av global helse
- Processes (prosesser): samordning, samarbeid, ansvarlighet, allokering av bistandsmidler
- Output (effekt): definere hva som er grunnleggende overlevelsesbehov

- Outcome (resultat): tilgang til helsetjenester
- Impact (virkning): helse for alle
- Enforcement (gjennomføring)

Analysen drøfter ikke hva som vil være den endelige virkningen av en rammekonvensjon (Impact). Virkningen, helse for alle, gjerne manifestert som en generell forbedring av folkehelsen blant verdens fattigste, blir snarere oppfattet som en potensielt tilsynekommende kvalitet forutsatt at et bindende regelverk implementeres.

RESULTAT

Rapporten argumenterer innledningsvis for at det eksisterer observerbare svakheter i menneskerettighetenes tilnærming til helse (se figur), blant annet at en vidtgående fortolkning av de sentrale helsebestemmelsene har usikker hjemmel. Imidlertid utelukkes det ikke at det fremdeles finnes gode grunner til å fortsette satsningen på internasjonale helserettigheter i tråd med for eksempel ICESCR artikkel 12 og CESCRs generelle kommentar nr. 14; blant annet bygger helse som menneskerett på allerede etablerte rettsakter som har bred formell tilslutning, og tilnærmingen har allerede tverrfaglig tilslutning.

Figur 2: Hjemmelsgrunnlaget for helse som en menneskerettighet blir svakere jo mer innhold som blir innfortolket.

Rapporten fastslår ellers at en global helsekonvensjon vil kunne representere et egnet instrument for å håndtere noen av de mest fastlåste problemene innenfor global helse, særlig:

- definere hva som menes med grunnleggende overlevelsesbehov
- oppstille av prinsipper for samarbeid, ansvarlighet, og fordeling av ressurser mellom aktører
- strukturere og koordinere finansiering av globale helseinvesteringer
- gi regler for tilgang til helsetjenester, inkludert krav til nasjonale prioriteringer med hensyn til tilbudet av helsetjenester

De mest fremtredende utfordringene kan særlig dreie seg om å mønstre internasjonal støtte til et sett med overnasjonale helsereguleringer, fremforhandle kompromisser mellom eksisterende aktører på den globale helse arena, samt å sikre WHOs støtte som samlingspunkt for relevante parter til en konvensjon, og som en tilrettelegger av en eventuell vedtakelsesprosess.

KONKLUSJON

Analysene i rapporten har vist at en global rammekonvensjon for helse kan være et velegnet instrument for å håndtere noen av de største utfordringer relatert global helse, nemlig å legge til rette for bærekraftig finansiering, samordning av globale helseforetak og allokering av hjelpeinnsats. En rammekonvensjon kan også bidra til å definere hva som skal regnes til de absolutt grunnleggende overlevelsesbehov, samt gi regler for hvordan man rent praktisk skal sørge for tilgang til helsehjelp.

Rapporten har vist at noen av de viktigste problemene som bør løses før man fortsetter arbeidet mot en global rammekonvensjon er å mønstre internasjonal støtte for overnasjonale helsereguleringer, samt å fremforhandle kompromisser mellom eksisterende aktører på den globale helsearenaen.

Det er grunn til å anta at WHO bør ha en koordinerende rolle i videre diskusjoner rundt konvensjonsideen, samt at dette i prinsippet kan skje uten at det foreligger noen forpliktelse til å gjennomføre en vedtakelsesprosess fullt ut.

BEHOV FOR VIDERE UTREDNING

Analyser i denne rapporten har vist at WHO er den mest sannsynlige kandidaten til å fungere som samordningsorgan for videre diskusjoner i retning av en global rammekonvensjon for helse. WHO er trolig også det riktige organ for igangsetting og gjennomføring av en formell vedtakelsesprosess. På grunnlag av dette er det nærliggende å etterlyse ytterligere utredninger av hva som allerede er gjort i WHO-systemet med tanke på en rammekonvensjon for helse. Slike utredninger kan blant annet konsentrere seg om hvilke vedtak og beslutninger WHO har gjort knyttet til ideen om universell tilgang til helse i løpet av de siste tiårene.

Videre utredninger bør også kartlegge potensialet for konstruktiv og effektiv arbeidsdeling mellom eksisterende aktører i den globale helsearenaen. Et slikt arbeid bør inneholde analytiske verktøy for å definere hvem som er de relevante partene til en konvensjon, samt hvilke sektorer av samfunnet som bør inkluderes i fremtidige satsninger. Det bør videre utarbeides diskusjonsgrunnlag basert på utredningene, og disse bør igjen bli distribuert til alle interesserte parter. På denne måten kan prosessen kvalitetssikres i nødvendig grad, og eventuelle resultat vil fremstå som omforen-

te. Fremtidig tilslutning til en rammekonvensjon bør være det viktigste mål for prosessene, og det er grunn til å anta at et slikt resultat er best sikret gjennom et åpent og inkluderende miljø.

For en potensiell forhandlingsfase i forkant av et konvensjonsvedtak, vil hovedutfordringen mest sannsynlig være å skape den riktige balansen mellom posisjoner, interesser og behov blant de involverte. Interessene til utviklingsland vil være klart polarisert i forhold til industrilandene, de rike mot de fattige. Andre lett identifiserbare konflikter kan være interessekonflikter mellom eksisterende aktører i den globale helsearenaen, for eksempel vertikale mot horisontale globale helseinitiativ.

Som et siste punkt fremhever rapporten utfordringer med hensyn til finansiering av videre skritt mot innføring av et bindende rettlig instrument for den globale helsearena. Det bør i denne sammenheng utredes hvordan man kan sørge for finansiering av en innledende brainstorming-prosess, de første samlingene av potensielle partier, samt kåring og valg av et formelt konvensjonssekretariat. Det er ikke rimelig å anta at noen enkeltinstitusjon eller –stat alene skal kunne bringe til veie alle de nødvendige midler i så måte. Utover dette bør konvensjonsideens støttespillere undersøke nærmere alternative finansieringskilder for globale helseinitiativ. En rekke slik har blitt utviklet i løpet av de siste årene, og det er grunn til å anta at troverdige modeller for fremtiden, herunder også et omfattende system av bindende internasjonale helsereguleringer, vil være avhengig av alternative finansieringskilder.

KONKRETE RESULTAT AV PROSESSEN, STATUS MAI 2010

I desember 2009 var det første utkastet til denne rapporten på høring blant personer, både i Norge og internasjonalt, som hadde ytret interesse for det tema som var tatt opp. Etter å ha lest utkastet inviterte professor Lawrence Gostin ved Georgetown University, O'Neill Institute for National and Global Health Law forfatterne til å publisere det overveiende av innholdet i en symposiumsutgave av det amerikanske tidsskriftet Journal of Law, Medicine and Ethics (JLME) som særlig befatter seg med ideen om en global rammekonvensjon for helse. En oppdatert og fagfellevurdert artikkeltekst ble således oversendt redaktøren av JLME i mars 2010. Artikkelen vil være tilgjengelig i publisert tilstand fra juli 2010.

I midten av mars 2010 avviklet Helsedirektoratet, i samarbeid med Kunnskapssenteret, en daglang arbeidssamling der spørsmålet om en global helsekonvensjon ble drøftet av mer enn 30 deltakere fra flere land. Deltakerne var for øvrig satt sammen av interessenter fra både offentlig sektor, IGOs, frivillige organisasjoner og private foretak. Målet med arbeidssamlingen var å presentere, diskutere og kvalitetssikre premisser så vel som de viktigste funnene i rapporten, og dermed skape en arena for utvidet fagfellevurdering samt tilbakemeldinger fra erfarne fagfolk.

Et resultat av arbeidssamlingen var en rapport som sammenfattet alle diskusjoner gjennom dagen. Et annet viktig resultat var et konkret forslag om å igangsette et prosjekt som følger opp enkelte viktige områder som særlig dreier seg om styring av utviklingen i den globale helsearenaen, et tema som også har vært undergitt behandling i rapporten. Et slikt prosjekt ble foreslått bygget på en bred konsensus rundt seks store temaer som er separate, men beslektede (se panel nedenfor). Hvert felt bør inkludere en prosess der styresmakter, det sivile samfunn, frivillige organisasjoner og privat næringsliv kan delta. Spesielle utfordringer vil trolig være av politisk, juridisk, økonomisk og sosial karakter. Det foreslåtte arbeidet vil gi mulighet til å analysere utfordringer fra en rekke perspektiver, og vil således bidra til større grad av tverrfaglig forståelse av utfordringer i den globale helsearenaen.

Panel 1: Forslag til arbeidsfelt under et prosjekt som dreier seg om styring av den globale helsearenean:
1. Helse som menneskerettighet - Hvor langt har menneskerettighetstilnærmingen til helse tatt oss, hvor mye kan vi forvente av den i fremtiden? Hva er grensene for en menneskerettighetstilnærming til helse, eventuelt: hva kan gjøres i stedet?
2. Grunnleggende overlevelsesbehov - Hva bør en minimumspakke til dekke av grunnleggende overlevelsesbehov for jordens befolkning inneholde?
3. Nasjonale forpliktelser til å sørge for helse – Hvilke helsetiltak bør land garantere sin egen befolkning, og hvordan skal slike tiltak evalueres?
4. Internasjonale forpliktelser til helse - Hvordan kan en global helseforsikringsordning konseptualiseres? Hvordan kan vi forbedre dagens bistandskonsept på en slik måte at global omfordeling og strukturering av goder blir rettferdig?
5. Koordinering og ledelse innen den globale helsearenaen - Hva er rollen til stater, private aktører, frivillige organisasjoner og andre eksisterende interessenter?
6. Prosesser for å etablere klarere styringsmekanismer - Hvordan kan styringsdiskusjonene videreføres og utdypes? Hvordan kan ulike interessenter spille en konstruktiv rolle?

Arbeidsmøtet konkluderte med at forslaget sannsynligvis ville oppnå bred støtte hos relevante aktører, og det ble foreslått å utarbeide en Viewpoint-artikkel til Lancet som neste skritt. En slik artikkel ble oppfattet som egnet til å kunngjøre prosjektet, samt å åpne for dialog med WHO vedrørende analyser og anbefalinger for fremtiden.

På et strategimøte avholdt 14-15 april 2010 i FNs generalforsamling, drøftet en rekke internasjonale eksperter en felles handlingsplan for global helse. Planen tok særlig utgangspunkt i FNs tusenårsmål 4 og 5, samt 1c, 3 og 6, som alle er knyttet til kvinner og barn helse. Handlingsplanen representerer en direkte innsats for å oppfylle tusenårsmålene med særlig vekt på kvinne- og barnehelse, og vil de neste seks månedene mest sannsynlig danne fokus i styringsdebatten for global helse. Av denne grunn bør den nødvendigvis også danne et tyngdepunkt for prosjektet som er i ferd med å springe ut av diskusjonene etter arbeidssamlingen i Helsedirektoratet.

Partene som var til stede på marsmøtet i Oslo opprettet i etterkant et arbeidsdokument som beskrev nærmere tittelen og innholdet i det foreslåtte styringsprosjektet. Underliggende innsikter var at prosjektet må innby til samarbeid uten å trenge inn på etablerte aktørers områder, være i overensstemmelse med de globale utviklings-

trekk innenfor helse, samt ta opp i seg at selve prosessen med å utvikle nye ideer og konsepter kan vise seg like viktig som de konkrete mål man setter seg.

Nasjonalt kunnskapssenter for helsetjenesten fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helsetjenester. Senteret er formelt et forvaltningsorgan under Helsedirektoratet, uten myndighetsfunksjoner. Kunnskapssenteret kan ikke instrueres i faglige spørsmål.

References

1. Collier P. The Bottom Billion. Why the Poorest Countries Are Failing and What Can Be Done About It. Oxford: Oxford University Press; 2007.

2. United Nations Millennium Summit, United Nations Millennium Declaration. Millennium Development Goals. 2000.

3. Ministers of developed and developing countries at meeting in Paris on 2 March 2005. The Paris declaration on aid effectiveness. 2005.

4. High-level forum on aid effectiveness. Accra agenda for action. 2008.

5. UNICEF, WHO, The World Bank. A Strategic Framework For Reaching The Millennium Development Goals On Child Survival In Africa. Through Health System Strengthening and Implementing at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions.: Prepared on Request of the African Union; 201.

6. Ravishankar N, Gubbins P, Cooley R, Leach-Kemon K, Michaud CM, Jamison DT, et al. Financing of global health: tracking development assistance for health from 1990 to 2007. Lancet 2009;373(9681):2113-24.

7. Gostin LO. Meeting basic survival needs of the world's least healthy people toward a framework convention on global health. Georgetown Law J 2007;96:331-92.

8. Hathaway OA. Do human rights treaties make a difference? Yale Law J 2002;111(8):1935-+.

9. Ruger JP. Normative foundations of global health law. Georgetown Law J 2008;96(2):423-43.

10. Ausubel JH, Victor DG. Verification of International Environmental Agreements. Annual Review of Energy and the Environment 1992;17:1-43.

11. Cheyes A, Cheyes AH. The new souvereignity: compliance with international regulatory agreements. United States of America: Library of Congress Catalog-ing -in- Publication Data; 1995.

12. Franck TM. The power of legitimacy among nations. Oxford: Oxford University Press; 1990.

13. Checkel JT. Why Comply? Social Learning and European Identity Change. International Organization, MIT Press 2001;55(3):553-88.

14. Finnemore M, Sikkink K. International Norm Dynamics and Political Change. International Organization 1998;52:887-917.

15. Bodansky D. What makes international agreements effective? Some pointers for the WHO Framework Convention on Tobacco Control. 1999. (WHO Framework Convention on Tobacco Control Technical Briefing Series). (WHO/NCD/TFI/99.4).

16. Fact sheet. Spending on health: A global overview. WHO; 2007. (319).

17. United Nations Committee on Economic Social and Cultural Rights. General comment no. 14 on the highest attainable standard of health. UN DOC. E/C.12/2000/4 ed. 2000.

18. Taylor AL, Bettcher DW. WHO framework convention on tobacco control: a global "good" for public health. Bull World Health Organ 2000;78(7):920-9.

19. General Assembly of the United Nations. United Nations Declaration on Human Rights. 1948.

20. Fifty-first world health assembly. World health declaration. 1998.

21. International conference on primary health care A-AU. Declaration of Alma-Ata.

22. United Nations General Assembly. International covenant on economic, social and cultural rights. 1966.

23. Ruger JP. Towards a theory of a right to health: capability and incompletely theorized agreements. Yale Journal of Law & the Humanities 2006;18:273-326.

24. United Nations Economic and Social Council. Summary Record of the 10th Meeting: Portugal. 04/05/2000. E/C. 12/2000/SR.10. (Summary Record) ed. 2010.

25. Mason AD, King EM. Engendering Development Through Gender Equality in Rights. Resources and Voice.: The World Bank; (21776).

26. Mccoy D, Chand S, Sridhar D. Global health funding: how much, where it comes from and where it goes. Health Policy Plan 2009;24(6):407-17.

27. Ooms G. From the global AIDS response towards global health? A discussion paper.: The Hélène de Beir foundation. The International Civil Society Support group; 2009.

28. Ooms G, Van Damme W, Temmerman M. Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment. PLoS Medicine 2007;4(4):605-8.

29. Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases. Organisation of African Unity; 2001.

30. People's Health Assembly 2. The Cuenca Declaration. 2005.

31. Anonymous. Making progress on global health in the Spanish, Belgian and Hungarian presidency of the European Union: civil society recommendations. 2009.

32. Anonymous. The future of global health: Ingredients for a bold & effective U.S. initiative.: www.theglobalhealthinitiative.org; 2009.

33. Reich MR, Takemi K. G8 and strengthening of health systems: follow-up to the Toyako summit. Lancet 2009;373(9662):508-15.

34. Frenk J. Bridging the Divide: Comprehensive Reform to Improve Health in Mexico. Nairobi, Kenya: Commission on Social Determinants of Health;

35. Price JE, Leslie JA, Welsh M, Binagwaho A. Integrating HIV clinical services into primary health care in Rwanda: a measure of quantitative effects. Aids Care-Psychological and Socio-Medical Aspects of Aids/Hiv 2009;21(5):608-14.

36. Special programme for research and training in tropical diseases. Community-directed interventions for major health problems in Africa: a multi-country study: final report. Geneva: WHO; 2008.

37. Best practice principles for global health partnership activities at country level. Paris: High-Level Forum on the Health MDGs; 2005.

38. Hunt P, Backman G. Health Systems and the Right to the Highest Attainable Standard of Health. In: Clapham A, Robinson M, Mahon C, Jerbi S, editors. Realizing the right to health. Swiss human rights books; Rüffer & Rub; 2009. p. 40-59.

39. Kacou A, Reuter L. Country team coordination. Case study: Senegal. What works & what doesn't.: United Nations Country Team Senegal.

40. Cometto G, Ooms G, Starrs A, Zeitz P. A global fund for the health MDGs? Lancet 2009;373(9674):1500-2.

41. Das Gupta M, Gostin LO. Policy research working paper: How can donors help build global public goods in health?: The World Bank Development Research Group Human Development and Public Services Team; 2009.

42. Bate R, Boateng K. How to promote global health. A foreign affairs roundtable: Reality Check. Foreign Affairs. The Council on Foreign Relations.

43. Glennie J. The trouble with aid. Why less could mean more for Africa. London, New York: Zed Books in association with International African Institute Royal African Society Social Science Research Council; 2008. (African Arguments).

44. Interactions between global health initiatives and health systems: Evidence from countries. The Maximizing Positive Synergies Civil Society Consortium; 201.

45. Poverty, aid and corrupton: Policy paper. Transparency international. The global coalition against corruption; 2007. (1).

46. Piva P, Dodd R. Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years. Bull World Health Organ 2009;87(12):930-9.

47. Marriott A. Blind Optimism. Challenging the myths about private health care in poor countries.: Oxfam International; 200. (125).

48. A scramble in Africa. The Economist print edition. 2008 Sep 4.

49. Wagstaff A, Claeson M. The millennium development goals for health: rising to the challenges.: The World Bank; 2004.

50. Horton R. Global science and social movements: towards a rational politics of global health. International Health 2009;1(1):26-30.

51. Council of Europe. European convention for the protection of human rights and fundamental freedoms. 1950.

52. Ruger JP. The changing role of the World Bank in global health. Am J Public Health 2005;95(1):60-70.

53. Peoples Health Movement, Medact, Global Equity Gauge Alliance, Zed Books. Global health watch 2: an alternative world health report. 2008.

54. WHO. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. 2007.

55. Ruger JP, Yach D. The global role of the World Health Organization. Global health governance 2010;II(2)

56. Amorim C, Douste-Blazy P, Wirayuda H, Store JG, Gadio CT, Dlamini-Zuma N, et al. Oslo Ministerial Declaration - global health: a pressing foreign policy issue of our time. Lancet 2007;369(9570):1373-8.

57. Dr.N.Daulaire. The John P. McGovern Award Lecture Presented at the 1999 Annual Meeting of the Association of Academic Health Centers: Global Dimensions of Domestic Health Issues. In: U.S. National Security, Foreign Policy and Global Health. Global Health Council; 1999.

58. Van Langendonck J. Globalisation and social security. 2010.

59. World Health Organization. About WHO.: World Health Organization;

60. Koplan JP, Bond TC, Merson MH, Reddy KS, Rodriguez MH, Sewankambo NK, et al. Towards a common definition of global health. Lancet 2009;373(9679):1993-5.

61. Winslow CEA. The untilled field of public health. Modern Medicine 1920;2:183-91.

62. Brown TM, Cueto M, Fee E. The World Organization and the transition from "international" to "global" public health. Am J Public Health 2006;96:62-72.

63. Alliance for Health Policy and Systems Research, World Health Organization. Systems Thinking for Health Systems Strengthening.: World Health Organization; 2009.

64. Greenspan A. Speech delivered at a symposium sponsored by the Federal Reserve Bank of Kansas City, Jackson Hole, Wyoming, August 29, 2003. 2010.

65. Implementation of tobacco control policies proves hard to do. Lancet 2007;369(9580):2133.

66. Tobacco convention needs signatories' full support. Lancet 2006;367(9510):542.

67. WHO. International health regulations. Second edition. 2005.

68. WHO. International health regulations. Revised. 2007.

69. ILO. The ILO at a glance. 2010.

70. Helfer LR. Understanding change in international organizations: Globalization and innovation in the ILO. Vanderbilt Law Review 2006;59(3):649-+.

71. International Labour Office SSD. Social Health Protection. An ILO strategy towards universal access to health care. Social Security Policy Briefings Paper.: ILO; 2008.

72. Anonymous. Who runs global health? Lancet 2009;373(9681):2083.

73. Hyden G. After the paris declaration: Taking on the issue of power. Development Policy Review 2008;26(3):259-74.

74. Renzio P, Whitfield L, Bergamaschi I. Reforming foreign aid practices: What country ownership is and what donors can do to support it.: Department of Politics and International Relations. University College Oxford; 2008.

75. Hill K, Thomas K, AbouZahr C, Walker N, Say L, Inoue M, et al. Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. Lancet 2007;370(9595):1311-9.

76. Loaiza E, Wardlaw T, Salama P. Child mortality 30 years after the Alma-Ata Declaration. Lancet 2008;372(9642):874-6.

77. UNAIDS. Report on the global AIDS epidemic. 2008.

78. WHO. Social determinants of health. http://www who int/social_determinants/en/.

79. Marmot M, Wilkinson R. Social Determinants of Health. Second edition. Oxford: Oxford University Press; 2006.

80. WHO Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. 2008.

81. World Health Organization. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO; 2007.

82. Chen L, Evans T, Anand S, Boufford JI, Brown H, Chowdhury M, et al. Human resources for health: overcoming the crisis. Lancet 2004;364(9449):1984-90.

83. Healthy development: the World Bank strategy for health, nutrition and population results. The World Bank; 2007.

84. People at the centre of health care: harmonizing mind and body, people and systems. WHO; 2007.

85. WHO. The World Health Report 2000. Health Systems: Improving Performance. WHO. [Lest 20 Jan 2010]. Available from: http://www.who.int/whr/2000/en/whr00_en.pdf.

86. Harding A. Keystone module background paper: private participation in health services handbook.: Human development network. The World Bank. Health, nutrition and population department; 2001.

87. Fidler D. After the revolution: global health politics in a time of economic crisis and threatening future trends. Global health governance 200;II(2)

88. Position paper on the establishment of the UNITAID. The international drug purchase facility.

89. Fact sheet on Tobin taxes. Centre for Environmental Economic Development.

90. Ramonet I. Disarming the markets. Le Monde diplomatique. 199.

91. Hubbard T, Love J. Medicines without barriers: From the human genome project to open development models for medical R&D. New Scientist 2003;

92. Szlezák NA, Bloom BR, Jamison DT, Keusch GT, Michaud CM, Moon S, et al. The global health system: actors, norms, and expectations in transition. PLoS Medicine 2010;7(1)

93. Medical Research and Development Treaty. Discussion draft 4.

94. Ford N, 't Hoen E. The Global Health Fund: moral imperative or industry subsidy? Lancet 2001;358(9281):578.

95. Silberschmidt G. The European approach to global health. Identifying common ground for a U.S.-EU agenda.: A report of the CSIS global health policy center;

96. Mccoy D, Kembhavi G, Patel J, Luintel A. The Bill & Melinda Gates Foundation's grant-making programme for global health. Lancet 2009;373(9675):1645-53.

97. Roemer R, Taylor A, Lariviere J. Origins of the WHO framework convention on tobacco control. Am J Public Health 2005;95(6):936-8.

98. Ruger JP. Global health governance and the World Bank. Lancet 2007;370(9597):1471-4.

99. Ruger JP. What will the new World Bank head do for global health? Lancet 2005;365(9474):1837-40.

100. Chan M. Why the world needs global health initiatives. Address at the high-level dialogue on maximizing positive synergies between health systems and global health initiatives, Venice, Italy. WHO

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