Realizing the right to health for everyone: the health goal for humanity

GO 4 HEALTH

Goals & Governance for health

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Abbreviations

Committee	Committee on Economic, Social and Cultural Rights
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
MDG	Millennium Development Goal
NCD	Non-Communicable Disease
OECD	Organization for Economic Co-operation and Development
OECD-DAC	Development Assistance Committee of the OECD
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
WHO	World Health Organization

Executive summary

Go4Health is a research consortium that includes academic and civil society partners from Africa, Asia, Australia, Europe, North- and Latin America. Our name stands for *goals* and for *governance*, both for health.

We use international human rights law and the right to health in particular as the benchmark for our analysis of the current Millennium Development Goals (MDGs) and progress towards them, as well as for our analysis of proposed new health goals formulated by others. We have also embarked on a series of consultations with people in marginalized communities in 11 countries to ascertain whether their expectations correspond with the prescriptions of international human rights law. To balance our normative enquiry with political realism, we analyze the current MDGs and the practice of international assistance for health as it evolved during the first decade of the new millennium, and three recent proposals that seem to have considerable support from global political leadership.

Our proposal

We propose a single overarching health goal, the realization of the right to health for everyone, with two targets, universal health coverage anchored in the right to health and a healthy social and natural environment. Other goals could also benefit from being framed as human rights.

The right to health should be understood as a *right to health protection*, including two components: *a right to health care* and a *right to healthy conditions*. The three recent proposals can all be broken down into these components. However, to respond to the legitimate expectations of the communities we consulted, these components need to be infused with the essential principles of the right to health: *progressive realization*, *non-discrimination*, *cost-effectiveness*, *participatory decision-making*, *prioritization of vulnerable or marginalized groups*, *minimum core obligations*, and *shared responsibility*.

The entitlement to health care

The communities we consulted expressed clear and substantial expectations with regards to health care. They reject the idea of an internationally defined minimum package that would only cater for specific groups or specific health issues: health care must be adapted to people's needs. Equally important as adaption to local needs is the demand for an accessible, welcoming and responsive health care system. The typical experience with health care systems of the communities we consulted is one of hostility, exclusion, discrimination and stigmatization.

The current health sector MDGs emphasise selective health care interventions. Partial coverage may be sufficient to realize the MDGs, but is insufficient to realize the right to health for everyone. It is not obvious why this selective approach was adopted. It could be a *spearhead strategy*: encouraging progress on specific issues in the hope that the entire health system would benefit. If so, recent international support for universal health coverage may signal an understanding that it is time to move to a comprehensive approach. If, however, the selective approach reflects the political reality of wealthier states emphasizing interventions abroad that directly benefit their constituencies – global infectious disease control – the linking of the international *poverty reduction* agenda with the international *sustainable development* agenda, and within the sustainable development agenda, the linking of *social* sustainability with *environmental* sustainability, may open the door for a comprehensive approach based on a shared interest in *sustainability, full stop*.

International human rights law provides an entitlement to health care that is related to each country's economic status, but entails the principle of *progressive realization*: as states become wealthier, they must provide more and better health care. Choices between available policies must take *cost-effectiveness* into consideration, but also the principles of *non-discrimination*, *participatory decision-making*, and *prioritization of vulnerable or marginalized groups.* Furthermore the right to health entails *minimum core obligations*, and *shared responsibility* for – at the very least – the realization of these core obligations. Universal health coverage infused with these principles, or anchored in the right to health, would have to include a minimum threshold and be responsive to people's needs.

The entitlement to a healthy natural and social environment

For the communities we consulted, water, food, and sanitation, but also decent education, housing and employment, are essential preconditions for health: as important as, if not more important than, health care.

The current MDGs – beyond the health sector MDGs – address some of these issues, albeit in a fragmented way.

International human rights law links the right to health to other human rights, including the rights to food, housing, work, education, and social protection. Framing the new health goal for humanity as the realization of the right to health for everyone would include these essential links.

Global governance and international cooperation

The communities we consulted are aware of the importance of good governance, but are focused on governance at the local and the national level. They are increasingly aware of the impact of global governance on their health, and expect that global governance promotes better governance at all levels.

The global governance of health in particular is a complex affair, and it has not become less so since the Millennium Declaration. Since 2000, increasing numbers of global health institutions and initiatives have been launched, each with their own governance structure. The *global health system* is composed of a wide variety of governance mechanisms: some based on the principle of *one country, one vote*; others more like a *plutocracy* in which the wealthier states have the most influence; and some have younger members of the global system opening door for civil society but also for private philanthropies and for-profit enterprises. If a simplification of the global health system does not seem a realistic perspective for the near future, the adoption of a common goal or set of goals may bring more coherence to it.

International human rights law does not clarify what ideal global governance looks like, but it highlights the tension between national and international responsibility. How should the international community react if some states seem *able but unwilling* to realize the right to health? How can states that are *willing but unable* obtain the assistance they need? If international human rights law highlights a vacuum in global governance, it also sets standards for what global governance is supposed to achieve.

Participatory decision-making

If there is one expectation that comes out most clearly from the consultations, it is the principle of participatory decision-making. All other objectives will either fall or stand with participatory decision-making. While difficult to measure, the new health goal for humanity should explicitly include a target *to provide a genuine role to the public in health-related priority-setting, policy-*

making, budgeting, and other decision-making and monitoring and evaluation at all levels.

While the Millennium Declaration emphasized the importance of "more inclusive political processes, allowing genuine participation by all citizens in all our countries", participatory decision-making seems to be one of the values lost in the translation of the Millennium Declaration into MDGs.

Participation is one of the key principles of international human rights law. If only for this reason, it would be worthwhile framing the new health goal for humanity as realization of the right to health for everyone. Participatory decision-making is not an optional extra, it is an essential principle.

Towards a global social contract?

The realization of the right to health will require reliable cooperation between states and a clearer definition of national and international responsibility. In the absence of a global government, such cooperation has to be voluntary cooperation.

Setting targets for national and international financing of efforts to improve health care and healthy natural and social environments may be the easiest part of a global social contract, but even for that part, there seems to be little political appetite at present. International negotiations to mitigate climate change may open the door for mutually binding commitments that ensure a form of globalization that is also socially sustainable, not only sustainable from an environmental perspective. A global fund for health, perhaps as a branch of a global green and social environment fund, could provide a limited solution.

However, when it comes to the social determinants of health, financing is only a tiny part of the solution. Much wider and deeper cooperation is required to ensure the sharing of the benefits of medical research and innovation, or to end the practice known as *land grabbing*, to name only two examples. If a framework convention for global health or on the right to development seem out of political reach today, a *global action plan* to achieve the new MDGs and the Sustainable Development Goals, framed as human rights, could recognize the need for and set in motion the development of such a convention.

Introduction

The Millennium Declaration's preamble sets forth a bold vision for humanity, advancing global responsibilities without diminishing national responsibilities: "We [heads of States and Government] recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level."[1]

The Millennium Declaration was translated into a set of Millennium Development Goals (MDGs) and related targets, most of them to be achieved by 2015. Long before reaching 2015, an international consensus emerged that the MDGs would be renewed and most likely embrace different goals. In 2011, the European Union called for proposals to establish a research coordination consortium to help "ensure that the health-related development objectives for the period after 2015 are based on the best scientific evidence available and address the main shortcomings of the current MDGs."

The name of our consortium, Go4Health, stands for *goals* and for *governance*, both for health. Our name reflects our belief that the new health goal (or set of health goals) for humanity should be embedded within a global social contract that clarifies where national and international responsibility meet.

We use international human rights law and the right to health in particular as the benchmark for our analysis of the current MDGs and the progress towards them, as well as for our analysis of proposed new health goals formulated by others.

However, we do not presuppose that international human rights law as it was developed and interpreted reflects the needs and claims of all people. Therefore we have embarked on a series of consultations in 11 countries to verify whether the expectations of people from marginalized and vulnerable communities correspond with the prescriptions of the right to health. The responses we collected so far have been included in this report.

To balance our human rights enquiry with political realism, we also analyze the current MDGs, the reality of international assistance for health as it evolved during the first decade of the new millennium, and new proposals that seem to have considerable support from international political leadership. The latter include:

- The Global Thematic Consultation on Health;[2]
- The High-Level Panel of Eminent Persons on the Post-2015 Development Agenda;[3]
- The Sustainable Development Solutions Network.[4]

The proposal by the Sustainable Development Solutions Networks is about the Sustainable Development Goals (SDGs), as agreed at the United Nations Conference on Sustainable Development in Rio de Janeiro

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[1] United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[2] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from: http://www.worldwewant2015.org/health

[3] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from: http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf

[4] Leadership Council of the Sustainable Development Solutions Network (2013) *An Action Agenda for Sustainable Development*. Available from: http://unsdsn.org/files/2013/06/130613-SDSN-An-Action-Agenda-for-Sustainable-Development-FINAL.pdf

in June 2012 and confirmed by the United Nations General Assembly in September 2012,[5] not about the MDGs. However, the inclusion of this proposal in our analysis is justified because of the concurrence of and links between the renewal of the MDGs and elaboration of the SDGs – they may even become a *single undertaking*, which means that nothing is agreed until everything is agreed, MDGs and SDGs.

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[5] United Nations General Assembly (2012) *The Future We Want.* Available from:
http://sustainabledevelopment.un.org/futurewewant.html

1. The goal we propose: the realization of the right to health for everyone

We propose a single overarching health goal: the realization of the right to health for everyone. We furthermore suggest that most of the other goals could be framed as human rights to be realized for everyone. As an overall frame, human rights could infuse coherence and shared principles throughout the goals.

As Fuenzalida-Puelma and Scholle Conner concluded after examining the right to health in the constitutions of several countries for the Pan American Health Organization, the right to health would be better understood as "a *right to health protection*, including two components: *a right to health care* and a *right to healthy conditions*."[6] That is why we propose one health goal – the realization of the right to health for everyone – with two targets being universal health coverage (UHC) anchored in the right to health and a healthy social and natural environment for all.

The MDGs are, essentially, norms for humanity or for cooperation between states; taken together, they can be seen as the "super-norm of ending global poverty".[7] Such a super-norm existed already, enshrined in the Universal Declaration of Human Rights: "Everyone is entitled to a social and interna-

tional order in which the rights and freedoms set forth in this Declaration can be fully realized".[8]

The report of the Global Thematic Consultation on Health proposes "Maximizing Healthy Lives" as the overarching health goal, which would include "accelerating progress on the [current] health MDG agenda; reducing the burden of [non-communicable diseases]; and ensuring universal health coverage and access".[9] In effect this is the first component of the right to health as defined by Fuenzalida-Puelma and Scholle Conner.[10] The report also recognizes that "good health is determined, not only by preventing and treating disease, but also by many other aspects of development, including education, gender equality, sustainable energy and nutrition, water and sanitation, and climate change adaptation and mitigation", and that "[g]oals in these areas of the post-2015 agenda could include health-related targets to address the underlying determinants of health"; this is the second component of the right to health.

The High-Level Panel of Eminent Persons proposes "Ensure Healthy Lives" as the overarching health goal, and suggests indicators with regards to health care – end preventable infant and child health, improve vaccination coverage, decrease maternal mortality, ensure universal sexual and reproductive health and rights, reduce the burden of disease – under the umbrella of "Leave No One

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[6] Fuenzalida-Puelma H, Scholle Connor S (1989) 'The Concept of the Right to Health.' In: Fuenzalida-Puelma H, Scholle Conner S (eds.) *The Right to Health in the Americas*. Washington, DC: Pan American Health Organization

[7] Fukuda-Parr S, Hulme D (2009) *International Norm Dynamics and 'the End of Poverty': Understanding the Millennium Development Goals (MDGs)*. Available from:
http://www.eadi.org/fileadmin/MDG_2015_Publications/fukuda-parr_and_hulme_2009_international_norm_dynamics.pdf

[8] United National General Assembly (1948) *Universal Declaration of Human Rights*. Available from:
http://www1.umn.edu/humanrts/instree/b1udhr.htm

[9] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from:
http://www.worldwewant2015.org/health

[10] Fuenzalida-Puelma H, Scholle Connor S (1989) 'The Concept of the Right to Health.' In: Fuenzalida-Puelma H, Scholle Conner S (eds.) *The Right to Health in the Americas*. Washington, DC: Pan American Health Organization

Behind".[11] This will require that all people worldwide have access to decent health care, or the first component of the right to health. Furthermore, the High-Level Panel acknowledges that ensuring healthy lives starts "with a basic commitment to ensure equity in all the interconnected areas that contribute to health (social, economic and environmental)", which is the second component of the right to health.

The Sustainable Development Solutions Network proposes "Achieve Health and Wellbeing at All Ages", which would include "to ensure universal health coverage for all citizens at every stage of life, with particular emphasis on the provision of comprehensive and affordable primary health services delivered through a well-resourced health system".[12] Furthermore, the Sustainable Development Solutions Network argues, "health systems also need to be supported by enabling actions in other sectors, including gender equality, education, improved nutrition, water, sanitation, hygiene, clean energy, healthy cities, and lower pollution." Again, we find the two components of the right to health in this proposal.

So, if *maximizing healthy lives*, *ensuring healthy lives*, or *achieving health and wellbeing at all ages*, the three proposals that are being considered by the international community, all contain the two essential components of the right to health, there is a strong case to advance the *realization of the right to health for everyone* as the overarching goal.

The added value of using the *realization of the right to health for everyone* as the overarching goal would be that human rights are rooted in international law and there is a body of jurisprudence and authoritative interpretation that provides, at least to some extent, key elements of governance that link the substance of people's rights with responsibilities – duty-bearers. Human rights inform the governance structures and processes, and obligations that will enable people to secure their rights.

In addition, if mixed progress towards the current MDGs is to some extent due to the "lack of domestic social movement among the rich countries in support of the MDGs",[13] a human rights based agenda may be able to generate a broader supportive movement. Furthermore, if the renewal of the MDGs and the elaboration of SDGs indeed becomes a single undertaking, requiring international agreement on international collective action on poverty reduction and sustainable development at the same time, the entire body of norms of international human rights law could provide extremely useful guidance.

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[11] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from: http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf
[12] Leadership Council of the Sustainable Development Solutions Network (2013) *An Action Agenda for Sustainable Development*. Available from: http://unsdsn.org/files/2013/06/130613-SDSN-An-Action-Agenda-for-Sustainable-Development-FINAL.pdf

[13] Hulme D, Scott J (2010) *The Political Economy of the MDGs: Retrospect and Prospect for the World's Biggest Promise*. Available from: http://www.bwpi.manchester.ac.uk/resources/Working-Papers/bwpi-wp-11010.pdf

2. The entitlements provided by the right to health

2.1. The entitlement to health care

2.1.2. The entitlement to health care from the perspective of marginalized communities

The health care demands of the highly marginalized communities that we engaged with lie at a very fundamental level: the need to have ready access to health care, and to have that care be responsive, respectful and non-discriminatory. When focusing on particular health issues, communities point to the major health concerns in their community, such as AIDS, maternal health and malaria in Africa (along with, in Uganda, *nodding syndrome*).

This demand for health care that meets communities' needs, and focuses on the health challenges they see in their community, tracks well with *universal health coverage* (UHC), proposed as the overarching health goal by the World Health Organization (WHO).[14]

Some communities strongly emphasized the importance of universality – meeting the needs of the whole population and not only interventions that target only one or another segment of the community. Indigenous communities in Guatemala rejected the very notion of health care priority setting where the needs of only some members of the community (e.g., children) would receive priority, rather than the needs of the whole community. This also implies the importance of ensuring that UHC covers such areas as mental health, to meet the health needs of

people with mental disabilities. In the same vein, Samoan migrants in Australia pointed to the need for more funding for cancer and for surgery, echoing the principle of non-discrimination in arguing that access to health care that people need should not be limited to only those who are well-off.

Ensuring UHC that meets people's demands also entails meeting their diverse but particular needs. For example lesbian, gay, bisexual, transgender and intersex populations in Uganda expressed the importance of circumcision, HIV post-exposure prophylaxis, elective surgery, psychosocial support, and sensitization of the community. Different population groups – men and women, youth and the elderly, people with disabilities and people with HIV – also emphasized different needs. UHC will need to incorporate the flexibility to account for this diversity.

Some health priorities of marginalized communities may be unexpected and not necessarily captured by common delineations of what UHC would include, or typically viewed as lower priority, such as dental services, highlighted as among their essential health needs by Afghan communities in Kabul District. UHC anchored in the right to health must therefore include sufficient scope and meaningful, representative local input to encompass certain essential health needs that might not be readily predicted from epidemiology alone.

Key principles of the right to health – prioritization of marginalized communities' needs and the participation in decision-making at all levels (described more below) – are therefore integral to ensuring that a post-2015 target of comprehensive UHC matches the essential health needs of not only a large portion of the population, but of everyone.

The views of marginalized communities also implicitly endorse the emphasis on equity that the right to health contains. Their

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[14] World Health Organization (2012) *Positioning Health in the Post-2015 Development Agenda*. Available from:
http://www.worldwewant2015.org/bitcache/7c4f4f265
f3d2dfdfed54c06afee939039865522?vid=302852&dispo
sition=attachment&op=download

needs, like everyone's, must be met. Yet currently, marginalized communities frequently find health systems failing them dramatically; hence their focus, when describing their health needs, not on particular health interventions, but on more general issues of access to respectful care. At present, the common experience for a wide range of marginalized populations – indigenous populations, the poor, people with disabilities, and many more – is that they have difficulty accessing health care. When they can access health care it is often sub-standard. Even worse, marginalized communities frequently find the health system hostile to them and their needs, resulting in discrimination, stigmatization and other forms of mistreatment by health workers, reinforcing experiences of marginalization and denial of their dignity and humanity.

In contrast to this frequent reality, marginalized communities expressed the view that they should have ready access to health care, and that health care should be responsive and respectful. This requires nearby clinics, available ambulances, and health facilities that have sufficient numbers of health workers and that offer the medicines that they are meant to provide. Cost barriers – both formal and informal fees – need to be removed. For some communities, access also has other components, such as security in Afghanistan, physical accessibility for people with disabilities, and language for populations who do not speak the dominant language.

Beyond this, meaningful access requires an end to the discrimination that significantly harms people's health. Members of marginalized communities will often avoid the formal health system as they anticipate mistreatment. When they do seek care from the formal health system, it may be denied entirely or be dangerously (even fatally) delayed. The quality of care may be lower, for example, because of provider preconceptions or their failure to listen to people's expres-

sion of their health concerns. Notably, non-discrimination is part of the core content of the right to health, while its essential elements include acceptable care, which is only possible where patients are treated with dignity.

UHC will thus need to be rooted in the right to health, and like the right, encompass not only particular health goods and services, but also how those goods and services are delivered and how people access them, ensuring that formal coverage translates into actual coverage and quality care, including for marginalized populations. This will require a range of measures to transform health care services to be more respectful of people. Measures could include recruiting health workers from communities of marginalized populations and organizing regular meetings between health workers and community members to build trust and understanding. Health worker education will need to incorporate human rights into curricula, and health workers will need to be sensitized to the needs and circumstances of marginalized populations, recognizing the rights of all people to be treated with dignity. Strong leadership will be required to create a culture of accountability and respect, including by ensuring effective mechanisms for holding health workers accountable for discrimination or other mistreatment. Support for health workers, from ensuring sufficient numbers to supportive supervision, safe working environments, and fair compensation, is also necessary.

Even these actions, while helpful, may be insufficient as long as people remain structurally marginalized. Broader measures, extending beyond the health sector, are required. All vestiges of discrimination must be removed from laws and policies; educational and media reforms must avoid stereotypes and promote equality and respect for all members of the population, and; respectful engagement needs to be promoted be-

tween marginalized communities and dominant populations. Furthermore, economic and political reforms that give marginalized communities greater political power and reduce economic inequalities are crucial to change. All are ultimately linked to effective, quality UHC, and ensuring healthy lives more broadly. UHC in the new international health goals, including through indicators and guidance, will therefore need to incorporate issues of access to quality care, addressing both barriers to access outside the health system and discrimination within the health system.

2.1.2. The entitlement to health care under the current MDGs

Although the Millennium Declaration from which the MDGs emerged refers to human rights, neither the Millennium Declaration nor the current MDGs speaks of the right to health as such. It seems that in the process of the *translation* of the Millennium Declaration into the MDGs, some important principles got lost, including human rights, equity, and good governance.[15][16][17][18]

The fact that three of the eight current MDGs are focused on health (MDG 4 to reduce child mortality; MDG 5 to improve maternal health; MDG 6 to combat HIV/AIDS, malaria, and other diseases) and

that several other goals include targets that are health-related, signals the high importance given by the international community to health. However, the plurality of the current health-related MDGs may have been a mixed blessing, leading to competing interests and encouraging sector-specific (and even issue-specific) responses, rather than facilitating inter-sectoral cooperation. Thus the MDGs may have contributed to fragmentation of the health systems of some countries.[19] Even the sum of the current health-related MDGs does not equate to the entitlement to health care provided by the right to health. Prevention and treatment for non-communicable diseases (NCDs), for example, is not included.

Several MDG targets seem to suggest that *partial* coverage is good enough. Target 5A, for example, is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, which may indicate that providing emergency obstetric care to *all* women who need it was not considered a priority – or perhaps not deemed feasible. Such partial targets may have encouraged *picking the low-hanging fruit*, or focusing efforts on the easier to reach people. Equity was not a major issue in monitoring the MDGs, which focused on aggregate targets and national indicators.[20] Disadvantaged and marginalized groups were left behind,[21][22] and at worst, inequities have widened.

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[15] Advisory Council on International Affairs of the Netherlands (2011) *The post-2015 development agenda: the Millennium Development Goals in perspective.* Available from:
http://www.beyond2015.org/sites/default/files/THE%20POST-%202015%20DEVELOPMENT%20AGENDA.pdf
[16] Vandemoortele J (2011) 'The MDG story: intention denied.' *Development and Change*, 42(1):1-21.
[17] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda.* Available from:
http://www.worldwewant2015.org/health
[18] Saith A (2006) 'From universal values to Millennium Development Goals: lost in translation.' *Development and Change*, 37(6):1167-1199

[19] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda.* Available from:
http://www.worldwewant2015.org/health
[20] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda.* Available from:
http://www.worldwewant2015.org/health
[21] Doyle C (2009) 'Indigenous peoples and the Millennium Development Goals – 'sacrificial lambs' or equal beneficiaries?' *The International Journal of Human Rights*, 13(1):44-71
[22] UN Human Rights Council (2008) *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development.* Available from:
http://www.refworld.org/docid/49a5223b2.html

Furthermore, the fragmentation caused by the plurality of health-related MDGs may have been exacerbated by uneven progress on each of them. New international health institutions have been created, such as the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the Global Alliance for Vaccination and Immunization (GAVI). Their mandates are limited; while their efforts undeniably contribute to improving maternal and child health, they only cover a limited range of factors that impact on maternal and child health.

On the face of it, the rise in international funding for health may not seem selective, as existing international institutions like the WHO and the World Bank benefitted too. The WHO biennial budget has more than doubled in the past decade from US$1647 million in 1998-99 to US$4540 million in 2010-11. If we examine the World Bank's health activities, total commitments have increased from US$1.7 billion in 1998-99 to US$4.7 billion in 2010-11. But a closer look at these numbers tells a different story. Within both of these agencies, core budgets are flat or fluctuating. Almost all of the growth is attributable to increases in discretionary funding, or 'multi-bi' aid. The Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC) estimates that about 30% of the multilateral funding is given through what it calls 'multi-bi' aid. This refers to the practice of donors choosing to route non-core funding, earmarked for specific sectors, themes, countries or regions through multilateral agencies. At first glance the funding looks multilateral but upon investigation, it is essentially controlled by a bilateral donor. Analysis by Grepin and Sridhar shows that since 2002, global health donors have increasingly prioritized multi-bi aid at the expense of more traditional forms of multilateral aid as a proportion of

all development assistance for health. [23] Multi-bi aid increased as a proportion of all aid at a rate of approximately 1.5-2.0 percentage points per year over this time period. Bilateral aid as a share of total development assistance for health has remained stable over this time period.

So while the right to health creates an entitlement for *all* people to health care for *all* common health threats, as we will explain further below, the MDGs created an entitlement for *some* people to health care for *some* health threats.

It seems important to try and analyze why the current MDGs are based on this rather selective approach. One plausible explanation is that the drafters adopted a *spearhead strategy*: they aimed for comprehensive health care, but selected a few targets which, to be achieved, required a more comprehensive effort. For example, to reduce maternal mortality, the entire health system needs strengthening. This hypotheses is supported by Vandemoortele and Delamonica, who argue that "[t]he MDGs were not conceived as a comprehensive or near-perfect expression of the complexity of human development"; they merely "offer a version of it that can be easily understood by a general audience."[24]

If this *spearhead strategy* hypothesis is correct, the international community may now be willing to embrace a more comprehensive health goal, after having witnessed the consequences of the selective approach. In 2012 critical momentum for UHC emerged in high-level political circles. In April 2012 Mexico hosted a forum on *Sustaining Uni-*

[23] Grepin K, Sridhar D (2012) 'Multi-bi aid and effects of the 2008-10 economic crisis on voluntary development assistance for health contributions: a time series analysis.' *Lancet*, doi:10.1016/S0140-6736(13)60289-5
[24] Vandemoortele J, Delamonica E (2010) 'Taking the MDGs Beyond 2015: Hasten Slowly.' *IDS Bulletin*, 41(1):60-69

versal Coverage involving WHO and delegates from 21 countries. This resulted in the Mexico City Political Declaration on UHC emphasizing universal coverage as "an essential component of sustainable development" and its inclusion as "an important element in the international development agenda".[25] In June 2012 a larger gathering met in Rio de Janeiro, Brazil, for the *Rio+20 Summit* on sustainable development. Despite initial reticence, the Rio+20 resolution explicitly recognized UHC in the aspiration "to strengthen health systems towards the provision of equitable universal coverage".[26] Later in 2012, a WHO Discussion Paper on the post-2015 health agenda identified UHC as a "way of bringing all programmatic interests under an inclusive umbrella".[27] In September 2012 the Foreign Policy and Global Health Group proposed a historic resolution to be tabled for negotiations at the UN to increase global commitment on UHC. [28] Consequently, on 12 December 2012, UHC received unequivocal endorsement from the UN General Assembly which approved a resolution on UHC, confirming the "intrinsic role of health in

achieving international sustainable development goals."[29]

According to another plausible hypothesis, the selective approach of the MDGs – and uneven progress on different health-related MDGs – merely illustrates the enduring relevance of national self-interest in international cooperation. As Kaul and Gleicher express it: "As the institution of the state has no full equivalent internationally, international cooperation has to happen voluntarily; and as past experience has shown, voluntary cooperation is more likely to happen when it makes sense for all, that is, if it is based on a clear and fair win–win agreement." [30] The *win-win deal* is clear for cooperation for combating infectious disease; less so for comprehensive health care.

If this *enlightened self-interest* hypothesis is correct, our proposal may look like an exercise in wishful thinking. However, as mentioned above, the *Rio+20 Summit* agreed to include UHC as a prerequisite for social sustainability, and social sustainability as an essential element *of sustainability full stop* – together with environmental and economic sustainability. Until recently, social sustainability may have been the stepchild of the sustainability agenda,[31] but if the new iteration of the MDGs and the first iteration of the SDGs become a *single undertaking*, then enlightened self-interest would support international cooperation in a wide range of social challenges, including UHC.

[25] Forum on Universal Health Coverage (2012) *Mexico City Political Declaration on Universal Health Coverage: Sustaining universal health coverage: sharing experiences and promoting progress.* Available from: http://www.who.int/healthsystems/topics/financing/MexicoCityPoliticalDeclarationUniversalHealthCoverage.pdf

[26] United Nations General Assembly (2012) *The Future We Want.* Available from: http://sustainabledevelopment.un.org/futurewewant.html

[27] World Health Organization (2012) *Positioning Health in the Post-2015 Development Agenda.* Available from: http://www.worldwewant2015.org/bitcache/7c4f4f265f3d2dfdfed54c06afee939039865522?vid=302852&disposition=attachment&op=download

[28] Oxfam (2012) *UN Resolution on Universal Health Coverage.* Available from: http://www.oxfam.org/en/pressroom/reactions/un-resolution-universal-health-coverage

[29] United Nations General Assembly (2012) *Global health and foreign policy.* Available from: http://www.un.org/ga/search/viewm_doc.asp?symbol=A/67/L.36

[30] Kaul I, Gleicher D (2011) *Governing global health: is Europe ready?* Available from: http://www.globalhealth.ie/uploads/files/GHE_ResearchSeries_GlobalPublicGoods.pdf

[31] Littig B, Griessler E (2005) 'Social sustainability: a catchword between political pragmatism and social theory.' *International Journal of Sustainable Development*, 8(1/2): 65-79

Enlightened self-interest in UHC can be found elsewhere as well. The resulting benefits to the global economy, including from increased productivity stemming from improved worker health, will contribute to economic growth globally, benefiting countries around the world in a globally interconnected economy. Moreover, the global level state endorsement of UHC demonstrates a level of support for UHC that was absent when the MDGs were developed, opening up possibilities now that may have been closed 15 years ago.

2.1.3. The entitlement to health care in international human rights law

The Universal Declaration of Human Rights – including the original super-norm of ending poverty – was codified in two *international covenants*: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The right to health is included in the International Covenant on Economic, Social and Cultural Rights.

Article 12(1) of the International Covenant on Economic, Social and Cultural Rights recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[32] This has to be read and understood in conjunction with article 2(1) according to which states commit to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means…".

The right to health does *not* provide an immediate entitlement to the best available health care in the world. The corresponding obligation upon states is *to take steps towards* providing the best available health care, taking into account that states' resources are limited and that there are many rights to be realized – even the wealthiest states do not have unlimited resources to commit to health care. Due to the greater availability of resources, the level of health care that a government of a wealthy state is obliged to ensure its residents is broader than that which a government of a poorer state is obliged to ensure its residents, such that the entitlement to health care will look different across different countries.

The somewhat indeterminate nature of the entitlement to health care does not mean, however, that states can easily exonerate themselves of their obligations. There are several important principles to be considered.

- First, and already implied, is the principle of *progressive realization* of the right in the context of each state using the *maximum of its available resources*. When unable to provide health care available in other parts of the world, states are obliged to demonstrate their inability.
- Second, the principle of *non-discrimination* demands that the health care ensured to some must be ensured to all.
- Third, if states are not obliged to provide the best health care available in the world, and if they are not allowed to discriminate against any particular group, then how are they supposed to make choices between the health care they will provide and the health care they will not provide? The principle of non-discrimination implies the public health principle of *cost-effectiveness*. "Expensive curative health services which are often accessible only to a small, privi-

leged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population", have been qualified as "[i]nappropriate health resource allocation [that] can lead to discrimination that may not be overt", by the Committee on Economic, Social and Cultural Rights (Committee) in its *General Comment* on the right to health.[33]

- Fourth, if the principle of non-discrimination implies a principle of cost-effectiveness, it also incorporates a principle of *participatory decision-making*. National public health strategies and plans of action that states are required to adopt and implement "shall be devised, and periodically reviewed, on the basis of a participatory and transparent process," according to the Committee. Thus, determining "the health concerns of the whole population" is not purely a matter of epidemiology, but also of people's expressed priorities.

- Fifth, "the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups", argues the Committee.[34] Because of the principle of *prioritizing vulnerable or marginalized groups*, even if a particular health concern affects only a small portion of the population – and might fall from consideration if a pure cost-effectiveness analysis guides decision-making – if it disproportionately affects vulnerable or marginalized populations, it may well be incumbent on the state to include it as part of the health care that

it ensures for everyone. And the participatory process of developing and monitoring national plans must include special efforts to ensure that marginalized populations are part of this process, and that they are informed and their views respected and listened to, such that their involvement is meaningful.

- Sixth, all human rights have a minimum core, and all states, no matter how rich or poor, therefore have *minimum core obligations*. With regards to the entitlement to health care, states have "at least the following obligations: (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) …; (c) …; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; …".[35]

- Seventh, the right to health includes the principle of *shared responsibility*. Article 2(1) of the International Covenant on Economic, Social and Cultural Rights prescribes that states "take steps, **individually and through international assistance and co-operation**, especially economic and technical, to the maximum of its available resources, …" (emphasis added), and when the Committee elaborated states' core obligations arising from the right to health, it explicitly referred to international assistance: "For the avoidance of any doubt, the Committee wishes to emphasize that it is particular-

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[33] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[34] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[35] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

ly 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…". Thus, states must prioritize these core aspects of health care in providing international assistance.

In a nutshell, the right to health entails an entitlement to health care that is both comprehensive and progressive – as states become wealthier, they have an obligation to provide more and better health care. Furthermore, there is a minimum threshold, for which the international community – or states and other *in a position to assist* – must indeed provide assistance. That minimum threshold is, according to the Committee, linked to the WHO *Action Programme on Essential Drugs*, which issues a *Model List of Essential Medicines*, to be adapted to each country's specific needs,[36] so there is some flexibility in the minimum threshold. While UHC comes closer to the entitlement to health care than the current health sector MDGs, UHC would need to have a minimum threshold to be compatible with the right to health.

2.2. The entitlement to a healthy environment

2.2.1. The entitlement to a healthy environment from the perspective of marginalized communities

The right to health covers more than an entitlement to health care. According to the Committee, the right to health is "an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health".[37]

In the current MDGs, elements of these *healthy conditions* – at times called *underlying preconditions for health*,[38] and called *healthy natural and social environment* in this proposal – are mentioned under MDG 1, on poverty and hunger (including targets on food), and MDG 7, on environmental sustainability, including water and sanitation.

In our research, water, sanitation, and hygiene are emerging as critical issues for a wide range of marginalized communities, from remote ethnic minority communities in Bangladesh to indigenous populations in Guatemala. Food, with an emphasis on healthy food, was another commonly cited health need. Such an emphasis points to the importance of the new health goal or goals for humanity ensuring not only universal health *care* coverage, but also universal access to safe drinking water, good sanitation, and healthy food. Each of these elements has multiple aspects. For example, sanitation and hygiene includes sufficient numbers of sanitary latrines, education on good hygienic practices, and proper trash disposal.

This is just part of the picture. Communities consistently express a holistic view of health, pointing to food, water, sanitation, employ-

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[36] World Health Organization(2010) *Medicines: essential medicines. Fact sheet N°325. Revised June 2010.* Available from: http://www.who.int/mediacentre/factsheets/fs325/en/

[37] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[38] Toebes B (1999) *The Right to Health as a Human Right in International Law*. Antwerpen – Groningen – Oxford: Hart – Intersentia.

ment and earning a livelihood, housing, and education as key determinants of health – as well as health care itself. In some communities, other aspects of healthy physical environments (including lack of pollution), as well as the social environment (e.g., issues of crime, domestic violence, and drug use) and infrastructure (such as roads), along with spiritual and mental health, emerged as additional determinants of their health.

A human rights framework captures this holistic understanding of health needs and entitlements, with many of these determinants directly covered by the right to health, and others the subject of other rights, including education and work. A right to health goal, complemented by other rights-based goals as part of the post-2015 development agenda, would therefore correspond well with community perspectives on the healthy environments to which they are entitled.

Emerging strongly from the responses of marginalized communities is the fact that providing a healthy environment extends to political, economic, and other realms, including the importance of protecting healthy lifestyles. A change of lifestyle can mean that communities that once produced their own food now must rely on often insufficient income to purchase food. Counter to the global trend of increased access to food, for these communities, access to healthy food is decreasing. For example, Samoan migrants now in Australia grew food in their back-yards and fished when they lived in Samoa. Now, unable to afford healthy foods on their low incomes, unhealthy diets are leading to problems of obesity, hypertension, and heart disease. Similarly, lifestyle changes mean that physical exercise is no longer an auto-matic part of their daily activities, again contributing to non-communicable diseases. Structuring urban environments to return exercise to a natural part of people's regular

activities will be an important way to address NCDs.

Ensuring a healthy environment can also mean challenging powerful economic and other forces, such as food and beverage corporations that can have far-ranging impacts on healthy foods, from the ingredients they use to their marketing and pricing techniques. Mines often create major environmental hazards for communities in Latin America and elsewhere. In Bangladesh, the army forced one ethnic minority community to relocate, driving them to abandon traditional practices of organic farming, which contributed not only to poor nutrition, but also challenged their capacity to earn an income.

The emphasis of communities on the importance of a healthy environment is consistent with the emerging post-2015 sustainable development agenda, highlighting the importance of ensuring for all people clean water and sanitation, nutritious food and education, economic opportunity, and more. Determining the post-2015 agenda will require holistic nuanced thinking to ensure that pursuit of some goals – such as economic growth – do not come at the expense of health. For instance, mines may contribute to a country's economy, but cannot be seen as contributing to sustainable development if they harm people's health.

Across the post-2015 agenda, there must be policy coherence for health, which could be promoted through specific strategies such as right to health impact assessments of government policy. Healthy environments will also require structuring into people's regular environments the opportunity to be healthy, such as ready access to affordable nutritional food, with the variety of measures that this could entail, such as how states regulate corporations, structure social programs, design urban environments, and protect both the

natural environment and land rights of marginalized communities.

2.2.2. The entitlement to a healthy environment under the current MDGs

Under the current MDG agenda, some of the broader determinants of health are addressed under separate goals and targets – the target of sustainable access to safe drinking water and basic sanitation under MDG 7 on sustainability; the target to halve the proportion of people who suffer from hunger under MDG 1; and education under MDG 2 (to achieve universal primary education).

The fact that the underlying determinants of health have been addressed under separate goals and targets in the current MDG agenda has been problematic. Critics argue there was no (or not enough) collaboration between the different MDG goal sectors, sometimes fostering competition rather than cooperation.[39]

However, progress on the targets that have an effect on health, but that have not been linked to health sector MDGs, has been notable. The proportion of the global population using improved sources of drinking water reached 89% in 2010, up from 76% in 1990. The proportion of undernourished people in developing regions decreased from 23.2% in 1990–1992 to 14.9% in 2010–2012. Between 2000 and 2011, the number of children out of school declined by almost half – from 102 million to 57 million.[40] So, while most of the international discourse on health focuses on health care, some crucial *healthy*

environment factors seem to have improved faster than health indicators.

What is the point, then, of proposing *a healthy social and natural environment for all*, as a target under a goal of *realizing the right to health for everyone*? To be sure, we are not suggesting that water, sanitation, food and education do not need their own goals. On the contrary, we suggest an MDG and SDG framework expressed as human rights, which would include the right to food, the right to water and the right to education – each as a specific goal. However, we do believe that it is necessary to emphasize that the realization of the rights to water, food, education and other rights are essential for the realization of the right to health.

Furthermore, a *healthy natural and social environment* requires more than progress on the natural determinants of health, but also requires progress on the social determinants of health, e.g. social inclusion and protection.[41] Natural and social environmental issues are closely linked and this relationship needs to be incorporated within the new development agenda. Sustainable development can only be achieved when societal and natural processes are harmonized.

2.2.3. The entitlement to a healthy environment in international human rights law

As mentioned above, the right to health covers much more than an entitlement to health care. The principles of *progressive realization*, *non-discrimination*, *cost-effectiveness*, *participatory decision-making*, *prioritization of vulnerable or marginalized groups*, *minimum core obligations*, and

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[39] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from:
http://www.worldwewant2015.org/health
[40] United Nations (2013) *The Millennium Development Goals Report 2013*. Available from:
http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf

[41] Commission on Social Determinants of Health (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Available from:
http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

shared responsibility, apply to the entitlement to a healthy environment, as they do to the entitlement to health care. Under section 2.1.3. we focused on the minimum core obligations related to health care, but the Committee also formulated the following core obligations under the right to health: "(a) …; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; …"[42]

Furthermore, the Committee emphasizes that "[t]he right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."[43] Referring to social protection, albeit implicitly – "Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all"[44] – the Committee also includes some of the social determinants of health into the right to health. These determinants are further developed in

General Comment 19 on the right to social security.[45]

The added value of adopting *the realization of the right to health for everyone* as the new health goal for humanity, within a context of other goals also expressed as human rights, would be that we do not have to include every aspect of health under a single goal. If the MDGs can be seen as the "super-norm of ending global poverty",[46] it is worth noting that we already had one, in the Universal Declaration of Human Rights: "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized".[47]

[42] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm
[43] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm
[44] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[45] Committee on Economic, Social and Cultural Rights (2008) *General Comment No. 19, The Right to social security*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom19.html
[46] Fukuda-Parr S, Hulme D (2009) *International Norm Dynamics and 'the End of Poverty': Understanding the Millennium Development Goals (MDGs)*. Available from: http://www.eadi.org/fileadmin/MDG_2015_Publications/fukuda-parr_and_hulme_2009_international_norm_dynamics.pdf
[47] United Nations (1948) *Universal Declaration of Human Rights*. Available from: http://www1.umn.edu/humanrts/instree/b1udhr.htm

3. Governance for the realization of the right to health

3.1. Global governance and international cooperation

3.1.1. Global governance and international cooperation from the perspective of marginalized communities

For a wide range of marginalized communities, issues of governance, of the roles and responsibility of government and mechanisms to hold governments accountable to these responsibilities – are focused at the local level, with local authorities and community leaders, and even with the non-governmental organisations (NGOs) that have resources and are implementing programs. The global level – and in some cases even the national government – is distant, practically an abstraction.

The sense of national government responsibility is strong among marginalized communities in South Africa, Afghanistan, Uganda, Guatemala, and elsewhere, including a responsibility to regulate third parties. Even among communities that emphasize local responsibility, some community members recognized the ministry of health or the national government more generally as holding responsibility for health, including for assuming a leadership role.

Even among some highly marginalized communities, such as ethnic minorities in Bangladesh, we found the belief that the international community should provide funding for health, especially for disadvantaged communities. Communities in some countries, especially where international actors have had a significant role in health, also recognize an international health responsibility, including in Uganda, Zimbabwe, South Africa, and Afghanistan. Marginalized communities in Uganda see a role for global health agencies in funding, technical guidance, and emergency response.

Wherever people locate primary responsibility, the relevant authorities are frequently failing to meet their responsibilities. The distance of national and global authorities, combined with the failures at the local level, appear for many communities to drive an emphasis on individual and family responsibility for their own health. The widespread perception among marginalized populations of the failure of government to meet their health needs leads to both people's hunger for accountability and their frustration that accountability mechanisms are ineffective or do not exist. Accountability systems at any level should ultimately be to rights-holders, the people meant to benefit from health programs. For example, national government accountability for funds received from development partners should first and foremost be to communities, even if accountability to development partners is required as well.

Along with addressing accountability, further discussed below, another important aspect of governance for the post-2015 agenda is the deep interconnectedness among issues that affect health, issues that will cut across the post-2015 agenda. The post-2015 agenda should therefore promote global, national, and local governance rooted in this reality, structures and processes that do not create artificial divisions within health or between health and other areas, but rather promote a holistic approach to governance, maximizing synergies and encouraging national and local structures that take such an approach.

3.1.2. Global governance and international cooperation under the current MDGs

The Millennium Declaration views "[d]emocratic and participatory governance based on the will of the people" as central to

assuring the rights of all people enshrined in the Declaration. The Millennium Declaration points out that meeting their key objectives such as *development and poverty eradication* depend on good governance at national as well as international level. Above all, good governance itself is one of the key objectives in the Millennium Declaration.[48]

The Millennium Declaration advances shared responsibility as one of the fundamental values considered to be essential to international relations in the twenty-first century. It is a shared responsibility for managing worldwide economic and social development, as well as threats to international peace and security.[49] It is explicitly agreed that this responsibility "must be shared among the nations of the world and should be exercised multilaterally".[50]

However, when the Millennium Declaration was *translated* into the current MDGs, good governance at all levels and shared responsibility were expressed only under MDG 8 – to develop a global partnership for development. Again, good governance and shared responsibility are among those values *lost in translation* from the Millennium Declaration to the MDGs and that has been one of the main critiques of the current MDGs.[51]'[52]'[53]

MDG 8 is rather vague and, in terms of governance, has not achieved much.[54] However, it fuelled discussion on aid effectiveness, resulting in the Paris Declaration on Aid Effectiveness agreed in 2005, with its five fundamental principles (ownership, alignment, harmonisation, results, and mutual accountability) to make aid more effective.[55]

Good governance is essential for development yet it is difficult to achieve. The Global Thematic Consultation on Health acknowledges that "[b]uilding the governance required to orchestrate a coherent response across government and society that results in better health outcomes ("health in all policies") remains one of the greatest challenges in global health".[56] Nevertheless these issues are essential to be included in the new development agenda. The Global Thematic Consultation on Health therefore proposes an approach guided by the principle that it should be "people-centred and rights-based, with attention to sustainability, good governance, and policy coherence for develop-

[48] United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[49] Millennium Declaration United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[50] Millennium Declaration United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[51] Advisory Council on International Affairs of the Netherlands (2011) *The post-2015 development agenda: the Millennium Development Goals in perspective*. Available from: http://www.beyond2015.org/sites/default/files/THE%2

0POST-%202015%20DEVELOPMENT%20AGENDA.pdf

[52] Vandemoortele J (2011) 'The MDG story: intention denied.' *Development and Change*, 42(1):1-21

[53] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from: http://www.worldwewant2015.org/health

[54] Advisory Council on International Affairs of the Netherlands (2011) *The post-2015 development agenda: the Millennium Development Goals in perspective*. Available from: http://www.beyond2015.org/sites/default/files/THE%2

0POST-%202015%20DEVELOPMENT%20AGENDA.pdf

[55] Ministers of developed and developing countries responsible for promoting development and Heads of multilateral and bilateral development institutions (2005) *Paris Declaration on Aid Effectiveness*. Available from: http://www.oecd.org/dac/effectiveness/34428351.pdf

[56] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from: http://www.worldwewant2015.org/health

ment."[57] The High Level Panel of Eminent Persons calls for good governance to be a core element of wellbeing, not merely an "optional extra".[58] Therefore it includes good governance explicitly under a proposed new goal (nr 10) of the new development agenda.[59]

The global governance of health in particular is a complex affair, and it has not been simplified since the Millennium Declaration. Since 2000, increasing numbers of global health institutions and initiatives have been launched, in part because of the inability of the WHO to respond adequately to emerging challenges, illustrated prominently by the need to create UNAIDS to tackle the emergence of HIV.[60] New multi-stakeholder, multi-sector partnerships have been particularly influential. At the start of her first term, WHO Director-General Margaret Chan acknowledged that the WHO was facing serious competition from other institutions with greater power, influence and dispensable resources in global health.[61] Additionally, corporations and private philanthropic organizations like the Bill and Melinda Gates Foundation, Rockefeller Foundation, Warren Buffett, and Bloomberg Philanthropies

have committed unprecedented billions of dollars to multi-stakeholder organizations combating global disease. These stakeholders are reconstituting governance processes by being granted greater decision-making power at the executive level of global health institutions and initiatives and are no longer perceived merely as financial donors.

If this *global health system*, defined by Szlezák and colleagues as *the constellation of actors whose primary purpose is to promote, restore or maintain health, including the persistent and connected sets of rules that prescribe behavioural roles, constrain activity, and shape expectations among them*,[62] were to be judged by the standard of *democratic and participatory governance based on the will of the people* as advanced in the Millennium Declaration, it would undoubtedly have to be declared inapt. Frenk and Moon argue "[t]he WHO is the only actor in the global health system that is built on the universal membership of all recognized sovereign nation states (though it is often identified only with its secretariat), and it therefore is central to the system."[63] That does not make the WHO an example of democratic and participatory governance. As Griffin notes, the principle of one country, one vote means that "a small country like Botswana with two million people has the same influence as India with a billion people."[64] But Griffin contrasts this with the "plutocracy" of the World Bank and the International monetary Fund (IMF), "since the votes on their boards of directors are weighted by financial contributions." Some of the new actors like the Global Fund have equal votes

[57] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from:
http://www.worldwewant2015.org/health
[58] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from:
http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf
[59] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from:
http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf
[60] Piot P (2012) *No Time to Lose: A Life in Pursuit of Deadly Viruses*. London: WW Norton
[61] Garrett L (2007) 'The challenge of global health.' *Foreign Affairs*, January/February 2007. Available from:
http://www.foreignaffairs.com/articles/62268/laurie-garrett/the-challenge-of-global-health

[62] Szlezák NA, Bloom BR, Jamison DT, Keusch GT, Michaud CM, Moon S, Clark WC (2010) 'The Global Health System: Actors, Norms, and Expectations in Transition.' PLoS Med 7(1): e1000183
[63] Frenk J, Moon S (2013) 'Governance Challenges in Global Health.' *New England Journal of Medicine*, 368:936-942
[64] Griffin K (2003) 'Economic Globalization and Institutions of Global governance.' *Development and Change,* 34(5):789-807

for the so-called *developing* and *developed* countries, which means that roughly 1 billion people living in high-income countries have the same voting weight as 6 billion people living in middle- and low-income countries – again not exactly democratic.

If the one country, one vote principle is the most democratic – or least undemocratic – of all governance structures available in the global health system, it is not necessarily participatory. Many country representatives have not been democratically elected, and even those that have do not necessarily represent the opinion of all the people they are supposed to represent. Most scholars searching for more participatory forms of global governance seem to be inclined towards *pluralist* models in which civil society organization are directly involved in decision making processes at the global level,[65][66][67][68] even if, as Tallberg and Uhlin note, "[a]mong civil society actors, well-organized and well-funded NGOs tend to be overrepresented, whereas marginalized groups from developing countries tend to be highly underrepresented."[69] However, Archibugi remarks "arguing that global democracy should wait for a world in which all states are democratic

seems to be the surest way to sink it even before birth."[70]

The global health system includes some actors that are at the forefront of *pluralist* governance and inclusion of civil society, like the Global Fund.[71] But the limitation of the Global Fund's mandate to three infectious diseases may reflect the enduring power imbalance in global governance: wealthier countries earmarking a substantial part of their international assistance for infectious disease control.

A reduction of the number of actors in the global health system, through mergers into bigger but fewer institutions with a wider mandate, governed under a combination of the principle of one country, one vote and the inclusion of civil society, does not seem feasible between now and 2015. However, the adoption of the *realization of the right to health for everyone* as the overarching health goal, may in itself enhance the legitimacy of the global health system and foster cooperation and perhaps even mergers over time. There are encouraging signs of policy convergence around the two essential components of the right to health: the increasing support for UHC – which, if adapted to the principles of progressive realization, non-discrimination, minimum core content, participatory decision-making and shared responsibility, could cover the entitlement to health care – and emerging consensus about *Health in all policies* – which, if further clar-

[65] Archibugi D (2012) 'From peace between democracies to global democracy.' In, Archibugi D, Koenig-Archibugi M, Marchetti R (eds.) *Global Democracy: Normative and Empirical Perspectives*. Cambridge: Cambridge University Press

[66] Held D (2010) *Cosmopolitanism: Ideals and Realities*. Cambridge: Polity

[67] Falk R (1995) *On Humane Governance: Towards a New Global Politics*. Cambridge: Polity

[68] Scholte JA (2011) 'Global governance, accountability and civil society.' In, Scholte JA (ed.) *Building Global Democracy? Civil society and Accountable Governance*. Cambridge: Cambridge University Press

[69] Tallberg J, Uhlin A (2012) 'Civil society and global democracy: an assessment.' In, Archibugi D, Koenig-Archibugi M, Marchetti R (eds.) *Global Democracy: Normative and Empirical Perspectives*. Cambridge: Cambridge University Press

[70] Archibugi D (2012) 'From peace between democracies to global democracy.' In, Archibugi D, Koenig-Archibugi M, Marchetti R (eds.) *Global Democracy: Normative and Empirical Perspectives*. Cambridge: Cambridge University Press

[71] Long C, Duvvury N (2011) 'Civil society and accountability promotion in the Global Fund.' In, Scholte JA (ed.) *Building Global Democracy? Civil society and Accountable Governance*. Cambridge: Cambridge University Press

ified, could cover the entitlement to a healthy environment.[72]

3.1.3. Global governance and international cooperation in international human rights law

The realization of the right to health for everyone poses some formidable challenges to global governance and international cooperation. It requires, first and foremost, that all states make their very best effort to realize the right to health for their residents. But what if some states appear to be *unwilling* to do so? How could or should other states react to the unwillingness of a particular state? Furthermore, some states may be willing but *unable* to realize the right to health, and will require international assistance, the burden of which should be shared among states that are able to provide such assistance. How should that burden-sharing be decided? And should the states that provide assistance to other states have a say in how the assistance should be used – if that is what their domestic constituencies (of the states providing assistance) demand?

We do not have, at the global level, an authority that has the legitimacy to exercise the functions of a government, as in setting priorities for collective action and distributing the burden of collective action. We have the WHO, which has a mandate to realize the right to health enshrined in its constitution, and several other international institutions that have been given a mandate to help realise elements of the right to health. However, all these institutions rely on voluntary cooperation – none of them has the mandate or the means to make a state do something against its will, whether domesti-

cally or abroad. And while it is relatively easy to illustrate the need for international collective decisions that cannot be overruled unilaterally by individual states, it is far less easy to imagine an international institution that could legitimately impose collective decisions upon states. As Christiano describes the dilemma, either international institutions must rely on voluntary cooperation, which means they will be effectively controlled by the most powerful states, or they must "have the kind of power to hold powerful states in check", and then "the ultimate standard by which they would be judged is a democratic standard".[73] However, Christiano argues, the representation of minorities, which is problematic even in modern democratic states, "would appear to be an even greater problem in global and transnational institutions even if they were fully democratized", because "[t]he larger the constituency, the larger the chance are that particular minorities would simply get lost in the democratic decision making." He concludes "the best we can do in constructing global institutions is to make sure that they respect and protect human rights and that they satisfy some basic standards of accountability such as transparency."

To be sure, these challenges to global governance and international cooperation are not exclusive to a human rights based approach. They appear as soon as a problem requires international collective action. If one accepts, in line with the Millennium Declaration, the existence of an international "collective responsibility to uphold the principles of human dignity, equality and equity at the global level",[74] one must accept that

[72] Ståhl T, Wismar M, Ollila E, Lahtinen E, Leppo K (2006) *Health in All Policies: Prospects and potentials.* Available from: http://www.dors.it/alleg/newcms/201305/2006_HiAP_Filandia.pdf

[73] Christiano T (2012) 'Is democratic legitimacy possible for international institutions?' In, Archibugi D, Koenig-Archibugi M, and Marchetti R (eds.) *Global Democracy: Normative and Empirical Perspectives.* Cambridge: Cambridge University Press
[74] United Nations General Assembly (2000) *United Nations Millennium Declaration.* Available from:

this collective responsibility is prone to unjust global governance, either because that global governance relies on voluntary cooperation between states – giving states with most bargaining power an unfair advantage – or because that global governance is transferred to an international institution that lacks democratic legitimacy. By tying such collective responsibility to the demands of human rights, an embryonic solution is provided, as the outcomes of the decision making process could be checked against those demands.

For example, marginalized communities report how user fees contribute to excluding them from health care in several countries. These user fees have been introduced in public health systems by national governments, so the responsibility for removing the barrier seems clear. It has been documented, however, that international institutions like the World Bank encouraged governments of developing countries to introduce user fees.[75] Thus the responsibility for removing them seems to rest upon the World Bank as well. But the World Bank does not take decisions on its own; it is governed by a board of governors, representing states. Does that make all member states of the World Bank responsible for removing user fees in developing countries? According to the Committee, "States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health", and "[a]ccordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international

measures of these institutions."[76] Thus there is a shared responsibility, arising from the right to health, a responsibility that does not arise clearly from the current MDGs.

It has been accepted for many decades that states have extra-territorial obligations – i.e., obligations outside of the territory they control – with regards to socio-economic human rights. Until quite recently, however, debates focused on the extra-territorial obligation to *respect* human rights (e.g., states must refrain from dumping toxic waste in other countries) and the extra-territorial obligation to *protect* the right to health (e.g. states must take steps to make sure that people and companies under their jurisdiction do not dump toxic waste in other countries). Whether and in which circumstances states are also obliged to *fulfil* socio-economic rights beyond their borders was a contentious issue. In recent years we have witnessed the emergence of intense debate on extra-territorial obligations to fulfil socio-economic human rights – and the MDGs may have helped to trigger that debate. In September 2011, a group of experts in international law and human rights adopted the Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights, which confirm the existence of extra-territorial obligations to respect, protect, *and* fulfil socio-economic human rights.[77]

http://www.un.org/millennium/declaration/ares552e.htm

[75] Yates R (2009) Universal health care and the removal of user fees. Lancet, 373(9680):2078-2081

[76] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14, The Right to the Highest Attainable Standard of Health*. Available from: http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

[77] Group of experts in international law and human rights (2011) *Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights*. Available from: http://www.fian.org/fileadmin/media/publications/2012.02.29_-_Maastricht_Principles_on_Extraterritorial_Obligations.pdf

With regards to the obligations to respect and protect, the principles for determining extra-territorial responsibility are fairly simple (although their application often is not). States must refrain from violating human rights elsewhere, so their corresponding extra-territorial obligation is limited to what they do or might do – e.g. if states consider dumping toxic waste outside their territory, their obligation is simply refraining from doing so. States must make sure that people and companies under their jurisdiction do not violate human rights elsewhere, so the corresponding obligation is limited to what people or companies under their jurisdiction do or consider doing. But with regard to the obligation to fulfil socio-economic human rights in the world, the scope is potentially endless. How can we determine the scope of this obligation? We will discuss this under the final section, introducing the option of a global social contract.

3.2. Participatory decision-making

3.2.1. Participatory decision-making from the perspective of marginalized communities

Beyond the legal obligation for engaging populations, especially disadvantaged ones, in health-related decision making, there are also a host of additional reasons to engage communities at every step in making and ensuring the effective implementation of health policies. These include to:

- *Ensure that health goals and policies meet people's actual health needs and understandings of their health.*
- *Develop enabling environments for health-related policies to have their intended impact, including on marginalized and vulnerable members of the community.*
- *Build local trust and ownership, use local knowledge, and tailor policies and actions to local circumstances, all leading*

to more effective health policies and programs and better implementation.[78]

- *Improve accountability, to ensure that health policies are being effectively implemented, and to facilitate advocacy and policy adjustment to improve implementation.*
- *Contribute to the process of empowerment, fostering health-enhancing dynamics, as people see that their input is valued and can affect health policies and practices.*
- *Resolve tension between power for health decision-making being in the hands of relatively few people, and the implications of these decisions on the lives of all people.*
- *Account for the fact that civil society representatives often come from very different circumstances (the middle class) than the communities whom they represent, and that they may have their own (however well-meaning) agendas.*

The importance of engaging communities is particularly vital for marginalized populations, whose voices are least likely to be heard and heeded in policymaking circles without deliberate and strategic engagement efforts. Power dynamics, discrimination, lack of information, or other obstacles may preclude such communities from meaningful participation even when there are mechanisms to engage communities. Special measures may be required to meet health needs of socially excluded members of society.

Notwithstanding this importance, marginalized communities overwhelmingly lack the ability to meaningfully engage and influence policymakers. Authorities rarely ask their

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[78] Leavy J, Howard J (2013) *What Matters Most? Evidence from 84 Participatory Studies with Those Living with Extreme Poverty and Marginalization*. Available from:
http://www.ids.ac.uk/files/dmfile/ParticipateSynthesis-WhatMattersMost.pdf

views, and when community members do seek to express their views, they find that they are not heard. "They do not listen" encapsulates the typical experience of marginalized populations in their efforts to influence health authorities. This feeling of powerlessness exists despite an extremely commonly expressed desire to be able to have a voice in how authorities respond to their health needs.

Some communities emphasize especially the importance of the ability of women to have a role in decision-making – and recognition that in some circumstances women face special obstacles to participation. Among some populations, such as refugees, fear of drawing attention to themselves can be a barrier to participation, while other populations view the government as less than beneficent.

In some communities, the responsibility of engaging with authorities on health matters rests with community leaders, with opportunities varying with people's ability to access and engage them Some populations are satisfied with this arrangement, while others are less confident about how effectively the community leaders will represent and advocate for their needs, and would like to themselves have a say in health-related decision-making – but do not have that opportunity. At times, even where there are spaces for participation, such as a national health assembly, community members might not be aware or invited, or face obstacles to their participation. Local structures may also exist but often do not receive the funding and other support they require to function effectively. And even when people can participate, they may not receive any feedback on the result of their participation. Similarly, even where community members or leaders are able to participate, they often feel that higher authorities do not listen.

The post-2015 goals and targets should reflect the importance of community engage-

ment, of empowering people to participate in health-related decision-making, from setting priorities and establishing policies to monitoring how those policies are implemented in their communities. There must be processes to ensure that where they are not being listened to, where policies are not being followed, where their rights are not being respected, there are correcting processes. Through the new health goal and its targets, indicators, and guidelines, the global community should provide an unequivocal message to every country on the importance of this participation – including ensuring the engagement of marginalized populations. National governments must act on their responsibility to ensure that their populations – including women and marginalized populations – have the space and capacity to meaningfully participate.

As Go4Health, we therefore welcome the target proposed by the High-Level Panel of Eminent Persons to "[i]ncrease public participation in political processes and civic engagement at all levels." However, a post-2015 target on engaging concerned populations should explicitly affirm the need to take proactive measures to include marginalized communities in a meaningful way – with communities well-informed, their voices respected, and their inputs having a genuine role in shaping policy, as well as in shaping responses to policy failure. A better target, and one that is health-specific (though could be adjusted for broader purposes) would be: *to provide a genuine role to the public in health-related priority-setting, policy-making, budgeting, and other decision-making and monitoring and evaluation at all levels (local, national, global) through informed and inclusive public participation that includes active outreach and support to ensure the full involvement of marginalized populations, to provide feedback to the public, and to ensure accountability for results of these processes.*

The new health goal or goals will also require accountability mechanisms and practices. The precise mechanisms should be left for countries to determine. In some cases this will require establishing new structures. In other cases, the priority will be making existing mechanisms function effectively. Mechanisms must be structured to represent and ensure accountability to even the most marginalized members of already marginalized communities, such as impoverished women refugees with disabilities. And they should feed back to communities explaining how their inputs have been taken into account.

Also, whether through these mechanisms or separately, countries require easily accessible complaint mechanisms for addressing discrimination or other mistreatment in the health sector, and other health systems failures (e.g., stock-outs), along with clear procedures for responding to violations. Also needed are broader measures to ensure accountability, consisting of improved access to the justice system, including courts; effectuating people's right of access to information, and; implementing policies and promoting community education and outreach so that people understand how to use the legal system and do not fear negative consequences from doing so (as might migrants with irregular status, for example).

The right of people to engage in health decision-making at the international level means that the very process of developing the post-2015 development agenda must respond to the importance of engaging communities. The United Nations has made extensive efforts to seek perspectives from people around the world to contribute to the post-2015 development agenda, and has highlighted the need to include traditionally excluded populations. [79] Broad participation should continue as the post-2015 agenda develops to ensure that it tracks with people's demands. We encourage the United Nations to ensure that its consultation processes incorporate a focused effort to include a range of marginalized communities, whenever possible through local partnerships enabling communities to benefit from this engagement beyond any benefits from the consultations themselves.

The United Nations and member states should pay particular attention to messages from communities, especially those comprising marginalized populations, regarding how they can be included in the post-2015 agenda, and how they can engage in local and national development and political processes. People must have the opportunity to actively engage national and local processes to translate the post-2015 health goal(s) and targets into national strategies and plans of action. Further, they have a right to and must be given a prominent role in monitoring and evaluating how these strategies and action plans are being implemented, as well as clear and responsible channels for responding to any shortcomings.

A full role in participating in health-related decisions at the international level also implies that members of marginalized communities and civil society organizations should have a formal role in the post-2015 negotiation process. Besides joining national delegations, this could entail their participation on a committee or at a forum that should endorse the post-2015 goals before they are adopted by the United Nations.

[79] United Nations Development Group (2013) *The Global Conversation Begins: Emerging Views for a*

New Development Agenda. Available from: http://www.undp.org/content/dam/undp/library/MDG/english/global-conversation-begins-web.pdf

3.2.2. Participative decision-making under the current MDGs

One of the chief criticisms of the MDGs is that they were largely defined by wealthier countries and shaped by a top-down process that reduced developing countries to mere recipients of aid.[80][81][82][83] In line with that approach, the intended beneficiaries of the MDGs (people and communities) had no opportunity to be involved in the development and implementation of MDG actions.[84]

The Millennium Declaration, however, acknowledges that efforts towards a better future must include "policies and measures, at the global level, which correspond to the needs of developing countries and economies in transition and are formulated and implemented with their effective participation".[85] The Millennium Declaration further includes a commitment "[t]o work collectively for more inclusive political processes, allowing genuine participation by all citizens in all our countries".[86]

The Global Thematic Consultation on Health points out that "[t]he participation of communities, young people, and civil society is vital both for strong policy development and implementation and for holding all stakeholders accountable for progress." It also demands inclusion of the most marginalized groups in decision-making, as it will help to ensure that laws, policies, and resources are used to create enabling, equitable, health-promoting environments for those most vulnerable to health risks.[87] The High Level Panel of Eminent Persons highlights citizen participation as helping to drive development.[88] Also the Rio Political Declaration on Social Determinants of Health calls for action to promote participation in policy-making and implementation.[89]

The discussion around the post-2015 agenda is well underway, and the United Nations have established a global consultation process thus trying to address the critique focused on the process by which the current MDGs were selected. This consultative process allows civil society, the private sector, media, universities, and also lay persons to participate and share their views and ideas, through different methods such as roundtables, focus group discussions or the internet and other e-methods. However, additional efforts must be made to engage groups that generally do not participate in policy discussions.

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[80] Sachs J (2012) 'From millennium development goals to sustainable development goals.' *Lancet*, 379(9832):2206-2211

[81] Saith A (2006) 'From universal values to Millennium Development Goals: lost in translation.' *Development and Change*, 37(6):1167-1199

[82] Hulme D (2009) *The Millennium Development Goals (MDGs): A Short History of the World's Biggest Promise*. Available from: http://www.bwpi.manchester.ac.uk/resources/Working-Papers/bwpi-wp-10009.pdf

[83] Olthaar M (2011) 'Less pretension, more ambition: development policy in times of globalization.' Review of Social Economy, 69(4): 521-524

[84] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from: http://www.worldwewant2015.org/health

[85] United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[86] United Nations General Assembly (2000) *United Nations Millennium Declaration*. Available from: http://www.un.org/millennium/declaration/ares552e.htm

[87] Global Thematic Consultation (2013) *Health in the Post-2015 Agenda*. Available from: http://www.worldwewant2015.org/health

[88] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from: http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf

[89] Heads of Government, Ministers and government representatives (2011) *Rio Political Declaration on Social Determinants of Health*. Available from: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf

Such an undertaking takes considerable time and whether the voices of the most marginalized will be heard is still questionable. As Go4Health, we try to include the voices of the most marginalized through community consultations, but this work encounters obstacles and challenges, such as the short and not always transparent timelines.

3.2.3. Participatory decision-making in international human rights law

Participation is one of the key principles of international human rights law. With respect to the right to health in particular, the Committee has affirmed that a critical element of this right "is the participation of the population in all health-related decision-making at the community, national and international levels," including, as referenced above, as part of developing and reviewing a national public health strategy.[90] Expanding on this obligation, the first United Nations Special Rapporteur on the right to health explained that states must "establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities."[91]

Accordingly, the right to health's imperative on participation must be integral to all aspects of the post-2015 development agenda and processes, from establishing the post-2015 goals, targets, and indicators, to translating them to and implementing them at national and community levels, to monitoring them and holding officials accountable.

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[90] Committee on Economic, Social and Cultural Rights, *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, UN Doc. No. E/C.12/2000/4 (2000), at paras. 11, 43(f). Available at http://www1.umn.edu/humanrts/gencomm/escgencom14.htm
[91] Hunt P (2008) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Available from: http://www.ifhhro.org/images/stories/ifhhro/documents_UN_special_rapporteur/3_4_2.pdf

4. Tying goals and governance together: towards a global social contract?

We adopted Go4Health – standing for *goals* and for *governance* for health – as the name of our consortium because we believe that the new health goal or set of health goals for humanity should be embedded within a global social contract that clarifies – better than the current MDGs do – where national and international responsibility meet. And we propose the *realization of the right to health for everyone* as the overarching goal because it would bring the body of international human rights law, case law, and authoritative interpretations with it, serving not only to clarify the goals, but also to clarify the governance required to achieve those goals.

The current MDGs include a specific goal on governance: MDG 8, to develop a global partnership for development. According to the Advisory Council on International Affairs of the Netherlands, MDG 8 was added at the last minute under pressure from developing countries, and became "the most comprehensive, yet least specific or measurable goal".[92] As a result, "responsibility for achieving results lies with developing countries, while MDG 8 does not demand that the rich countries provide any measurable support or ensure fair trade rules."

Is human rights law clearer on the requirements of shared responsibility than the current MDGs? Until quite recently, debates focused on the extra-territorial obligations to *respect* human rights and the extra-

territorial obligations to *protect* human rights, but remained hesitant on the extra-territorial obligations to *fulfil* socio-economic human rights – and the MDGs may have helped to trigger that debate. The Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights, confirm the existence of extra-territorial obligations to respect, protect, *and* fulfil socio-economic human rights,[93] and stipulate that, "[i]n fulfilling economic, social and cultural rights extraterritorially, States must:

a) prioritize the realization of the rights of disadvantaged, marginalized and vulnerable groups;

b) prioritize core obligations to realize minimum essential levels of economic, social and cultural rights, and move as expeditiously and effectively as possible towards the full realization of economic, social and cultural rights;

c) observe international human rights standards, including the right to self-determination and the right to participate in decision-making, as well as the principles of non-discrimination and equality, including gender equality, transparency, and accountability; and

d) avoid any retrogressive measures or else discharge their burden to demonstrate that such

e) measures are duly justified by reference to the full range of human rights obligations, and are only taken after a comprehensive examination of alternatives."

Can we translate the obligation to fulfil the right to health into measurable goals? Khalfan proposes an approach that starts

[92] Advisory Council on International Affairs of the Netherlands (2011) *The post-2015 development agenda: the Millennium Development Goals in perspective.* Available from: http://www.beyond2015.org/sites/default/files/THE%20POST-%202015%20DEVELOPMENT%20AGENDA.pdf

[93] Group of experts in international law and human rights (2011) *Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights.* Available from: http://www.fian.org/fileadmin/media/publications/2012.02.29_-_Maastricht_Principles_on_Extraterritorial_Obligations.pdf

from states' ability to assist,[94] while Ooms and Hammonds propose an alternative approach, using states' most urgent assistance needs as the point of departure.[95] In practice, both approaches may converge.

As explained above, all states have minimum core obligations; under the right to health they must ensure the essential level of the entitlement to health care and the essential level of the entitlement to a healthy environment. If they are unable to do so, after having used the maximum of available resources, wealthier states – states in a position to assist – must provide the necessary assistance. If we were able to estimate the cost of the essential levels of the entitlement to health care and the entitlement to a healthy environment, and if we were able to estimate the maximum available resources for health of all states that may need assistance, we would be able to identify the gap between both, which would have to be covered with international assistance. In 2009, the High-Level Taskforce on Innovative International Financing for Health Systems estimated that, in low-income countries, the cost of achieving the current health sector MDGs is about US$50-55 per person per year.[96] In a recent communication about "a comprehensive and integrated approach to financing poverty eradication and sustainable development", the European Commission – referring to the United Nations Development Programme – argues that even low-income countries can achieve a level of domestic government revenue of at least 20% of Gross Domestic Product (GDP).[97] If the governments of these countries would allocate 15% of their budgets to the health sector – as the members of the African Union committed to doing in the Abuja Declaration[98] – we can estimate the maximum available resources for ensuring the entitlement to health care to be 3% of GDP – or 15% of 20% of GDP. The difference between 3% of GDP of a given country and $50 per person per year multiplied by the number of inhabitants of that country would be the most urgent assistance need. For all countries needing assistance together, we estimate this most urgent need to be about $40 billion per year. Sachs uses very similar figures, calling it "basic arithmetic".[99]

Khalfan's approach starts from states' ability to assist, using self-assessment and three criteria: internationally agreed benchmarks and unilateral commitments; comparison to peer states; and progressive increase.[100] In 1970, *developed* countries promised to allocate the equivalent of 0.7% of GDP to inter-

[94] Khalfan A (2013) 'Division of Responsibility amongst States.' In, Langford M, Vandenhole W, Scheinin M, van Genugten W (eds.) *Global Justice, State duties. The extraterritorial scope of economic, social and cultural rights in international law.* Cambridge: Cambridge University Press

[95] Ooms G, Hammonds R (2010) 'Taking up Daniels' challenge: the case for global health justice.' *Health & Human Rights*, 12(1):29-46

[96] Taskforce on Innovative International Financing for Health Systems (2009) *More Money for Health, and More Health for the Money.* Available from: http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/Taskforce_report_EN.2009.pdf

[97] European Commission (2013) *Beyond 2015: towards a comprehensive and integrated approach to financing poverty eradication and sustainable development.* Available from: http://ec.europa.eu/europeaid/what/development-policies/financing_for_development/documents/accountability-report-2013/accountability-report-2013-01_en.pdf

[98] Organization of African Unity (2001) *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.* Available from: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

[99] Sachs J (2012) 'Achieving universal health coverage in low-income settings.' *Lancet*, 380(9845):944-947

[100] Khalfan A (2013) 'Division of Responsibility amongst States.' In, Langford M, Vandenhole W, Scheinin M, van Genugten W (eds.) *Global Justice, State duties. The extraterritorial scope of economic, social and cultural rights in international law.* Cambridge: Cambridge University Press

national assistance. [101] Honest self-assessments would probably reveal that they can do more, while comparison to what peer states really allocate to international assistance may result in a lower estimate. Nevertheless, the 0.7% of GDP target remains valid, as it has been reconfirmed several times, and the High Level Panel of Eminent Persons again refers to it.[102] But this is a target for all international assistance, not only for the entitlement to health care. According to the OECD-DAC, about 15% of international assistance is allocated to the health sector (16% in so-called *fragile states*, 14% in other developing countries).[103] Combined, 15% of 0.7% of GDP of all high-income countries makes a bit more than $40 billion per year: the same result as the one resulting from the needs-based assessment.

To be sure, the targets of 3% of GDP of countries needing assistance complemented with 0.1% of GDP would cover the entitlement to *health care* only (at $50 per person per year only), not the entitlement to a healthy environment. Using Khalfan's approach and OECD-DAC estimates for international assistance for agriculture (8%), education (10%), and water and sanitation (7%), and assuming that this distribution matches with domestic revenue allocation in line with the principle of progressive realization, all people could have an entitlement to these central components of a healthy environment at a cost of $83 – in addition to the entitlement to health care at a cost of $50 – that would cover the rights to food, educa-

tion, water and sanitation. Furthermore, if all these resources – domestic government revenue and international assistance combined – were distributed via mechanisms of social protection, it would create a healthier *social* environment as well.

Would the inclusion of a set of targets for domestic government revenue and international assistance in the new MDGs be sufficient to create the global social contract, needed for the realization of the right to health for everyone? It would certainly be a big step forward, coming from the current MDGs that lack targets for both domestic government revenue and international assistance. But it would not be sufficient for a global social contract, for at least five reasons.

- First, the estimate of the High-Level Taskforce on Innovative International Financing for Health Systems for achieving the current health sector MDGs (at about US$50-55 per person per year),[104] is not only incomplete, it is also a snapshot. In line with the principle of progressive realization, the international community should gradually aim higher, until all global health inequalities are consigned to the past. A global social contract should allow for regular and progressive adjustment.

- Second, a global social contract requires more than targets; it requires reliable commitments. The Abuja Declaration is more than a decade old now, yet the vast majority of African Union members do not live up to it; the 0.7% of GDP international assistance target is more than four decades old now, and the vast ma-

[101] Fürher H (1996) *The Story of official development assistance*. Available from:
http://www.oecd.org/dac/1896816.pdf
[102] High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (2013) *A New Global Partnership: Eradicate Poverty and Transform Economies Through Sustainable Development*. Available from:
http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf
[103] Organization for Economic Co-operation and Development (2011) *Aid to health*. Available from:
http://www.oecd.org/dac/stats/49907438.pdf

[104] Taskforce on Innovative International Financing for Health Systems (2009) *More Money for Health, and More Health for the Money*. Available from:
http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/Taskforce_report_EN.2009.pdf

jority of high-income countries do not live up to it. Both problems tend to be mutually reinforcing. As Foster explains, "donor disbursement performance remains volatile and unreliable", and "[g]overnments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure." [105] Governments that are highly dependent on unreliable international assistance (and therefore reluctant to increase recurrent expenditure) will probably not reject international assistance; they are more likely to keep domestic government revenue allocation lower than it could be and save the international assistance. At the same time, wealthier countries providing international assistance will understandably become reluctant to increase international assistance if that does not lead to corresponding increases in domestic expenditures.

- Third, there is a problem of accountability and allocation. While governments of wealthier countries providing international assistance are accountable to their constituencies, and have to be able to explain how the international assistance will be used, governments of countries receiving international assistance are accountable to their own constituencies first. If the human rights principles of *participatory decision-making* and *prioritization of vulnerable or marginalized groups* are to be observed, governments of countries receiving international assistance cannot promise in advance exactly how they will use it – they have to allow

for regular reassessment of needs. But governments of countries providing assistance will not sign a *blank cheque*.

- Fourth, although financial resources are essential for the realization of the right to health for everyone, other factors are also at play – both nationally and internationally. For example, the realization of the entitlement to health care requires medicines, the cost of which is influenced by international trade rules and agreements; the realization of the entitlement to a healthy environment is menaced by international practices known as *land grabbing*.[106] The allocation of shared responsibility for problems like these cannot be expressed in terms of financial resources. Nor can the substantial obstacles to realizing the right to health discussed earlier that go well beyond funding. These include lack of accountability – from health providers and village leaders through to local and national governments, and even the international community – lack of participation at all levels, again from the community through to the global level, corruption, and the often multi-faceted social, political, economic, and cultural factors that lead to the social exclusion that marginalized communities experience. A global social contract for the right to health would need to respond to these concerns as well.

- Fifth, if we are correct in predicting that the new iteration of the MDGs and the first iteration of the SDGs will become a *single undertaking*, we are at the doorstep of negotiations in which international assistance as we know it may be eclipsed by compensation for responsi-

[105] Foster M (2005) 'Fiscal space and sustainability: towards a solution for the health sector.' In, *High-Level Forum for the Health MDGs, Selected papers 2003-2005*. Geneva: World Health Organization; Washington, DC: World Bank. Available from: http://www.who.int/hdp/publications/hlf_volume_en.pdf

[106] Borras S, Franco J (2010) 'From Threat to Opportunity? Problems with the Idea of a "Code of Conduct" for Land-Grabbing.' *Yale Human Rights and Development Law Journal*, 13(2):507-523

bility for climate change. As von der Goltz summarizes the position of developing countries, "dues owed to developing countries in exchange for their likely reaching lower historical per-capita emission levels",[107] in the order of $200-400 billion per year, could be a condition for a global agreement on social, economic and environmental sustainability, of which health would be only one of the many sections.

A global fund for health, as proposed by some members of Go4Health elsewhere,[108] would be able to address the first, the second and the third issue above. Indeed, if a global fund for health were financed by an agreed burden-sharing mechanism like the tri-annual *replenishment* of the International Development Association – the arm of the World Bank that provides grants and long-term low- or no-interest loans to poor countries[109] – it would be able to provide reliable international assistance in the form of *counterpart financing*, meaning that countries applying for assistance would have to demonstrate that they are making their best effort in line with the human rights principle of *progressive realization*. Applications for continued assistance could be revised at regular intervals, and would be based on the human rights principles of *participatory decision-making* and *prioritization of vulnerable or marginalized groups*. Rather than be-

ing able to explain exactly how international assistance will be used, governments of countries providing the assistance would be able to explain to their constituencies the conditions under which the global fund for health will distribute the assistance. The level of financing aimed for could be adjusted regularly and progressively. If, as the European Commission proposes, we are moving towards "a comprehensive and integrated approach to financing poverty eradication and sustainable development",[110] a global fund for health could evolve towards a global equalization scheme,[111] as a branch of a broader *global green and social environment fund*.

To address the fourth issue above, additional international cooperation – going beyond financing – is essential. This could take the form of a framework convention on global health, as proposed by members of Go4Health.[112] Such a convention, grounded in the right to health with health equity as its organizing principle, could codify standards for inclusive participation, and require plans and specific measures to improve accountability at all levels, as well as to address obstacles to health care and healthy environments that each marginalized populations

[107] von der Goltz J (2009) *High Stakes in a Complex Game: A Snapshot of the Climate Change Negotiating Positions of Major Developing Country Emitters.* Available from: http://www.cgdev.org/files/1422602_file_High_Stakes_FINAL081009.pdf

[108] Ooms G, Hammonds R (2010) 'Taking up Daniels' challenge: the case for global health justice.' *Health & Human Rights*, 12(1):29-46

[109] International Development Association (2010) *A Review of IDA's Long Term Financial Capacity and Financial Instruments.* Available from: http://siteresources.worldbank.org/IDA/Resources/Seminar%20PDFs/73449-1271341193277/IDA16-Long_Term_Financing.pdf

[110] European Commission (2013) *Beyond 2015: towards a comprehensive and integrated approach to financing poverty eradication and sustainable development.* Available from: http://ec.europa.eu/europeaid/what/development-policies/financing_for_development/documents/accountability-report-2013/accountability-report-2013-01_en.pdf

[111] Holst J (2013) 'Implementing the Solidarity Principle Through Financial Equalization.' In, Holst J (ed.) *Global Social Protection Scheme: Moving from Charity to Solidarity.* Available from: http://www.medico.de/en/media/workshop-reader-global-social-protection-scheme.pdf

[112] Gostin LO, Friedman EA, Ooms G, Gebauer T, Gupta N, Sridhar D, Chenguang W, Røttingen J-A, Sanders D (2011) 'The Joint Action and Learning Initiative: towards a global agreement on national and global responsibilities for health.' *PLoS Medicine*, 8(5)

in a country faces. It could also elevate the status of health in other sectors, insisting upon right to health assessments, thus responding to such concerns as ensuring that trade law does not restrict access to medicines. Central to the convention would be ensuring that all people have quality health care and the underlying and broader social determinants of health that are at the core of our proposal, establishing standards to ensure healthy conditions of life for all people, and processes to tailor these standards to local circumstances through participatory mechanisms. The convention would also include an international financing framework, sufficient to universalize the conditions of good health and clearly allocating domestic and international financing responsibilities. The power of the law would also enable stronger compliance mechanisms, with a mixture of incentives and sanctions, and enhancing the potential for people to claim the right to health within their own systems of health and justice.

The fifth issue may require a much wider solution, like a framework convention on the right to development, as proposed by De Feyter.[113]

Between now and 2015, neither of these solutions seems feasible. In our opinion, however, formulating the new health goal for humanity as the realization of the right to health – within a wider framework of human rights – would already entail a significant step in the direction of these innovative solutions. Furthermore, a *plan of action* for the achievement of the new MDGs and the SDGs could already incorporate human rights principles, even if such a plan of action would not have the status of a legal convention – though it could recognize the need for and set in motion the development of such a convention.

[113] De Feyter K (2013) *Towards a Framework Convention on the Right to Development.* Available from: http://library.fes.de/pdf-files/bueros/genf/09892.pdf

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