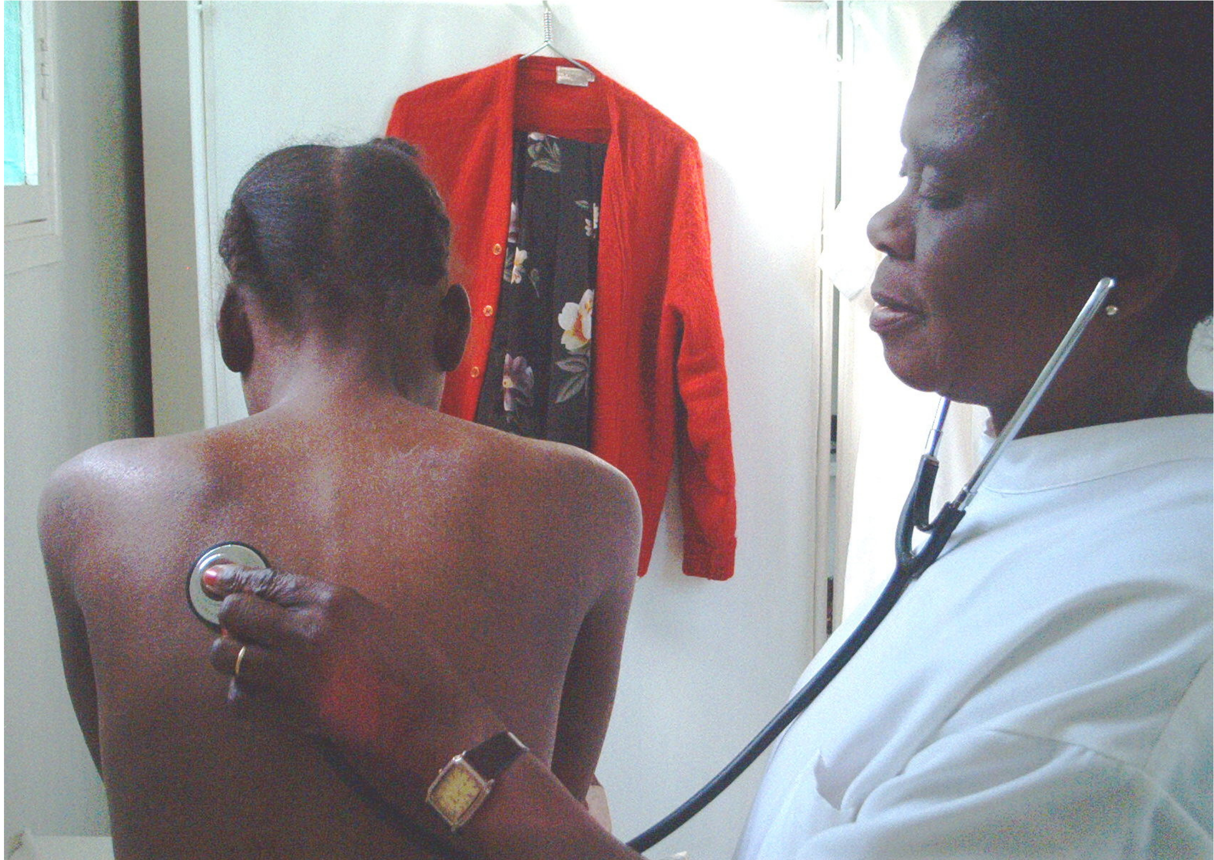
From the Global AIDS Response towards Global Health?



A discussion paper

For
the Hélène de Beir foundation
www.hdbf.org
and the International Civil Society Support group
www.icssupport.org

Written by

Gorik Ooms

January 2009

Table of contents

Table of contents **2**
Acknowledgements **3**
Acronyms **4**
General introduction and overview **5**
Section 1. The global AIDS response: a synthesis of medical relief and health development paradigms **10**
1.1. Introduction 10
1.2. The health development paradigm: aiming for sustainability, defined as self-sufficiency 11
1.3. The medical relief paradigm: not aiming for sustainability 12
1.4. The global AIDS response: technical sustainability at the national level, financial sustainability at the international level 14
1.5. The expanding mandate of the Global Fund 16
1.6. 'Fiscal space' and 'fiscal sustainability': a straitjacket to ensure self-sufficiency 17
1.7. Conclusions of the first section 19
Section 2. Global Health: moving towards global social health protection? **20**
2.1. Introduction 20
2.2. A global social health protection floor: an inclusive and a minimalist design 22
2.3. The Global Fund, seen as an emerging global social health protection floor 24
2.4. Conclusions of the second section 25
Section 3. Global Health: if health is a human right, there is a globally shared responsibility for the health of all people **26**
3.1. Introduction 26
3.2. Defining the right to health 27
3.3. Progressive Realisation: what it does and does not mean 28
3.4. Core obligations and the obligation to provide assistance 29
3.5. Collective entitlement, collective obligation and ways to manage them 31
3.6. Conclusions of the third section 32
Section 4. Global Health in practice: moving towards a single Global Health Fund? **33**
4.1. Introduction 33
4.2. From the global AIDS response to Global Health, through a single Global Health Fund? 34
4.3. Ten pragmatic reasons for a single Global Health Fund 36
4.4. Conclusions of the fourth section 40
Section 5. General conclusions **41**
References **42**

Acknowledgements

This discussion paper is the result of discussions, correspondence, drafting papers (of which some were published and others were not), presentations and debates, following the defence of my doctoral thesis.[1]

I owe gratitude to many people, some of whom I could not leave unmentioned here: Paul Avondroodt, Brook Baker, Christoph Benn, Marleen Boelaert, Bart Criel, Lola Dare, Francis de Beir, Nathan Ford, Gregg Gonsalves, Rachel Hammonds, Mark Harrington, Paul Hunt, Masamine Jimba, Andreas Kalk, Michel Kazatchkine, Marie Laga, Geert Laleman, Rene Loewenson, Sigrun Møgedal, Réginald Moreels, Francis Omaswa, Erik Peeters, Sue Perez, Peter Piot, Marjan Pirard, Thomas Pogge, Bernard Rivers, Rick Rowden, Asia Russell, Margot Salomon, Rotimi Sankore, Ted Schrecker, Francisco Songane, Keizo Takemi, Marleen Temmerman, Wim Van Damme, Jozef Van Langendonck, Peter van Rooijen, Ellen Verheul, Alan Whiteside and Paul Zeitz.

Support from the Hélene de Beir Foundation and the International Civil Society Support group allowed me to write this discussion paper, bringing the emerging ideas together. Both organisations are committed to supporting the follow-up to this discussion paper, in the form of e-mail discussions and eventually an international conference to be held later this year.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CMH	Commission on Macroeconomics and Health
CCM	Country Coordination Mechanism
CSO	Civil Society Organisation
G8	Group of the seven biggest economies and Russia
GDP	Gross Domestic Product
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GTZ	Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Office
IMF	International Monetary Fund
IHP	International Health Partnership
IHP+	International Health Partnership and Related Initiatives
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
P4H	Providing For Health
PEPFAR	President's Emergency Plan For AIDS Relief
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USA	United States of America
WHO	World Health Organization

General introduction and overview

'Global Health' has recently become a fashionable term. New Global Health institutes have been created, and new Global Health trainings organised. But what does the term Global Health really mean? Perhaps it is best defined by the World Health Organization (WHO)'s mandate: "health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats".[2]

There are two 'global' elements in this description: a globally shared responsibility for the health of all people, and global threats posed by infectious diseases. However, these two global elements of an emerging Global Health paradigm are not mutually exclusive. The fact that viruses do not respect national borders contributes to an awareness of global responsibility for the health of all people. Further, the risk of uncontrolled epidemics proliferating from low-income to middle- and high-income countries motivates the more wealthy to help poor people because the more wealthy do not want to get poor people's diseases. It is probably not a coincidence that Official Development Assistance (ODA) for health seems to focus on infectious diseases disproportionately.[3] However, a global responsibility for the health of all people should extend beyond a willingness to tackle the global threats posed by infectious diseases and ensure that there is equal attention and solidarity for non-infectious diseases. In this discussion paper, I will examine the emerging Global Health paradigm as one that addresses a global responsibility for the health of all people.

The Global Health paradigm: does it exist already?

If Global Health in the sense of a globally shared responsibility for the health of all people is broadly accepted as a concept, it is still in its infancy. There is some trans-national solidarity to promote the health of all people, but it is limited and it is most often intended to be temporary: the objective is to help other countries assume their responsibilities towards their inhabitants, within a foreseeable future. The temporary nature of this solidarity reflects – at least to a certain extent – a rejection of a globally shared responsibility for the health of all people: it confirms that each country ultimately remains responsible for the health of its own inhabitants.

There are indeed fundamental differences between the way people living in high-income countries practice solidarity for health *within* the borders of their countries, and the way those same people practice solidarity in health *beyond* the borders of the countries they live in.

First of all, there is a huge difference in quantity. It is not uncommon for people in high-income countries to spend more than 10% of their Gross Domestic Product (GDP) on health. In Germany, for example, people spent the equivalent of 10.7% of their GDP on health, in 2005.[4] For the people living in France it was 11.2%, for the people living in the United Kingdom (UK) it was 8.2%, and for the people living in the United States of America (USA) it was an impressive 15.2% of GDP. Even if a lot of that health expenditure is private – and therefore not an act of solidarity – a substantial part of it is public expenditure, raised and

disbursed in accordance with the principles of solidarity or social protection: you contribute what you can, and you receive what you need. In Germany, public health expenditure was 76.9% of total health expenditure in 2005. In France it was 79.9%, in the UK it was 87.1%, and even in the USA – not known for the excellence of its social protection – public health expenditure was substantial: 45.1%. If one combines those figures, it leads to the surprising conclusion that public health expenditure in the UK was 7.1% of GDP, only a little bit higher than the 6.9% of GDP of the USA.

Perhaps one should not expect a similar level of solidarity beyond borders. For most people, it seems very natural and fair that one looks after one's family first, one's compatriots second, and only then after people in need elsewhere. Only thoroughbred cosmopolitans would argue that state borders are totally irrelevant, when it comes to mutual responsibility or solidarity. However, while one might expect some difference, the scale of the difference remains shocking.

If the inhabitants of France, Germany, the UK and the USA valued their responsibility towards the lives and the health of their compatriots *ten times higher* than their responsibility towards the lives and the health of people living in other counties, one would expect the equivalent of 0.7% of GDP of high-income countries to be spent on health promotion (prevention and treatment of health problems) for people living in low- and middle-income countries. If they valued their responsibility towards the lives and the health of their compatriots *one hundred times higher* than their responsibility towards the lives and the health of people living in other counties, one would expect the equivalent of 0.07% of GDP of high-income countries to be spent on health care for people living in low- and middle-income countries. Notwithstanding a spectacular increase over the past five years – from US$7 billion in 2001 to US$20 billion in 2006 – ODA for health was only 0.05% of the US$40 trillion GDP of high-income countries. In fact, the inhabitants of high-income countries seem to value their responsibilities towards the lives and the health of their compatriots as *more than one hundred times higher* than their responsibilities towards the lives and the health of people living in low- and middle-income countries.

The second and arguably even more important difference relates to the intention behind the practice of solidarity. *Within the borders of a country*, solidarity in health does not aim to be temporary; it aims for ongoing reciprocal solidarity. A person needing surgical care will not be told: "We will pay for this once, then we will help you find a better job, and the next time you need surgery you will be able to pay yourself". Ending the solidarity is not the intention behind the act of solidarity. The intention is that the beneficiary will get well soon and become productive if possible, thus contributing to ongoing reciprocal solidarity. *Beyond the borders of a country*, the intention behind solidarity changes fundamentally. The intention of trans-national solidarity is not that the beneficiaries would become contributors to an ongoing reciprocal solidarity mechanism between countries. The intention is that all the beneficiaries will become self-reliant within a foreseeable future, and then trans-national solidarity could end, as solidarity within countries would be sufficient. For some reason, we can endorse the metaphor of a 'single global market', but not the metaphors of a 'single global hospital' and a 'single global school'.

The consequences of temporary trans-national solidarity

The consequences of approaching trans-national health solidarity as a temporary issue can be dramatic. Perhaps they are not for the majority of people living in developing countries: namely the 4.3 billion people living in middle-income countries, according to the World Bank's classification. Perhaps these people could indeed help themselves. They might be better off if a real Global Health paradigm were pursued, but if they organise themselves well, they might be able to cope with their major health problems without the introduction of a real Global Health paradigm.

It is for the 1.3 billion people living in low-income countries that the rejection of a Global Health paradigm is dramatic.

In low-income countries, in which the total GDP in 2007 was US$810 billion for 1.3 billion people, or US$600 per person per year, domestic public health expenditure of US$18 per person year on health is a challenge. It requires government revenue (excluding grants) of 20% of GDP, and public health expenditure of 15% of government revenue. Both targets are quite ambitious.

Providing universal access to primary health care at US$18 per person per year (15% of 20% of US$600 per person per year) is more than a challenge, it is a 'mission impossible'. According to the findings of the Commission on Macroeconomics and Health (CMH), governments need to spend at least US$40 per person per year on basic health, and that does not fully cover comprehensive primary health care.[5]

ODA for health can complement domestic public health expenditure, but when ODA for health is provided within the current development paradigm (that is, without a Global Health paradigm), it can become problematic, mainly because ODA has been unreliable in the past (which should not come as a surprise, as ODA is intended to be temporary and therefore not reliable in the long run).

One consequence of the unreliability of ODA for health in the long run is that it is sometimes spent badly, i.e. not where it is most needed or could give the biggest benefit, or even not spent at all. For example, for a Minister of Health, it is less risky to use ODA for the purchase of a few four-wheel-drive ambulances than for the recruitment of additional nurses. The ambulances will not make any noise if they are left without fuel when donors decide it is time to focus on something else; but nurses will make noise if they are left without salaries. Furthermore, the International Monetary Fund (IMF) and the World Bank actively discourage governments of low-income countries from increasing the levels of recurrent health expenditure, e.g. salaries for health professionals, using ODA for health because ODA for health is unreliable in the long run. According to the Independent Evaluation Office of the IMF, more ODA is diverted to increase the foreign exchange reserves of low-income countries, than is used for the purpose for which it was intended, which is to increase public expenditure.[6]

The global AIDS response creates an emerging Global Health paradigm, but requires a conscious affirmation

Leaders of high-income countries have approached the fight against the Acquired Immune Deficiency Syndrome (AIDS) epidemic in a way that is consistent with a real Global Health paradigm: accepting a globally shared responsibility for the health of all people. It was evident, from the beginning, that some of the highly affected countries would not be able to finance AIDS treatment themselves, within the foreseeable future. Thus, if AIDS treatment were to become available in low-income highly affected countries, then sustainability (in the sense of self-reliance) had to be abandoned and replaced with the concept of globally shared responsibility for the health of all people.

This paradigm shift emerged perhaps unconsciously and unwittingly. The global AIDS response originated within the 'medical relief' paradigm: a paradigm for temporary responses to temporary crises, under which self-sufficiency is side-lined as irrelevant.[7]

But how long will this last? How many years will it take, before donors and other actors grow tired of 'AIDS exceptionality' and start squeezing the global AIDS response into the conventional 'health development' paradigm, where it does not fit, because it is too expensive for some of the worst affected countries? In fact, this might be happening already.

The global response to the AIDS crisis underlines the need for an alternative paradigm for AIDS and other chronic crises, one that borrows elements from the medical relief paradigm and from the health development paradigm, without being squeezed into the health development paradigm.

Overview of this discussion paper

In the *first section* of this paper, I will argue how a Global Health paradigm – through the global AIDS response – is emerging from a synthesis of the medical relief and health development paradigms.

In the *second section*, I will discuss how the Global Health paradigm is promoting the extension of social health protection, as intended by some of the major donor countries and the International Labour Office (ILO).[8] I will argue that if the extension of social health protection is understood as the export of social health protection models – in the sense of promoting national social health protection schemes as a strategy to achieve domestic self-reliance – it is doomed to fail, at least in the low-income countries. But I will also argue that if the extension of social health protection is understood as the expansion of present national social health protection schemes beyond their borders, it could become a real Global Health paradigm.

In the *third section*, I will argue that a new philosophical, ethical or legal basis for a Global Health paradigm is not needed. If we simply recognise and treat health as a human right, the underlying conceptual framework of this approach encompasses trans-national obligations, on which a Global Health paradigm can be built.

In the *fourth and final section* of this paper, I will explain how the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) can be used as a model or even foundation for a Global Health Fund, which could turn a Global Health paradigm from an idea into a reality.

Good idea, bad timing?

Some people have told me lately that they like the concept of a Global Health paradigm (in the sense of globally shared responsibility for the health of all people), but that the timing is wrong. The present global financial crisis, they argue, does not leave any space for increased global solidarity.

But I would argue that the present global financial crisis might also be an opportunity. This financial crisis is affecting people living in all parts of the world. In the middle of the crisis, the leaders of the twenty most powerful economies remained concordant on this: the global economic interdependence is a given; and so is the world's increasingly interdependent financial architecture. Even if this financial architecture allowed overconfidence in the market mechanism and deregulation in one country to create a global crisis, nobody is seriously considering a return to closed autonomous economies.

Therefore, this may be just the right time to push the message that if the risk is global, the insurance against the consequences of the risk should be global as well.

Section 1. The global AIDS response: a synthesis of medical relief and health development paradigms

1.1. Introduction

Resolution 46/182 of the General Assembly of the United Nations – which paved the way for the United Nations Department of Humanitarian Affairs and later the Office for the Coordination of Humanitarian Affairs (OCHA) – explicitly prescribes that "to ensure a smooth transition from relief to rehabilitation and development, emergency assistance should be provided in ways that will be supportive of recovery and long-term development. Thus, emergency measures should be seen as a step towards long-term development."[9]

This resolution seems to confirm the primacy of (health) development over (medical) relief, and the exceptionality of relief. In short, if and only if the magnitude and duration of a crisis is beyond the response capacity of the affected country, the relief response is appropriate, and even then only in a manner that is supportive of future development efforts.

But how does one judge whether or not the magnitude and duration of a problematic situation is significant enough to call it an emergency? And how does one determine what the appropriate response would be, and whether or not it is within or beyond the capacity of the affected country?

Could it be that the non-existence or inaccessibility of primary health care constitutes a crisis in itself? And if countries are not wealthy enough to finance the US$40 per person per year required for the equitable provision of a basic set of much needed health services[10] – in other words: if the adequate response is beyond their capacity – will they receive medical relief for ever, or for as long as needed?

1.2. The health development paradigm: aiming for sustainability, defined as self-sufficiency

As Pavignani and Colombo observe: "Sustainability is continuously invoked as a key criterion to assess any aid-induced activity or initiative. Sometimes, the concept is given the weight of a decisive argument. Thus, to declare something 'unsustainable' may sound as equivalent of 'worthless' or even 'harmful', in this way overruling any other consideration."[11]

How does one define sustainability? According to Gottret and Schieber, in the World Bank's 'Health Financing Revisited: A Practitioner's Guide': "Sustainability has generally been described in terms of self-sufficiency."[12]

However, if US$40 per person per year is required for the equitable provision of a basic set of much needed health services, then sustainability – in the sense of (financial) self-sufficiency – might not be realistic. First, let us assume that developing countries can increase government revenue to the equivalent of 20% of the GDP and allocate 15% of government revenue to health expenditure – both of which are quite optimistic. Second, if one compares these assumptions with present levels of government revenue and allocation to health expenditure – only countries with a GDP of US$1,333 per person can achieve government revenue of US$266 per person per year and government health expenditure of US$40 per person per year. By definition, low-income countries cannot achieve this, as they are classified as such by the World Bank because their Gross National Income (GNI) is only US$935 or less.[13] (Even if GNI is not exactly the same as GDP – GNI includes income earned by 'nationals' abroad – it will be hard to find a country with a GNI per person per year below US$935 and at the same time a GDP per person per year above US$1,333.)

Therefore, for the 1.3 billion people living in low-income countries, sustainability in the sense of self-sufficiency is not compatible with an equitable provision of a basic set of health services. That makes it difficult to link medical relief to health development. As long as international health aid is considered to be medical relief (and financed by specialised relief sub-agencies of donors), self-sufficiency is not an issue and health budgets in the order of US$40 per person per year are not perceived as problematic per se. However, as soon as international health aid becomes health development, health budgets in the order of US$40 per person per year become problematic, because the recipient countries are unable to sustain them from their own budgets in a foreseeable future.

1.3. The medical relief paradigm: not aiming for sustainability

The medical relief paradigm was originally designed to respond to acute health crises. Until recently, humanitarian organisations were guided by the concept of 'temporary disruption of a pre-existing equilibrium', or, as one humanitarian aid critique describes, to "help populations get back to where they were before disaster struck".[14] Therefore, the issue of sustainability is not considered when determining the extent of the medical relief response. One can use helicopters to rescue people after floods in countries that will not be able to finance a helicopter fleet themselves; as the floods are exceptional, the response is not supposed to be sustainable.

However, many humanitarian crises last for decades and some form of sustainability is required: in these cases, the sustainability of medical relief relies on sustained international aid as an alternative form of sustainability (as opposed to self-sufficiency).

Chronic health crises – mainly the epidemics of AIDS, tuberculosis and malaria, but also recurring episodes of malnutrition, or even generalised lack of access to the most basic forms of health care – shook up the medical relief paradigm. The World Disasters Report 2008 of the International Federation of Red Cross and Red Crescent Societies (IFRC) focuses on the AIDS epidemic, as "a disaster in many ways."[15] There are more people dying today in Mozambique due to these chronic crises than during 20 years of war: average life expectancy has declined from 40 to 27 years.[16] In parts of the Democratic Republic of Congo not affected by conflict, mortality exceeds emergency thresholds.[17] In these contexts, the objective to "help populations get back to where they were before disaster struck" is meaningless.

OCHA once defined 'humanitarian crises' or 'emergencies' as "any situation in which there is an exceptional and widespread threat to life, health or basic subsistence, that is beyond the capacity of individual and the community".[18] As explained above, if the incapacity of the affected individuals, communities or countries to cope with a situation is what turns a development challenge into a humanitarian crisis, then 1.3 billion people living in low-income countries are facing a permanent humanitarian crisis as neither they nor their communities are able to provide what it takes to cope.

This is not rhetoric: typical humanitarian actors and providers of medical relief like the IFRC and Médecins Sans Frontières (MSF) have expanded their definitions of humanitarian crises or disasters to intervene in the fight against AIDS, tuberculosis and malaria. Furthermore, if the President's Emergency Plan For AIDS Relief (PEPFAR), launched by the USA, contains 'relief ' in its name, it is not merely because PEPFAR sounds better than PEPFADA – which could have been the acronym of a President's Emergency Plan For AIDS Development Assistance – but because PEPFAR was conceived as a medical relief programme: not aiming for self-reliance within a foreseeable future, but an emergency response to a crisis.

Not everyone is satisfied with this situation. First of all, this broader definition of humanitarian crises creates a field of intervention that is too vast for humanitarian organisations. As a result, intervention criteria inevitably include some arbitrary choices. Whiteside blames humanitarian actors for failing "to provide clear guidelines as to when an

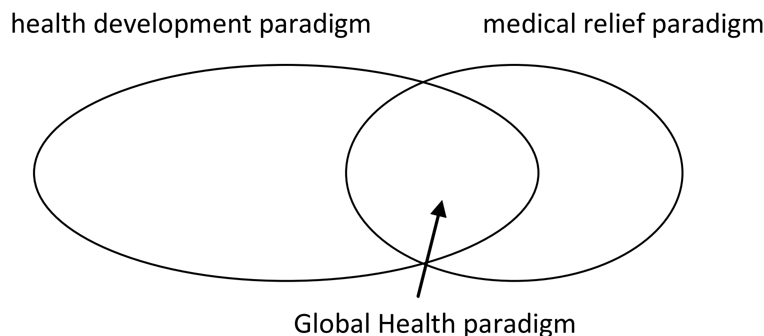
event is severe enough to be declared an emergency", for failing "to recognise change in the nature of disasters", and thus for not addressing the real crises.[19] Perhaps more fundamentally, humanitarian organisations were not created to respond to chronic crises (and they never pretended they were): their reliance on expatriate implementers and parallel management systems and their need to remain independent from governments – all strategies designed for acute crises and interventions in armed conflicts in particular – seriously limit their potential as a catalyser for improved primary health care for all.

The first hand experience of humanitarian organisations demonstrates the potential of interventions that do not aim for sustainability (in the sense of financial self-sufficiency). But the appropriate response cannot and will not come from endless medical relief. National and international civil society actors, including humanitarian organisations, need to call upon Ministries of Health to assume responsibility and replicate and expand those interventions, and call upon donor countries to provide the much needed international health aid, for as long as needed.

1.4. The global AIDS response: technical sustainability at the national level, financial sustainability at the international level

Pavignani and Colombo also observe: “Sustainability tends to be employed as an all-encompassing term, but it seems useful to distinguish between technical sustainability, which relates to the capacity to carry out certain functions, and financial sustainability, which results from resource availability, fiscal capacity and the relative priority of health care provision.”[20]

Distinguishing between technical sustainability and financial sustainability is key to creating the foundations of a Global Health paradigm. This paradigm would aim for operational sustainability in the conventional sense of self-sufficiency (like health development does), but allow for open-ended reliance on international financial support (like medical relief does). In doing so it would recognise a globally shared responsibility for the health of all people and respond to the need for a new approach to providing basic health care to people in middle-income and low-income countries.



This is in fact what the Global Fund is already doing: it has abandoned financial sustainability in the conventional sense as a condition for support, but unlike PEPFAR it does require technical or operational sustainability of the interventions it supports. Hence, the Global Fund did not abandon financial sustainability completely: it invented a new kind of sustainability, sustainability at the international level, relying on sustained international solidarity as well as on domestic resources. When countries use their Global Fund grants wisely and effectively, they can count on continued support from the Global Fund.

As Michel Kazatchkine, the executive director of the Global Fund, explained in his speech closing the XVII International AIDS Conference: “The Global Fund has helped to change the development paradigm by introducing a new concept of sustainability. One that is not based solely on achieving domestic self-reliance but on sustained international support as well.”[21]

The Global Fund did not invent this new concept of sustainability in isolation. While the United Nations General Assembly Special Session on HIV/AIDS of June 2001 lead to a declaration in which member states promised to “make every effort to provide progressively and <u>in a sustainable manner</u>, the highest attainable standard of treatment for HIV/AIDS” (emphasis added),[22] the follow-up assembly of June 2006 lead to a declaration in which member states committed themselves “to supporting and strengthening existing financial mechanisms, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as

relevant United Nations organizations, through the provision of funds in a sustained manner" (emphasis added).[23]

The Global Fund thus created a Global Health paradigm, filling parts of the grey zone between health development and medical relief paradigms. The Global Health paradigm borrows the aim of operational sustainability at the national level from the health development paradigm, and the aim of financial sustainability at international level from the medical relief paradigm.

This emerging Global Health paradigm provides an answer to the challenge raised by Van Damme et al. many years ago: "In other non-development non-emergency situations, the objectives and the approach will also have to be adapted to the context. Creative compromise strategies will have to be worked out, adapted to the local situation, and have to be adjusted over time, with changes in the situation".[24]

1.5. The expanding mandate of the Global Fund

The Global Fund approach, unfortunately, contains a major limitation. Focused on the main killer diseases in Sub-Saharan Africa, it supports only interventions to fight those diseases: AIDS, tuberculosis and malaria. This does not have to be problematic for most middle-income countries, which can finance the 'backbone' of their health systems from domestic funding, and use Global Fund grants for extra 'muscle'. However, for low-income countries the Global Fund's limitation creates a two-tier system: the fight against AIDS, tuberculosis and malaria is not hampered by the restriction of financial self-sufficiency, the fight for primary health care in general is. The result is the current paradox; international health aid to strengthen the backbone of health systems is much harder to find (because of the financial self-sufficiency restriction) than international health aid for extra muscle to fight AIDS, tuberculosis or malaria.

This two-tier system has produced a growing contrast between sufficiently funded muscle to fight AIDS, tuberculosis and malaria, and grossly under-funded health systems' backbone. It has led to critiques of the Global Fund in articles in Foreign Affairs,[25] the British Medical Journal,[26] the Financial Times,[27] the Los Angeles Times,[28] the New York Times,[29] and many others.

Unfortunately, while all of these critiques implicitly blame the Global Fund for having too narrow a mandate, none of them blames the conventional health development approach and its aim of financial self-sufficiency, which is in fact the heart of the problem. These critiques are blaming the Global Fund for the successes of its exceptional approach in part because their authors want this exceptional approach to exist for primary health care in general. I would argue that instead of critiquing the Global Fund's success they should be pushing for its approach to be expanded.

The Global Fund is countering these critiques by taking on or re-affirming its responsibility in financing the backbone of health systems. But this will require additional financing, which will in turn only happen if donor countries fully support a broadened mandate for the Global Fund.

1.6. 'Fiscal space' and 'fiscal sustainability': a straitjacket to ensure self-sufficiency

For a number of years, the IMF has applied the concept of 'fiscal space' to health financing in developing countries. Peter Heller of the IMF defines fiscal space as "room in a government's budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy".[30] And he adds: "Countries that receive significant flows of foreign resources for a specific sector (such as health care) may, as a result of the associated expansion of the sector, face additional future spending needs that may essentially preempt [sic] a share of the growth of future domestic budgetary resources".

The IMF assumes that aid-driven health sector expansion will inevitably pre-empt a share of domestic resources. It is unwilling or unable to imagine that international health aid could finance the expansion of the health sector in the long run. Therefore, it warns countries against using too much international aid for expanding the health sector, a warning echoed by the World Bank: "Obviously, then, it is not prudent for countries to commit to permanent expenditures for such items as salaries for nurses and doctors on the basis of uncertain financing flows from development assistance funds".[31]

The IMF pushes its message on the unreliability of international solidarity with the goal of making recipient governments fearful of increasing expenditures. It does this by repeating the findings of Bulíř and Hamann – who found that international aid is "substantially more volatile than domestic revenues" – over and over again.[32] It chooses to ignore the work of Collier[33] – who found that international aid is, in fact, more reliable than domestic revenue – and Celasun and Walliser[34] – who found that while international aid is slightly less reliable than domestic revenue, international aid shortfalls in the past did not force recipient countries to reduce recurrent expenditure, as these shortfalls were compensated by reduced investments.

A March 2007 report by the Independent Evaluation Office of the IMF revealed that only 27% of the additional international aid to sub-Saharan Africa from 1999 to 2006 was actually allowed (or "programmed") to be spent.[35] The other 73% was put into savings. This practice allows the IMF to impose compliance with fiscal space constraints: whenever a country is at risk of exceeding fiscal space, the IMF can programme international aid to be saved by the recipient nation instead of being spent, for example, to expand health services to vulnerable groups. This is hardly an incentive for donors to increase international aid.

On this issue again, the global AIDS response found a path between the medical relief and health development paradigms. International aid in the form of medical relief is not hampered by fiscal space constraints. It is not a coincidence that Peter Piot, then the general director of the United Nations Joint AIDS Programme (UNAIDS), explicitly compared countries affected by AIDS with countries in or emerging from conflict, when he asked for a general exemption for AIDS expenditure from fiscal space constraints.[36]

Nonetheless, the unpredictability of international aid in the long run is a problem. It is difficult for health ministries to make long-term commitments to salaries for additional health workers, for example, if those commitments are only backed by short-term

international health aid commitments. However, the practice of fiscal space austerity creates a vicious circle: it is justified by the unreliability of international aid in the long run; it leads to international aid being saved rather than being spent, thus creating frustration for donors who do not see the expected results; which leads to a feeling that 'all that aid is not helping anyhow' and thus increases the unreliability of international aid.

A Global Health paradigm – in the sense of a globally shared responsibility for the health of all people – would solve this problem, or turn it into a merely technical matter. How can we make international health aid predictable and reliable in the long run? We already have the technical solutions: the 'replenishments' of the International Development Association (IDA) – also known as the soft loan arm of the World Bank – are based on the principle of burden-sharing between wealthy countries,[37] and at least some of those countries consider them as mandatory.[38] If we could copy this practice of burden-sharing and mandatory contributions to the financing of primary health care in low-income countries, we would not need to place limits on increases in recurrent health expenditure in low-income countries that are funded by increased international health aid.

1.7. Conclusions of the first section

The global AIDS response did not fit within the then existing international health aid paradigms. It was too expensive for the health development paradigm, which aims for sustainability in the sense of financial self-reliance. It was too big, too huge, both geographically and in time, to fit within the conventional medical relief paradigm; it had to rely on domestic operational capacity. It therefore invented a new paradigm, which we could call a Global Health paradigm: it assumes that there is a globally shared responsibility for the health of all people, and that this globally shared responsibility is not limited in time and not just applicable to temporary crises.

Section 2. Global Health: moving towards global social health protection?

2.1. Introduction

"*In the course of the 19th century, many governments in richer countries came to realise, or were pressured to accept, that extreme social and economic inequities were unsustainable. Political parties of the centre, left and right eventually accepted that governments had a responsibility to ensure that people had basic education, sanitation and enough to eat, and that workers' rights to organise ought to be protected*." With this statement, Robert Archer of the International Council on Human Rights Policy started exploring the existence of international duties to realise essential social rights.[39]

Social protection mechanisms succeeded in reducing the extreme inequities that existed within the borders of high-income countries. However, they did not reduce extreme inequities at the global level. According to the Human Development Report 2007/2008 of the United Nations Development Programme (UNDP), the average life expectancy for a girl born in Japan today is 85 years, while the average life expectancy for a girl born in Zambia is only 40 years.[40]

Social protection mechanisms were not designed to provide international solutions. Their members – contributors and beneficiaries – typically live in the same state, which organises and often supports the mechanisms. According to World Bank estimates for the year 2004, the inhabitants of high-income countries spend 10% of their GDP on health and 66% of that expenditure is public expenditure.[41] Assuming those estimates remained valid in 2007, when the combined GDP of high-income countries was US$40 trillion,[42] the inhabitants of high-income countries spent US$4 trillion on health, and US$2.7 trillion of that was public health expenditure. If only 1% of that were shared with low- and middle-income countries, it could provide US$27 billion in ODA for health.

By comparison, the same inhabitants of high-income countries in 2006 collectively provided US$20 billion in ODA for health.[43] Even if ODA for health does not include all international health aid – philanthropic contributions through medical Non-Governmental Organisations (NGOs) are not included for example – the contrast remains stark. The international solidarity in health of the inhabitants of high-income countries as expressed through ODA for health represents less than 1% of their national solidarity in health.

In recent years, European high-income countries have expressed their intention to encourage the development of social health protection in the poorest countries of the world. In June 2007, at its summit in Heiligendamm, Germany, the 'G8' (the group of the seven biggest economies and Russia) welcomed the German and French 'Providing for Health' (P4H) initiative. The 'Consortium on Social Health Protection in Developing Countries' – composed of the German development agency Gesellschaft für Technische Zusammenarbeit (GTZ), the ILO, and the WHO – prepared this initiative, and was later joined by France.[44]

P4H aims explicitly at extending social health protection to developing countries. The 'International Health Partnership' (IHP), announced in August 2007 by the UK's Prime

Minister Gordon Brown, in the presence of Germany's Chancellor Angela Merkel,[45] has a similar objective. The IHP became the flagship of the 'International Health Partnership Plus Related Initiatives' (IHP+), embracing Providing for Health (P4H) and other initiatives.[46] According to its 'Scaling Up for Better Health' work plan, the IHP+ will "[u]se the Providing for Health Initiative to increase attention on sustainable and equitable health financing".[47]

Unfortunately, both P4H and the IHP+ consider international support to social health protection in low- and middle-income countries as a temporary effort, intended to 'develop' the domestic financing capacity. The leaders behind the IHP+ and P4H seem to remain convinced that low- and middle-income countries will have to, and will somehow be able to, finance social health protection themselves in the foreseeable future.

They are not alone. For example, a May 2008 ILO briefing paper, making the case for a global social security 'floor', mentions: "We know that the world can afford to make the right to social security a reality not just a dream. According to ILO calculations, less than 2 percent of the global Gross Domestic Product would be necessary to provide a basic set of social security benefits to all of the world's poor."[48] Yet it continues: "Most of the resources needed will obviously have to come from national resources."

Why is that so obvious? This myopic national approach becomes unsustainable within a single global economy, in which the erosion of social protection in one country provides a comparative economic advantage on global markets and thus creates pressure on other countries to follow the downwards spiral. Furthermore, if extreme inequities within the borders of states became 'unsustainable' in the course of the 19th century – meaning they represented a threat to wealthy people, because poor people were no longer willing to accept their fate – one should wonder how long the existing inequities at the global level will remain 'sustainable', and when the world's poor will challenge their fate, through massive migration or otherwise.

Some experts in social security or social protection dare to think otherwise, and more ambitiously. Van Langendonck, for example, argues:[49] "The very notion of solidarity, on which our social security systems are based, demands an universalisation of its extent. It is contradictory to the idea of solidarity itself, to limit it to a certain group to which one belongs. Solidarity within one occupational group, or within one nation, is limited solidarity. It means the absence of solidarity with the others, who might need it more. When this limited solidarity occurs among the rich, to the exclusion of the poor, it is not solidarity at all. It is protectionism and collective selfishness, not deserving the name "social"."

A Global Health paradigm would not assume that the resources needed to finance social health protection have to be provided from national sources alone. On the contrary, a Global Health paradigm would entail the extension of social health protection in the sense of expansion, not export, of national social health protection mechanisms.

2.2. A global social health protection floor: an inclusive and a minimalist design

A global social health protection floor would not replace national social health protection mechanisms. It would indeed merely constitute a global social health protection floor, on which national social health protection mechanisms can be built. Furthermore, a global floor for social health protection would be based on burden-sharing between states, rather than on burden-sharing between individuals.

This would allow a global floor for social health protection to be a lot less-detailed than one would expect from national social health protection mechanisms because the fine-tuning – both in terms of contributions from and distributions to individuals – would happen within the national social health protection system built on the global floor. Nonetheless, there are still choices to be made about the basic design of such a global floor.

An *inclusive* design would aim at including all people of the world in the global floor, both as duty-bearers and rights-holders. If we assume that even the poorest countries of the world can afford to raise US$10 per person per year for social health protection, they would need an additional US$30 per person per year, at least, to achieve the US$40-50 needed. A total of almost US$200 billion would be needed to finance that for the World's 6.6 billion people.

To finance that, 0.37% of the combined US$54 trillion GDP of all countries would be needed:
- High-income countries, with their combined GDP of US$40 trillion for 1 billion people, would contribute US$148 billion and receive US$30 billion.
- Middle-income countries, with their combined GDP of US$13 trillion for 4.3 billion people, would contribute US$48 billion and receive US$130 billion.
- Low-income countries, with their combined GDP of less than US$1 trillion for 1.3 billion people, would contribute US$4 billion, and receive US$40 billion.

In fact, all countries with an average GDP per person per year of US$8,100 or more would be net contributors to a global floor for social health protection. All countries with an average GDP per person per year of less than US$8,100 would be net recipients.

If we would allow all countries with an average GDP per person per year of US$8,100 or more to waive their 'entitlements' by subtracting them from their 'dues'; and if we would allow all countries with an average GDP per person per year of less than US$8,100 to waive their dues by subtracting them from their entitlements; we would have a yearly envelope of more or less US$100 billion, contributed by high-income countries and some upper-middle-income countries, to low-income countries and some middle-income countries.

A *minimalist* design would be based on the assumptions that:
- Middle-income countries can take care of their own social health protection needs;
- Low-income countries should not contribute US$4 billion and receive US$40 billion, but should only receive the net balance of US$36 billion;
- High-income countries should only contribute the US$36 billion needed by low-income countries.

Using the *minimalist* design, high-income countries should contribute US$36 billion per year to a global social health protection floor. This is less than 15% of 0.7% of GDP – an old promise, waiting to be fulfilled.

While the *inclusive* design would confirm the global social health protection vision best – all countries contribute in accordance with their means and receive in accordance with their needs – the *minimalist* design is probably more realistic. But even under the *minimalist* design, it should be understood that low-income countries are not merely recipients. They are contributors as well, but for merely pragmatic reasons, their contributions stay within their borders. It would be essential, however, to formalise this as a condition: to be a participant in the global social health protection mechanism, low-income countries must live up to the Abuja Declaration[50] commitment of 15% of their annual budget allocated to health expenditure.

Is it realistic to expect high-income countries to allocate the equivalent of 15% of 0.7% of their GDP – or, when combined, the equivalent of 0.1% of their GDP – to an emerging Global Health paradigm? In June 2008, the UK's Department for International Development (DfID) published its revised 'Strategy for halting and reversing the spread of HIV in the developing world'.[51] It includes a promise to spend UK£6 billion on health systems and services to 2015. This commitment came in addition to a UK£1 billion commitment to finance the Global Fund. When the declaration was made, UK£7 billion was worth US$14 billion, and spread over seven years it meant US$2 billion per year. For a population of 60 million people, it meant US$33 per inhabitant per year. If all governments of high-income countries would do the same, US$33 billion per year would be available for a global social health protection floor.

This would be consistent with the purpose of a social health protection floor – a globally shared responsibility for the health of all people. The only innovation would be that the top billion people would share a percentage of their contribution to social health protection, not with their top billion compatriots, but with the 'bottom billion' people on the other side of the globe.

2.3. The Global Fund, seen as an emerging global social health protection floor

When the first AIDS treatment medicines became available – not powerful enough to cure AIDS, but powerful enough to turn AIDS into a manageable chronic disease – AIDS activists in high-income countries did not just fight for access to those medicines for their own constituencies. They fought for access to those medicines for all people living with AIDS, wherever they were living. This fight was initially perceived as both a public health and a development assistance heresy, because some of the most affected countries would never be able to finance these treatments from domestic resources, within a foreseeable future. But high-income countries succumbed to the pressure and agreed to create the Global Fund.

The Global Fund pioneered a new approach. It does not expect recipient countries to replace international health aid with domestic funding within a foreseeable future. It expects recipient countries to use international health aid wisely: as long as they demonstrate tangible results, they can count on continued international health solidarity. The result is an emerging global social health protection floor.

Although high-income countries never formally accepted the 'Equitable Contributions Framework' proposed by AIDS activists,[52] contributions to the Global Fund do reflect the relative wealth of donor countries. Within high-income countries, taxes are used to raise the funds needed for contributions to the Global Fund, and most high-income countries use progressive taxation: the more one earns, the more one has to contribute. Thus what we have on the contributors' side of the Global Fund reflects the principles of social health protection: the more one earns, the more one contributes.

On the recipients' side, low- and middle-income countries propose interventions based on real needs. The greater the need, the more expensive the proposals should be. If we can assume that Global Fund grants are used in an equitable manner, the more a country needs international health solidarity, the more this country receives international health solidarity. Therefore, on the recipients' side as well, the Global Fund reflects the principles of social health protection.

One can argue that the same is valid for all international health aid. Most contributions to international health aid are raised through progressive taxation, and – ideally – all international health aid addresses the highest needs first. The difference is that most international health aid is intended to be temporary, while the Global Fund accepts that its solidarity is open-ended. It operates on the premise that as long as needed, wealthy people living in wealthy countries will contribute in accordance with their means, while poor people living in poor countries will receive in accordance with their needs.

In that sense, the Global Fund is an emerging global social health protection floor.

2.4. Conclusions of the second section

To become a full-fledged global social health protection floor, the Global Fund should gradually abandon its focus on three diseases. The Global Fund will have to expand its mandate to become a Global Health Fund. At this stage in the ongoing debate about a Global Health Fund I would support the idea that it is a concept, which could be realised through the creation of a series of complementary global health funds: one focusing on AIDS, tuberculosis and malaria (the Global Fund), another focusing on vaccines (the Global Alliance on Vaccines and Immunizations, or GAVi), another focusing on reproductive health and rights and another focusing on child mortality. (In the fourth section of this discussion paper, I will argue why a single Global Health Fund might make even more sense.)

To become a Global Health Fund, contributions to the Global Fund should become mandatory, based on an agreed burden sharing key (like national social health protection mechanisms) and be sufficiently high to finance its broadened mandate.

This transformation is already taking place. In April 2007, the Board of the Global Fund agreed to "establish new procedures that will allow applicants to submit national strategies for HIV/AIDS, tuberculosis or malaria for Global Fund financing under conditions that differ in some respects from existing application requirements ("National-Strategy Applications")."[53] This new 'funding window' seems to be tailor-made for the national health compacts, which should result from the IHP+.[54]

One of the major obstacles to a global social health protection floor is that donor countries have very different opinions about how social health protection should be realised: France and Germany are supportive of the Bismarckian model, which is based on membership fees and benefits to members; the UK is supportive of the Beveridgean model, which is based on taxation and benefits to all inhabitants (all are supposed to pay taxes). The Global Fund has demonstrated its flexibility in supporting both 'Bismarckian' social health protection (in Rwanda, the Global Fund finances social health insurance membership fees for orphans, widows and people living with AIDS) and 'Beveridgean' social health protection (in Malawi, the Global Fund finances increased salaries of all health workers), in each case reflecting the countries' own choices.

The stage is set for the Global Fund to become a global social health protection floor. There is, however, one not so minor problem, a funding shortfall. Even with its currently projected financial volume of US$8 billion per year – which is far away from present reality – the Global Fund can never provide the additional US$30 per person per year of financing, badly needed by at least 1.3 billion people living in low-income countries. And even if we consider all of the present US$20 billion ODA for health as part of a virtual Global Health Fund, it would still be only half of what is urgently needed.

Section 3. Global Health: if health is a human right, there is a globally shared responsibility for the health of all people

3.1. Introduction

Ethics and values lie at the heart of the formal framework of international human rights law. In this section of the discussion paper I will explore the extent to which the formal framework of international human rights law provides a foundation for an alternative aid paradigm, specifically the Global Health paradigm, in which foreign assistance becomes a duty, responding to an entitlement, and thus open-ended rather than temporary, under certain conditions.

The 1948 Universal Declaration of Human Rights[55] is the foundation of the modern human rights movement, and although not a legally binding document in itself, later international human rights treaties that are based on the values found in the Universal Declaration of Human Rights do give rise to legally binding obligations on governments. As Gruskin and Tarantola explain, “In practical terms, international human rights law is about defining what governments can do to us, cannot do to us and should do for us.”[56]

Two key treaties arising from the Universal Declaration of Human rights, the International Covenant on Civil and Political Rights[57] and the International Covenant on Economic, Social and Cultural Rights[58] contain legally binding obligations for the states that ratify them. The International Covenant on Economic, Social and Cultural Rights is of most relevance for this paper as it defines states obligations with regard to the right to health. However it is important to remember that human rights cannot be realised in isolation, which simply means the right to health cannot be achieved without advances in the right to education and respect for civil and political rights.

3.2. Defining the right to health

Article 12 of the International Covenant on Economic, Social and Cultural Rights defines the right to health as "the right to the highest attainable standard of physical and mental health" and the related state obligations include the provision of medical services and the underlying preconditions necessary to health, including things like clean water, sanitation, etc. This bare bones definition has been affirmed and expanded on in later international conventions, including the 1989 Convention on the Rights of the Child, and other national and international legislation. In addition, several United Nations Committees have taken an active role in further defining key elements of the right to health in their General Comments and in reviews of States' compliance with obligations under the International Covenant on Economic, Social and Cultural Rights and other more recent treaties. Thus there is a dynamic evolution of the understanding of the right to health in international law; it is not just frozen in the bare bones definition from the mid 1960s.

The 1989 Convention on the Rights of the Child, which has been ratified by all States except the USA and Somalia, can be viewed as an indicator of global intentions on the evolution of understanding of the right to health and the obligations it entails. Article 24 of the Convention on the Rights of the Child provides more guidance in understanding what the right to health means as well as establishing norms for governments regarding the right to health of children. An example of how these legal documents help shape government policy comes from the UN Committee on the Rights of the Child which has interpreted Article 24 of the Convention on the Rights of the Child as requiring governments to take some specific actions to ensure the right to health of children. First, a government must provide certain data on the health of children to the Committee on the Rights of the Child. Second, a government must show that it is taking steps to ensure that it adequately invests in the health of children. Third, a state must take steps to ensure that the health of all children is respected. Individual government compliance with these actions and other obligations is reviewed by the Committee on the Rights of the Child, when governments submit their periodic reports.

A further important development occurred in 2000 when the Committee on Economic, Social and Cultural Rights issued General Comment 14 on the Right to Health,[59] addressing implementation of the Covenant on Economic, Social and Cultural Rights, the scope of the right to health and the importance of international cooperation in achieving the right to health, which will be discussed below.

3.3. Progressive Realisation: what it does and does not mean

A key element of economic and social rights like the right to health is that they can only be realised in a progressive manner, overtime and not immediately, as is the case with many civil and political rights.[60] With regard to the right to health the Committee on Economic, Social and Cultural Rights notes: "The concept of progressive realization constitutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time." The principle of progressive realization is "critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible."[61]

The concept of progressive realisation, however, should not be misinterpreted as justifying endless delays in the realization of economic, social, and cultural rights, while waiting for economic growth and sufficient domestic resources to become available. It is not to be viewed as "an escape hatch (for) recalcitrant states."[62] Such an interpretation would deprive economic, social, and cultural rights of any meaningful value, especially for the disadvantaged and vulnerable. Thus, the Committee on Economic, Social and Cultural Rights noted that States parties have "an obligation to move as expeditiously and effectively as possible."[63] Progressive realisation also applies to resource-rich countries.[i]

To counter interpretations of "progressive realisation" as implying "no immediate obligations," the Committee on Economic, Social and Cultural Rights emphasises a series of principles that define the nature of States parties' obligations: the principle of non-retrogression (a State should not take steps backwards), the obligation to provide international assistance, the principle of core obligations. I have chosen to focus on the principle of core obligations and the obligation to provide international assistance as they provide us with useful concepts for advancing our thinking on a Global Health paradigm.

[i] Articles 55 and 56 of the UN Charter provide that all states are obliged to cooperate in the realization of universal respect for and observance of human rights and to further conditions of economic and social progress and development. The international community recognized this obligation in the Declaration on the Right to Development, adopted December 4, 1986, G.A. Res. 41/128, UN GAOR, 41st Sess., at 3.

3.4. Core obligations and the obligation to provide assistance

In 1986, Esin Örücü elaborated the notion of the 'core content' of a human right: the essential substance of a right, its raison d'être, without which it would have no meaning.[64] The 1997 Maastricht Guidelines, drafted by international legal experts expanded further on this idea. [ii] The concept of 'core content' was endorsed by the Committee on Economic, Social and Cultural Rights' 2000 General Comment which clarified that there are limits to the compromises that states can make with regards to realising economic, social and cultural rights by invoking the explicitly acknowledged impossibility of realising all of them completely and at once. Further, there is a minimum threshold, a minimum essential level or a core content, which must be realised without further delay. [65]

The Committee on Economic, Social and Cultural Rights further clarified that neither resource constraints nor progressive realisation can excuse non-compliance with the core obligations noting that the burden rests with the State to demonstrate that it has used all available resources to satisfy its core obligations, which are non-derogable.[66]

The Committee on Economic, Social and Cultural Rights defined the minimum essential level of the right to health indirectly, through the definition of the core obligations of States parties with regards to the right to health. The list includes an obligation to ensure access, to health facilities, goods and services as well as basic shelter, housing, safe and potable water and ensuring freedom from hunger through ensuring access to minimum essential food. The core obligations also include the obligation to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs. The fundamental importance of non-discrimination is emphasised throughout, as is the obligation for a state to pay particular attention to vulnerable or marginalized groups. [67]

For most health practitioners with experience in developing countries, this definition of the minimum essential level of the right to health is a distant dream. In 37 of the world's low-income countries, public health expenditure was less than US$10 per person per year in 2004.[68] The inadequacy of this level of spending is glaring when compared with the above mentioned CMH estimate of US$40 per person per year needed for an adequate package of healthcare interventions including AIDS treatment.

In light of this shortfall, at a May 2000 Committee on Economic, Social and Cultural Rights session Paul Hunt remarked: "if the Committee decided to approve the list of core obligations, it would be unfair not to insist also that richer countries fulfil their obligations

---

[ii] With regard to core obligations, the Maastricht Guidelines state, "Violations of the Covenant occur when a State fails to satisfy what the Committee on Economic, Social and Cultural Rights has referred to as 'a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights [...]. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, violating the Covenant.' Such minimum core obligations apply irrespective of the availability of resources of the country concerned or any other factors and difficulties." The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights were adopted in January, 1997, and reprinted in Human Rights Quarterly 20 (1998): pp. 691-704.

relating to international cooperation under article 2, paragraph 1, of the Covenant. The two sets of obligations should be seen as two halves of a package." Later, in reporting on his Mozambique mission Hunt re-emphasised this point stressing that financial and technical assistance is an international responsibility under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child.[69]

The importance of international cooperation in helping all States to fulfil their obligations to their citizens is recognised in Article 24(4) of the Convention on the Rights of the Child which states: "States parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries."

The principle of international cooperation is also a key feature of the founding documents of several international bodies. For example, articles 55 and 56 of the Charter of the United Nations (1945) affirm the principle of cooperation among states. The necessity of international cooperation to realise the right to health in particular was confirmed in the preamble to the Constitution of the WHO: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States."[70] Also, Article 2(1) of the International Covenant on Economic, Social and Cultural Rights creates an obligation on States parties to provide international assistance and cooperation to the maximum of their available resources. Further, in General Comment 3, the Committee on Economic, Social and Cultural Rights clarified that the drafters of the treaty intended the phrased 'to the maximum of its available resources' to refer to both a State's resources and those available through international cooperation and assistance. [71]

If the right to health is in itself meaningless without the realisation of at least the core content, and if some countries lack the resources to realise the core content of the right to health, then the right to health cannot be realised on a global scale without the obligation to provide assistance. In turn, this legal obligation only takes effect when developing countries have demonstrated their best efforts to comply with their obligations.

3.5. Collective entitlement, collective obligation and ways to manage them

Even if all high-income countries were to accept that they have an obligation to contribute to the health of all people – which we can argue all of them except the USA have done by ratifying the Convention on the Rights of the Child – we would still face the challenge of attribution. Which countries owe how much and to which countries do they owe it?

On the one hand, we seem to have a collective entitlement. As argued above, it seems unrealistic to expect low-income countries to fulfil even their core obligations, if they cannot claim foreign assistance. So we have a collective entitlement: at least 49 low-income countries and a handful of lower-middle-income countries are entitled to assistance.

On the other hand, we seem to have a collective obligation. For the 65 countries or economies presently classified as high-income, it would be difficult to argue that they are not 'in a position to assist'.

As Kenneth Roth of Human Rights Watch explained:[72] "…the treaty assigns responsibility for compliance more broadly – not only to the immediate national government, but also to the international community as a whole, through the duty to provide international assistance. This gradualism and shared responsibility make it much more difficult to shame a particular national government for its poor state of health care or, for that matter, its inadequate education or housing. Governments can deflect criticism by blaming others. There is no easy way to move beyond this finger-pointing. Or governments can simply assert that their current contributions, stingy as they might be, are all they owe to meet the AIDS challenge. Again, there are no clear benchmarks by which to rebut these claims."

Legal theory will not solve this problem. But some common sense pragmatism can, quite easily in fact. Kenneth Roth suggested a pragmatic solution: "We need a series of World Conferences in which all industrialized governments convene to consider a country in need, the doors are locked, and no one leaves the room until the finger-pointing and evasions stop, no one goes home until the resources are finally committed that are adequate to the emergency at hand."

In fact, much of what Roth proposed in 2000 has been accomplished since then, but not through a 'series of World Conferences'. The creation of the Global Fund allowed countries in need of assistance to develop AIDS treatment plans, and created pressure on governments of states in a position to assist to provide the needed assistance. Furthermore, even if the outcomes of the Global Fund process of country proposals assessed by an independent Technical Review Panel (TRP) does not lead to a perfect distribution of means in accordance with needs, it probably comes close to being a needs-based distribution approach. And last but not least, the present process of voluntary contributions to the Global Fund is not a perfect burden-sharing mechanism, but it too moves towards means-based contributions.

Therefore, the Global Fund is in itself a pragmatic solution to manage a collective entitlement and a collective obligation. The main problem is the Global Fund's focus on three diseases: from a human rights point of view, this limitation cannot be justified.

3.6. Conclusions of the third section

If we agree that health is a human right for all human beings, there must be a globally shared responsibility for the health of all people.

This is not merely a truism. I discussed how the right to health is subject to progressive realisation – countries must realise it step by step – but also to immediate realisation: there is a minimum level, a core content that countries must realise immediately. Realising this minimum level is too expensive for low-income countries. Therefore, the right to health can only exist if low-income countries are entitled to assistance from high-income countries. Thus, health can only be a human right for all human beings if there is a globally shared responsibility for the health of all people.

We should take all donor agencies endorsing health as a human right at their word; if health is a human right, there must be an international obligation responding to an international entitlement.

The collective entitlement and collective obligation create a challenge, which cannot be tackled with legal theory alone. We need a pragmatic solution. The Global Fund demonstrates that a pragmatic solution is feasible. However, the Global Fund should become a Global Health Fund in order to achieve this.

Section 4. Global Health in practice: moving towards a single Global Health Fund?

4.1. Introduction

So far, I have used the idea of a Global Health Fund as a concept: something like the current Global Fund, but supporting all primary health care needs (not merely AIDS, tuberculosis and malaria responses), creating open-ended global responsibilities for the health of all people rather than temporary charitable donations, but not necessarily a single organisation or institution. A virtual Global Health Fund requires first and foremost a mental shift; if the mental shift occurs, a patchwork of bilateral agreements between high-income countries, low-income countries and a handful of lower-middle-income countries could be sufficient.

I have used the idea of a Global Health Fund as merely a concept for pragmatic and strategic reasons. The pragmatic reasons are that it would be feasible to create a virtual Global Health Fund without a real Global Health Fund. The strategic reasons are that hundreds of donor agencies and global health initiatives have vested interests that are incompatible with a single Global Health Fund. I would like the leaders of those organisations to be able to think about a virtual Global Health Fund free from the distraction of thinking about their job disappearing.

Nonetheless, in this fourth section of this discussion paper, I will argue that a single Global Health Fund, or an architecture that comes as close as possible to a single Global Health Fund, is preferable.

4.2. From the global AIDS response to Global Health, through a single Global Health Fund?

Let us assume that the Global Health paradigm, as discussed above, will indeed become broadly accepted. That would lead to a substantial increase in international aid for health. It would also change the nature of international aid for health: it would change from temporary to ongoing and from charity to a collective obligation corresponding to a collective entitlement, or a global dimension to social protection. How should this international health aid be delivered? The Global Fund provides a model for how international health aid can be delivered according to ambitious country-defined responses to real and urgent needs. The way the Global Fund operates is summarised in Panel 1,[73] while Panel 2 outlines how the IHP+[74] is already reshaping the Global Fund's mandate. [75]

Panel 1 – How the Global Fund works

The Global Fund is driven by countries' demands. It does not propose interventions. Once or twice per year, it launches a call for proposals, to which so-called *Country Coordination Mechanisms* (CCMs) can apply. CCMs include a wide range of stakeholders including: the Ministry of Health, the National AIDS Council, bilateral donors, United Nations agencies, international and national NGOs, faith-based organisations, associations of people living with AIDS, associations of health services users, and representatives of the private for-profit sector. Proposals require the consensus of the entire CCM to be eligible.

A *Technical Review Panel* of the Global Fund, composed of independent experts, makes recommendations for accepting, amending, or rejecting proposals. These recommendations are confirmed by the *Board* of the Global Fund, comprising representatives from eight donor countries, seven recipient countries, two NGOs (from the North and from the South), one patient group, the private sector and a private foundation. The NGOs and the communities are considered to be on the recipient countries' side, while the private business sector foundations are considered to be on the donor countries' side, thus creating two blocks of ten votes each.

Once approved by the Board, the proposal is transformed into a grant agreement between the Global Fund and the *Principal Recipient* – often the Ministry of Health or the National AIDS Council, although UN agencies and NGOs have also played this role. The grant agreement is valid for two years, after which it can be continued for another three years without a new proposal. After that, the same package of interventions can be considered for two more three-year terms. The Global Fund thus creates an 11-year financing perspective, which could become a 14-year, a 17-year, or a 20-year financing perspective, if the Board decides to create third, fourth and fifth three-year terms. This approach is coming close to the long-term perspective needed for ambitious national health plans, which other aid mechanisms rarely offer.

Grant agreements appoint a *Local Fund Agent*, typically an international consultancy or accounting agency selected through a competitive bidding process. The Local Fund Agent does not judge grant agreements and their implementation on their intrinsic merits; it simply verifies whether Principal Recipients did what was agreed.

Panel 2 - National Strategy Applications and the International Health Partnership

The Global Fund was created in 2002 to accelerate the fight against the three main killer diseases in the developing world: AIDS, Tuberculosis and Malaria. Although the Global Fund accepts applications to strengthen general health systems and services, these should be linked to the provision of treatment and prevention of the three diseases, which sometimes requires an artificial demarcation. In April 2007, the Board of the Global Fund agreed to create a separate window for 'National Strategy Applications'. National Strategy Applications, that have "undergone a rigorous technical certification by an independent review mechanism", will be eligible for Global Fund financing.

In September 2007, the International Health Partnership was launched, and soon became the flagship of the 'International Health Partnership and Related Initiatives' (IHP+), embracing initiatives by Canada, France, Germany, and Norway. The IHP+ encourages low-income countries to develop national comprehensive and integrated long-term health plans or 'compacts'. These compacts seem to fit perfectly within the definition of National Strategy Applications. One can expect the 13 'first wave' countries of the IHP+ to submit their health compacts to the Global Fund as early as 2009. The question will then be which part of the compacts the Global Fund will finance: the entire compact or only the part that can be linked with the fight against AIDS, tuberculosis and malaria?

It seems somewhat paradoxical to invite countries to develop comprehensive and integrated compacts, and then to ask them to disaggregate them again, in order to submit one big piece to the Global Fund, and other bits and pieces to other donors and funding channels. It would be more logical if the Global Fund were encouraged and enabled to finance those compacts integrally. In doing so, the Global Fund would become a Global Health Fund.

4.3. Ten pragmatic reasons for a single Global Health Fund

4.3.1. Enabling robust and ambitious national health plans, aiming for truly comprehensive primary health care for all

The subtitle of the Paris Declaration on Aid Effectiveness is: 'Ownership, Harmonisation, Alignment, Results and Mutual Accountability'.[76] These objectives require robust and ambitious national health plans, aiming for truly comprehensive primary health care for all, as defined in the Alma Ata Declaration,[77] and in conformity with the minimum essential level of the right to health.

In the eighties, the original objective of the Alma Ata Declaration – to provide primary health care for all, in a comprehensive manner – was abandoned because the costs were estimated as too high.[78] Selective primary health care was promoted as an 'interim' strategy. After almost three decades of operating in a continual state of uncertainly about future resources, it is not surprising that developing countries do not develop or 'own' national health plans that aim for truly comprehensive primary health care for all. If uncertainty about future resources obliges health ministries to develop selective national health compacts, prioritising one urgent need above another, national ownership will always be questionable. Donors may fully support these compacts by harmonising their procedures and aligning their funding with them, but they will be supporting compacts born of impossible choices made under the duress of artificial financial constraints and broken promises.

The CMH estimated that it would cost at least US$40 per capita per year to provide comprehensive primary health care.[79] Many developing countries that are at present developing national health compacts for the 'International Health Partnership Plus Related Initiatives' (IHP+) are working with much smaller health budgets: US$11 per person per year in Kenya, US$9 per person per year in Mozambique, US$5 per person per year in Niger, to name only a few.[80] These countries certainly want to support comprehensive primary health care, but in the absence of long-term funding commitments may be forced to opt for cheaper and less ambitious national health plans, thus imposing selective primary health care on themselves.

To enable true national ownership, a realistic prospect of obtaining sufficient long-term funding is required. This can only happen if high-income countries deliver on their promises, and clarify how additional long-term international health aid will be made accessible to developing countries.

4.3.2. Simplifying the patchwork of bilateral aid relationships and global health initiatives and promoting harmonisation

The World Bank's classification of economies includes 65 high-income countries or economies, 95 middle-income countries and 49 low-income countries.[81] If all high-income countries are considered as potential contributors to international health aid, and all low- and middle-income countries as potential recipients of international health aid, this creates almost ten thousand possible bilateral relationships. In addition, estimates indicate that

there are more than a hundred public-private partnerships supporting various health interventions.[82] A single Global Health Fund would provide a means to rationalise the number of potential international health aid relationships and to harmonise procedures.

4.3.3. Increasing alignment of international health aid with national priorities

The current patchwork of thousands of potential international health aid relationships allows individual donor countries to remain focused on their own priorities, and to assume that someone else will take care of the rest. A single Global Health Fund, to which developing countries would submit their health compacts, would be a way to reflect their real priorities – adjusted and co-owned by civil society – and this is what high-income countries would have to support.

4.3.4. Increasing the involvement of civil society: true national ownership and mutual accountability

Although all international health initiatives involve civil society to a certain degree, no international health initiative has taken it to the level of the Global Fund, where NGOs and civil society organisations (CSOs) in recipient countries are co-owners of the interventions they have helped to design, and play an important watchdog role in overseeing the implementation of these interventions.

At the level of high-income countries, NGOs and CSOs feel responsible for making sure that the Global Fund receives enough funding to finance the approved proposals. Campaigns are launched to pressure governments of high-income countries into increasing their contributions during each replenishment cycle.

This is a rare example of mutual accountability at the level of civil society: civil society of the 'Global North' mobilising to generate the international health aid needed; civil society of the 'Global South' mobilising to generate increased domestic health financing and to make sure that all health financing is well spent.

4.3.5. Improving the long-term reliability of international health aid: pooling, burden-sharing and monitoring

If all OECD members would follow the example of the UK, US$33 billion in international health aid would be available per year, for seven years. But what happens after 2015? If high-income countries accept mutual accountability for the health compacts they help support, their solidarity will have to continue.

International health aid flows have not always been stable. Pooling international health aid from many high-income countries creates a buffer against unexpected shortfalls, and would allow for agreement on a burden-sharing mechanism between all high-income countries: the level of contributions reflecting a high-income country's capacity to contribute based on the

relative wealth of its economy. This is how financing for the World Bank currently operates.[83]

Finally, pooling all international health aid into a single Global Health Fund would also allow for monitoring by civil society in the Global North of their governments' contributions.

4.3.6. Expanding the new approach to financial sustainability, creating 'fiscal space' for health

The conventional approach to financial sustainability aims for domestic financial self-reliance. The Global Fund has abandoned this approach, recognising that the poorest countries, often hardest hit by the AIDS epidemic, will not be able to replace Global Fund grants with domestic resources, and provides a financing horizon of up to 20 years.

This new approach to financial sustainability is what comprehensive primary healthcare for all needs as well. The major bottleneck in low-income countries scaling up health services is the shortage of health workers. To increase their health workforce, some low-income countries have to increase training capacity (three to five years at least), train more people (again three to five years minimum), then increase capacity to pay the salaries of additional health workers for at least ten years. A 20 year financing horizon is needed at a minimum.

Furthermore, as discussed above in section 1.6, present International Monetary Fund (IMF) policies hamper the full use of present international health aid,[84] and the IMF justifies such policies by referring to the long-term unpredictability of international aid. It links 'fiscal space' (the maximum expenditure level, regardless of what donors are willing to provide) to 'fiscal sustainability' (the capacity of a government to finance its desired expenditure, without relying on development assistance in the long run).[85] In other words, fiscal space or expenditure ceilings for the health sector are based on the assumption that, sooner or later, international health aid will disappear.

The Independent Evaluation Office of the IMF estimated that only 27% of all additional aid to sub-Saharan Africa between 2000-2006 was programmed to increase expenditure – the other 73% was programmed to increase savings.[86] These IMF policies could no longer be justified if a Global Health Fund would provide a more predictable flow of international health aid or solidarity.

4.3.7. Increasing domestic contributions for health

The essential counterpart of this new approach to financial sustainability is increased domestic contributions for health. If sustained international health aid would lead to stagnating or even decreasing domestic health financing, it would limit gains and undermine high-income countries' willingness to sustain international health solidarity.

If the Global Fund became a Global Health Fund, it could establish an agreed road map towards allocating 15% of government revenue to healthcare as a condition for continued

international health aid. This may sound like ‘patronising conditionality’, but it should be understood as ‘emancipating conditionality’: a human rights approach, considering both national and international responsibilities and duties, or simply mutual accountability. Further it reflects the pledge made in the 2001Abuja Declaration. [87]

4.3.8. Adding flesh to the bones of health as a human right

Health is a human right, and access to health care is an essential element of it. As the Committee on Economic, Social and Cultural Rights explains, countries “have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights … including essential primary health care.”[88]

But what if a country is too poor to ensure the satisfaction of comprehensive primary healthcare? In that case, ‘states in a position to assist’ bear a duty to provide assistance.[89] Currently, it is not clear where the duties lie: poor countries can blame rich countries for not providing enough assistance and rich countries can blame each other, or the poor countries for not trying hard enough.[90]

A Global Health Fund, based on agreed international and domestic contributions, would create benchmarks. ‘Patronising conditionality’ would become ‘emancipating conditionality’: as long as developing countries are fulfilling their conditions, Global Health Fund grants are not charity; they are the fulfilment of corresponding international legal duties.

4.3.9. Avoiding political strings

Channelling donor funding through a Global Health Fund would prevent the attachment of political strings. Proposals would be submitted to the independent Technical Review Panel, and based on technical appraisal, approved or rejected by the Board, in which the ‘donors’ and the ‘recipients’ have an equal number of votes.

Using development assistance to cajole a recipient country into voting a particular way at the United Nations,[91] or providing favourable conditions for the exploitation of their natural resources, would be avoided.

4.3.10. Fighting corruption and misuse of funding

Finally, a single Global Health Fund would be in a much stronger position to deal with corruption and misuse of funding. Under the current system – with thousands of possible donor funding channels – a new donor can replace a dissatisfied one. Furthermore, the involvement of civil society as a watchdog would help detect corruption and misuse of funding.

4.4. Conclusions of the fourth section

When the Global Fund was created, it held the promise of becoming a US$10 billion per year fund. The prospect of 'unlimited' funding encouraged many countries to develop ambitious proposals to fight AIDS, tuberculosis and malaria, reflecting their countries true needs and intentions. To achieve similar progress for comprehensive primary health care, the expectation that sufficient long term funding could be available is needed. The principles of the Paris Declaration on Aid Effectiveness – ownership, harmonisation, alignment, results and mutual accountability – are meaningless if the point of departure is insufficiency of financial resources. The Global Fund has demonstrated how all those principles can become reality if they are backed by a real commitment from all stakeholders.

The transformation of the Global Fund into a Global Health Fund is not an idle wish or an imaginary nightmare: it is already happening. At present, 13 countries are developing national compacts and in 2009 they will probably submit applications based on these compacts to the Global Fund. The question as to whether or not the Global Fund will be enabled to finance those compacts integrally needs to be answered.

This perspective provides an opportunity and a threat. The opportunity is that comprehensive primary health care will benefit from the innovations obtained in the fight against AIDS, tuberculosis and malaria: the exceptional momentum will be broadened. The threat is that interventions to fight AIDS, tuberculosis and malaria will again be forced to comply with the rules of the 'Ancien Régime' of health development: preoccupations over sustainability and fiscal space that perpetuate the under-funding of anything that requires long-term external support, and no real involvement from civil society.

Section 5. General conclusions

As this paper is a discussion paper, I believe that this section should remain empty, for the time being. There are no general conclusions for the time being, there is the beginning of a discussion.

I would like you to forward this discussion paper to as many people as possible, so we can begin this important discussion.

References

[1] Ooms G (2008). The right to health and the sustainability of health care: Why a new global health aid paradigm is needed. Gent: Academia press. Available from: http://www.icrh.org/files/academia-doctoraat%20Gorik%20Ooms_0.pdf, accessed on January 2, 2009.
[2] World Health Organization (2008). Website, Home page. Available from: http://www.who.int/about/en/index.html, accessed on January 2, 2009.
[3] Stuckler D, King L, Robinson H, McKee M (2008). WHO's budgetary allocations and burden of disease: a comparative analysis. Lancet, 372(9649): 1563-69.
[4] World Health Organization (2008) Website, National health accounts, Country information. Available from: http://www.who.int/nha/country/nha_ratios_and_percapita_levels_2001-2005.xls, accessed on January 2, 2009.
[5] Commission on Macroeconomics and Health (2001). Investing in Health for Economic Development. Geneva: World Health Organization. Available from: http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf, accessed on January 2, 2009.
[6] Independent Evaluation Office of the International Monetary Fund (2007). The IMF and aid to Sub-Saharan Africa. Washington D.C.: Independent Evaluation Office of the International Monetary Fund. Available from: http://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf, accessed on January 2, 2009.
[7] Ooms G (2006). Health Development versus Medical Relief: The Illusion versus the Irrelevance of Sustainability. PLoS Med, 3(8): e345. Available from: http://medicine.plosjournals.org/archive/1549-1676/3/8/pdf/10.1371_journal.pmed.0030345-S.pdf, accessed on January 2, 2009.
[8] International Labour Office (2005). Campaign on Social Security and Coverage for All, Campaigns, website. Available from: http://www.ilo.org/global/What_we_do/Events/Campaigns/lang--en/WCMS_025342/index.htm, accessed on January 2, 2009.
[9] United Nations General Assembly (1991). Strengthening of the coordination of humanitarian emergency assistance of the United Nations. A/RES/46/182. Available from: http://www.un.org/documents/ga/res/46/a46r182.htm, accessed on January 2, 2009.
[10] Carrin G, Evans D, Xu K (2007). Designing health financing policy towards universal coverage. WHO Bulletin, 85(9): 652. Available from: http://www.who.int/bulletin/volumes/85/9/07-046664.pdf, accessed on January 2, 2009.
[11] Pavignani E, Colombo A (2006). Analysing Health Sector Financing and Expenditure. Module 6 of Analysing disrupted health sectors – Manual. Geneva: World Health Organization. Available from: http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_06/en/index6.html, accessed on January 2, 2009.
[12] Gottret P, Schieber G (2006). Health Financing Revisited: A Practitioner's Guide. Washington: The World Bank. Available from: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf, accessed on January 2, 2009.
[13] World Bank (2008). Website, Data, Country classification. Available from: http://go.worldbank.org/K2CKM78CC0, accessed on January 2, 2009.
[14] Trench P, Rowley J, Diarra M, Sano F, Keita B (2007). Beyond Any Drought. London: Sahel Working Group. Available from: http://www.careinternational.org.uk/download.php?id=617, accessed on January 2, 2009.
[15] International Federation of Red Cross and Red Crescent Societies (2008). World Disasters Report 2008. Focus on HIV and AIDS. Geneva: International Federation of Red Cross and Red Crescent Societies. Available from: http://www.ifrc.org/Docs/pubs/disasters/wdr2008/WDR2008-full.pdf, accessed on January 2, 2009.
[16] Stanecki K (2004). The AIDS Pandemic in the 21st Century. Washington D.C.: U.S. Census Bureau. 2004. Available from: http://www.census.gov/prod/2004pubs/wp02-2.pdf, accessed on January 2, 2009.

[17] Kassa A, Van Herp M, Philips M, Ponsar F (2005). Access to health care, mortality, and violence, in Democratic Republic of the Congo. Brussels: Médecins Sans Frontières. Available from: http://www.doctorswithoutborders.org/publications/reports/2005/drc_healthcare_11-2005.pdf, accessed on January 2, 2009.
[18] United Nations Office for the Coordination of Humanitarian Affairs (2005). Humanitarian Strategic Framework for Southern Africa 2005. Johannesburg: United Nations Office for the Coordination of Humanitarian Affairs. Available from: http://www.sahims.net/doclibrary/Sahims_Documents/050613_och1.pdf, accessed on January 2, 2009.
[19] Whiteside A (2007). Reviewing 'Emergencies' for Swaziland: Shifting the Paradigm in a New Era. Durban: HEARD. Available from: http://data.unaids.org/pub/Report/2007/swaziland%20emergency%20report_final%20pdf_en.pdf, accessed on January 2, 2009.
[20] Pavignani E, Colombo A (2006). Analysing Health Sector Financing and Expenditure. Module 6 of Analysing disrupted health sectors – Manual. Geneva: World Health Organization. Available from: http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_06/en/index6.html, accessed on January 2, 2009.
[21] Kazatchkine M (2008). Closing Speech at the XVII International AIDS Conference in Mexico. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria, 2008. Available from: http://www.theglobalfund.org/en/pressreleases/?pr=pr_080811, accessed on January 2, 2009.
[22] United Nations General Assembly (2001). Declaration of Commitment on HIV/AIDS. A/RES/S-26/2. Available from: http://www.un.org/ga/aids/docs/aress262.pdf, accessed on January 2, 2009.
[23] United Nations General Assembly (2006). Political Declaration on HIV/AIDS. A/RES/60/262. Available from: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf, accessed on January 2, 2009.
[24] Van Damme W, Van Lerberghe W, Boelaert M (2002). Primary health care vs. emergency medical assistance, a conceptual framework. Health Policy and Planning, 17(1): 49-60
[25] Garrett L (2007). The Challenge of Global Health. Foreign Affairs, 86(1). Available from: http://www.foreignaffairs.org/20070101faessay86103/laurie-garrett/the-challenge-of-global-health.html, accessed on January 2, 2009.
[26] England R (2007). Are we spending too much on HIV? BMJ, 334(7589): 344.
[27] Jack A (2007). From symptom to system. Financial Times, September 28, 2007. Available from: http://www.ft.com/cms/s/0/2318ea9c-6d60-11dc-ab19-0000779fd2ac.html, accessed on January 2, 2009.
[28] Piller C, Smith D (2007). Unintended victims of Gates Foundation Generosity. LA Times, December 16, 2007. Available from: http://www.latimes.com/news/nationworld/nation/la-na-gates16dec16,0,3743924.story, accessed on January 2, 2009.
[29] Halperin D (2008) Putting a Plague into Perspective. New York Times, January 1, 2008. Available from: http://www.nytimes.com/2008/01/01/opinion/01halperin.html?_r=1&oref=slogin&ref=opinion&pagewanted=print, accessed on January 2, 2009.
[30] Heller P (2005). Fiscal Space: What it is and how to get it. Finance & Development, 42(2). Available from: http://www.imf.org/external/pubs/ft/fandd/2005/06/basics.htm, accessed on January 2, 2009.
[31] Wagstaff A, Claeson M (2004). The Millennium Development Goals for Health: Rising to the Challenges. Washington D.C.: World Bank. Available from: http://www.hlfhealthmdgs.org/documents.asp, accessed on January 2, 2009.
[32] Bulíř A, Hamann J (2003). Aid Volatility: An Empirical Assessment. Washington D.C.: IMF. 2003. Available from: http://www.imf.org/External/Pubs/FT/staffp/2003/01/PDF/Bulir.pdf, accessed on January 2, 2009.
[33] Collier P (1999). Aid 'Dependency': A Critique. Journal of African Economies, 8(4): 528-45.

[34] Celasun O, Walliser J (2005). Predictability of Budget Aid: Experiences in Eight African Countries. Washington D.C.: Center for Global Development. Available from: http://www.cgdev.org/doc/event%20docs/Predictability%20of%20Budget%20Aid%20revised.pdf, accessed on January 2, 2009.

[35] Independent Evaluation Office of the International Monetary Fund (2007). The IMF and aid to Sub-Saharan Africa. Washington D.C.: Independent Evaluation Office of the International Monetary Fund. Available from: http://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf, accessed on January 2, 2009.

[36] Piot P (2003). AIDS: The Need For An Exceptional Response to An Unprecedented Crisis. Presidential Fellows Lecture. Washington D.C.: World Bank. Available from: http://go.worldbank.org/LI94OXMKY0, accessed on January 2, 2009.

[37] International Development Association (2005). Report from the Executive Directors of the International Development Association to the Board of Governors. Additions to IDA Resources: Fourteenth Replenishment. Washington D.C.: World Bank. Available from: http://siteresources.worldbank.org/IDA/Resources/14th_Replenishment_Final.pdf, accessed on January 2, 2009.

[38] Directorate-General for Development Cooperation (2006). DGCD Annual Report 2005. Brussels: Directorate-General for Development Cooperation. Available from: http://www.dgos.be/documents/en/annual_report/2005/dgdc_annual_report_2005.pdf, accessed on January 2, 2009.

[39] Archer R (2003) Duties Sans Frontières: Human rights and Global Social Justice. Versoix: International Council on Human Rights Policy. Available from: http://www.ichrp.org/files/reports/3/108_report_en.pdf, accessed on January 2, 2009.

[40] United Nations Development Programme (2007). Human Development Report 2007/2008. New York: United Nations Development Programme. Available from: http://hdr.undp.org/en/media/hdr_20072008_en_complete.pdf, accessed on January 2, 2009.

[41] Gottret P, Schieber G (2006). Health Financing Revisited: A Practitioner's Guide. Washington: The World Bank. Available from: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf, accessed on January 2, 2009.

[42] Word Bank (2008). Website, Data & Research, Data, Quick query. Available from: http://go.worldbank.org/SI5SSGAVZ0, accessed on January 2, 2009.

[43] Schieber G, Fleisher L, Gottret P (2006). Getting Real on Health Financing. Finance & Development, 43(4). Available from: http://www.imf.org/external/pubs/ft/fandd/2006/12/schieber.htm, accessed on January 2, 2009.

[44] GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries (2007). Website, Home page. Available from: http://www.socialhealthprotection.org/, accessed on January 2, 2009.

[45] Brown G (2008). Joint Statement with Chancellor Angela Merkel on International Health Partnership. Available from: http://www.number10.gov.uk/Page12904, accessed on January 2, 2009.

[46] International Health Partnership Plus Related Initiatives (2008). Website, Home page. Available from: http://www.internationalhealthpartnership.net/, accessed on January 2, 2009.

[47] International Health Partnership Plus Related Initiatives (2008). Scaling up for better health. Available from: http://www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf, accessed on January 2, 2009.

[48] International Labour Office (2008). Can low-income countries afford basic social security? Geneva: International Labour Office. Available from: http://www.ilo.org/public/english/protection/secsoc/downloads/policy/policy3e.pdf, accessed on January 2, 2009.

[49] Van Langendonck J (2007). The Meaning of the Right to Social Security. In: Van Langendonck (editor). The Right to Social Security. Antwerpen/Oxford: Intersentia.

[50] Organization of African Unity (2001). Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Diseases. Available from: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf, accessed on January 2, 2009.

[51] Department for International Development (2008). Achieving Universal Access. The UKs strategy for halting and reversing the spread of HIV in the developing world. London: DfID. Available from: http://www.dfid.gov.uk/pubs/files/achieving-universal-access.pdf, accessed June 26, 2008

[52] France T, Ooms G, Rivers B (2002). The Global Fund: Which Countries Owe How Much? New York: Aidspan. Available from: http://www.aidspan.org/documents/aidspan/gfo15.pdf, accessed on January 2, 2009.

[53] Global Fund to fight AIDS, Tuberculosis and Malaria (2007). Fifteenth Board Meeting. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria. Available from: http://www.theglobalfund.org/documents/board/15/GF-BM15-Decisions_en.pdf, accessed on January 2, 2009.

[54] International Health Partnership Plus Related Initiatives (2008). Scaling up for better health. Available from: http://www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf, accessed on January 2, 2009.

[55] United Nations (1948). Universal Declaration of Human Rights. G.A. Res. 217A (III), UN Doc. A/180. Available from: http://www.un.org/Overview/rights.html, accessed on January 2, 2009.

[56] Gruskin S, Tarantola D (2000). Health and Human Rights. Working Paper, Boston: François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, page 4. Available from: http://www.hsph.harvard.edu/fxbcenter/FXBC_WP10--Gruskin_and_Tarantola.pdf, accessed on January 2, 2009.

[57] United Nations (1966). International Covenant on Civil and Political Rights. G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966). Available from: http://www2.ohchr.org/english/law/pdf/ccpr.pdf, accessed on January 2, 2009.

[58] United Nations (1966). International Covenant on Economic, Social and Cultural Rights. G.A. Res. 2200A (XXI), UN Doc. A/6316 (1966). Available from: http://www2.ohchr.org/english/law/pdf/cescr.pdf, accessed on January 2, 2009. Available from: http://www.unhchr.ch/html/menu3/b/a_cescr.htm, accessed on January 2, 2009.

[59] UN Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14; The Right to the Highest Attainable Standard of Health. UN Doc. E/C.12/2000/4. Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.

[60] Article 2(1) of the ICESCR and Article 24(4) of the CRC recognize that the right to health, as with other economic and social rights, will be achieved progressively and not immediately.

[61] Gruskin S, Tarantola D (2000). Health and Human Rights. Working Paper, Boston: François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, page 4. Available from: http://www.hsph.harvard.edu/fxbcenter/FXBC_WP10--Gruskin_and_Tarantola.pdf, accessed on January 2, 2009.

[62] Leckie S (1998). Another Step Towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights. Human Rights Quarterly*,* 20(1): p. 94.

[63] UN Committee on Economic, Social and Cultural Rights (1990). General Comment No. 3; The Nature of States Parties' Obligations. UN Doc. No. E/C.12/1991/23. Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.En?OpenDocument, accessed on January 2, 2009.

[64] Örücü, E (1986). The Core of Rights and Freedoms: the Limits of Limits, in Campbell, T (editor). Human Rights: From Rhetoric to Reality. New York: Blackwell.

[65] UN Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14; The Right to the Highest Attainable Standard of Health. UN Doc. No. E/C.12/2000/4 (2000). Available from:

http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.

[66] UN Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14; The Right to the Highest Attainable Standard of Health. UN Doc. No. E/C.12/2000/4 (2000). Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.

[67] UN Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14; The Right to the Highest Attainable Standard of Health. UN Doc. No. E/C.12/2000/4 (2000). Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.

[68] Ooms G, Derderian K, Melody D (2006). Do We Need a World Health Insurance to Realise the Right to Health? PLoS Med 2006; 3(12): e530. Available from: http://medicine.plosjournals.org/archive/1549-1676/3/12/pdf/10.1371_journal.pmed.0030530-S.pdf, accessed on January 2, 2009.

[69] Committee on Economic, Social and Cultural Rights (2000). Summary Record of the 10th Meeting. Geneva: Office of the High Commissioner for Human Rights. Available from: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/d8711da53e337f75802568d9003bc930?Opendocument, accessed on January 2, 2009.

[70] World Health Organization (1946). Constitution of the World Health Organization. Geneva: World Health Organization. Available from: http://www.searo.who.int/LinkFiles/About_SEARO_const.pdf, accessed on January 2, 2009.

[71] UN Committee on Economic, Social and Cultural Rights (1990). General Comment No. 3; The Nature of States Parties' Obligations. UN Doc. No. E/C.12/1991/23 (1990). Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.En?OpenDocument, accessed on January 2, 2009.

[72] Roth K (2000) Human Rights and the AIDS Crisis: the Debate over Resources. Canadian HIV/AIDS Policy & Law Review, 5(4): 93-98.

[73] Global Fund to fight AIDS, Tuberculosis and Malaria (2009). Website, Who we are, Core structures. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria. Available from: http://www.theglobalfund.org/en/about/how/, accessed on January 2, 2009.

[74] International Health Partnership Plus Related Initiatives (2008). Scaling Up for Better Health. Geneva: International Health Partnership Plus Related Initiatives. Available from: http://www.internationalhealthpartnership.net/pdf/02_IHP_Workplan_EN_Feb20_2008_FINAL.pdf, accessed on January 2, 2009.

[75] Global Fund to fight AIDS, Tuberculosis and Malaria (2007). Fifteenth Board Meeting. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria. Available from: http://www.theglobalfund.org/documents/board/15/GF-BM15-Decisions_en.pdf, accessed on January 2, 2009.

[76] Ministers of developed and developing countries responsible for promoting development and Heads of multilateral and bilateral development institutions (2005). Paris Declaration on Aid Effectiveness. Paris: Organisation for Economic Co-operation and Development. Available from: http://www.oecd.org/dataoecd/11/41/34428351.pdf, accessed on January 2, 2009.

[77] International Conference on Primary Health Care (1978). Declaration of Alma-Ata. Geneva: World Health Organization. Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, accessed on January 2, 2009.

[78] Maciocco G (2008). From Alma Ata to the Global Fund: The History of International Health Policy. Social Medicine, 3:1, 36-48. Available from: http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/186/380, accessed on January 2, 2009.

[79] Commission on Macroeconomics and Health (2001). Macroeconomics and Health: Investing in Health for Economic Development. Geneva: World Health Organization. Available from: http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf, accessed on January 2, 2009.
[80] World Health Organization (2008). Website, National health accounts. Geneva: World Health Organization. Available from: http://www.who.int/nha/country/nha_ratios_and_percapita_levels_2001-2005.pdf, accessed on January 2, 2009.
[81] World Bank (2008). Website, Data, Country classification. Washington D.C.: World Bank. Available from: http://go.worldbank.org/K2CKM78CC0, accessed on January 2, 2009.
[82] Buse K, Harmer A (2007). Global health: Making partnerships work. London: Overseas Development Institute. Available from: http://www.odi.org.uk/publications/briefing/bp_jan07_global_health.pdf, accessed on January 2, 2009.
[83] International Development Association (2007). IDA's Long-term Financial Capacity. Washington D.C.: World Bank. Available from: http://siteresources.worldbank.org/IDA/Resources/IDAFinancialCapacity.pdf, accessed on January 2, 2009.
[84] De Renzio P, Goldsbrough D (2007). IMF Programs and Health Spending: Case Study of Mozambique. Washington D.C.: Center for Global Development. Available from: http://www.cgdev.org/doc/IMF/Mozambique.pdf, accessed on January 2, 2009.
[85] Heller P (2005). Understanding Fiscal Space. Washington D.C.: International Monetary Fund. Available from: http://www.imf.org/external/pubs/ft/pdp/2005/pdp04.pdf, accessed on January 2, 2009.
[86] Independent Evaluation Office of the International Monetary Fund (2007). The IMF and aid to Sub-Saharan Africa. Washington D.C.: Independent Evaluation Office of the International Monetary Fund. Available from: http://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf, accessed on January 2, 2009.
[87] Organization of African Unity (2001). Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Diseases. Available from: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf, accessed on January 2, 2009.
[88] Committee on Economic, Social and Cultural Rights (2000) General Comment No. 14. The Right to the Highest Attainable Standard of Health. Geneva: Office of the High Commissioner for Human rights. Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.
[89] Committee on Economic, Social and Cultural Rights (2000) General Comment No. 14. The Right to the Highest Attainable Standard of Health, paragraphs 45. Geneva: Office of the High Commissioner for Human rights. Available from: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument, accessed on January 2, 2009.
[90] Roth K (2000). Human Rights and the AIDS Crisis: the Debate over Resources. Canadian HIV/AIDS Policy & Law Review, 5(4): 93-98.
[91] Young G (2002). The Golden Rulemakers. The Guardian, November 11, 2002. Available from: http://www.globalpolicy.org/reform/business/2002/1111cashiraq.htm, accessed on January 2, 2009.