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Global Governance of Health and the Requirements of Human Rights

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Abstract

As globalisation increases interdependence health becomes a subject of global governance, posing new challenges to the present global governance mechanisms. The authors explore two areas in which new mechanisms of global governance of health have emerged in the first decade of the 21st century: firstly, international assistance to finance healthcare and the Global Fund to fight AIDS, tuberculosis and malaria; and secondly, the Social Protection Floor which aims to ensure basic social guarantees for all. They argue that human rights can help to combine and strengthen these mechanisms, serving as a guide for a true partnership between people across borders, rather than merely a set of norms imposed upon states. Through a Framework Convention on Global Health, the Global Fund could become the cornerstone of a global social protection regime and act as an incentive for compliance with the Social Protection Floor.

New global governance mechanisms of health and their limitations

Health is recognised as a human right in several international treaties. International human rights scholars generally accept that the right to health entails duties that primarily rest on the shoulders of states, and are almost exclusively directed towards the inhabitants of each state. In reality, the realisation of the right to health of the inhabitants of any given state also depends on the decisions taken by other states, and, increasingly, on new global governance mechanisms that have been devised to address problems of interdependence.

Here, we will briefly explain two areas of interdependence and the corresponding new global governance mechanisms to which it has given rise:

1. Financial dependence on international assistance for healthcare financing, and the Global Fund to fight AIDS, tuberculosis and malaria (Global Fund);
2. Tax competition or dependence on tax and social standards adopted by other states, and the International Labour Organisation (ILO) – UN Social Protection Floor.

Financial dependence on international assistance

Some countries are simply too poor to self-finance even a basic level of health care; meaning they are unable to provide lifesaving prevention or treatment to their inhabitants for common diseases. According to the World Health Organisation (WHO), universal health coverage – or access to a basic level of health-promoting, health-protecting and health-restoring goods and services – costs at least US$60 per person per year in low income countries.[1] Very poor countries – like Burundi with an average annual Gross Domestic Product (GDP) of US$164[2]– simply cannot afford those expenses. Even if Burundi managed to increase government revenue to 20 per cent of GDP – which is quite ambitious for a low income country – and to spend 15 per cent of government revenue on efforts to improve health – again quite ambitious – it would have only US$5 per person per year available.

International assistance can bridge the gap between needed and available resources. However, international assistance for 'development' – intended to be temporary to develop the recipient state's own capacity – is insufficiently reliable in the long run to finance recurrent expenditure.[3] The underlying logic of development assistance dictates that it should be temporary, offering a hand-up, resulting in two counter-intuitive guiding principles: the poorest countries should not receive the most assistance, as they have the highest risk of becoming too dependent on assistance; and development assistance should be limited to a level that allows gradual

replacing of external assistance with domestic revenue, even if that level is insufficient to address the real needs of the population.

In the mid-1990s the limitations of development assistance became painfully obvious in light of the HIV/AIDS epidemic and the price of antiretroviral medicines: providing lifelong AIDS treatment in low income countries required a massive increase in recurrent health expenditure. The Global Fund, created in 2001, tried to address this problem by reversing the development assistance logic: no longer would future domestic capacity define the level of international assistance; the real needs would define the level, and the duration of the assistance would be adapted accordingly. The Global Fund informed potential applicants that they were 'not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term'.[4] By this it meant that the sustainability of the interventions was not tied to future domestic ability alone, but included sustained international assistance, as long as needed, that would be available through the Global Fund.

This new approach towards sustainability allowed for a dramatic increase in recurrent expenditure; it saved millions of lives that would have been lost under the conventional approach. But it will only work for as long as states are willing to support the Global Fund in this new approach. In November 2011, the board of the Global Fund had to cancel its 11th Round because it did not receive enough funding to be able to finance new proposals.[5]

Tax competition, or the race to the social bottom in slow motion

There are many ways in which global economic integration affects the ability of states to realise the right to health for their inhabitants: prices of medicines are influenced by decisions on intellectual property rights taken by states at the global level and the availability of health workers in any given country is influenced by the demand for health workers in other countries. We focus here on tax competition because it negatively affects the health of ordinary people in wealthier countries and thus it may create common grounds for true international partnership.

Dani Rodrik argues that "[g]overnments today actively compete with each other by pursuing policies they believe will earn them market confidence and attract trade and capital inflows: tight money, small government, low taxes, flexible labor legislation, deregulation, privatization, and openness all around".[6] Governments face pressure to reduce tax levels on mobile production factors, leading to decreasing progressivity of taxation, and a growing share of the tax burden being carried by labour instead of capital.[7] This is true too for developed and developing countries.[8] Although the relationship between competitiveness and tax levels is too complex to be described as a simple race to the bottom, there is an undeniable relationship between attempts to attract capital and highly skilled workers and declining tax revenue, leading to a decreasing ability to finance social protection, including public health expenditure.

The Employment and Social Developments in Europe 2011 report of the European Commission concludes that "the concentration of income – and the wealth and power that go with it – is now reverting to levels not experienced since the beginning of the 20th century".[9] One of the contributing factors is that within the 27 countries of the European Union, the "top average personal income tax rate was reduced from 47.3 per cent in 1995 to 37.1 per cent in 2011",[10] which is but one example of decreasing government revenue and decreasing government ability to finance social policies.

Nonetheless, we are not yet witnessing a race to the social bottom: social policies are resilient and deeply embedded in the social fabric of states that have developed them.[11] What we are witnessing is a kind of race to the social bottom in slow motion, with specific policies becoming less generous without disappearing, or creating a public debt that will eventually force their termination.

In the long run, the only way to avoid a race to the bottom in slow motion is to rely on enhanced cooperation between states.[12] And we do have an emerging mechanism that could mitigate tax competition: the Social Protection Floor (SPF). The idea underpinning this initiative is that all states would commit to agreed minimum levels of social protection tailored for their respective country: "basic income security, in the form of various social transfers (in cash or in kind), such as pensions for the elderly and persons with disabilities, child benefits, income support benefits and/or employment guarantees and services for the unemployed and working poor", and "universal access to essential affordable social services in the areas of health, water and sanitation, education, food security, housing, and others defined according to national priorities".[13] The SPF Advisory Group argues that the cost of introducing a well-designed SPF is affordable for low income countries and is low compared to tax revenue foregone by poor revenue collection and savings from improved efficiencies that come with enhanced social policy coherence.[14]

So far, the SPF is too conceptual, too voluntary and too vague to have a real impact on global tax competition or the race to the social bottom in slow motion. It will not be easy to convince poorer states to accept social standards that require increased taxation and may thus decrease their competitiveness. This will only happen if the people of wealthier states are able to demonstrate to

the people in other parts of the world that the SPF is not about ensuring social protection in wealthier states nor fundamentally about economic competition between *states* but about a partnership across borders to reduce inequalities.

How human rights can help

Can a human rights perspective strengthen the fragile mechanisms discussed above?

If the Global Fund were reshaped using a human rights perspective it would no longer be a global fund focused on three diseases; it would become a Global Fund for Health.[15] In this transition to a broader mandate, it may again attract support from health advocates who currently resent its disease-specific focus. However, it may not be able financially to support health systems offering comprehensive health care and prevention. In theory that should not be a problem: from a human rights perspective, states in a position to assist (wealthier states) would finance the Global Fund as a matter of duty, not charity.[16] In practice, however, the duty may not be easy to enforce[17] and the Global Fund could remain too poor to expand its mandate.

From a human rights perspective the SPF is somewhat redundant. There is nothing foreseen in the SPF that has not been foreseen in international human rights treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR). But this scepticism works in both directions: after almost half a century of existence, ICESCR has not been able to ensure states adopt the social policies required to realise the enshrined rights.

Our contention here is that human rights provide an umbrella that allows for combining these two new global governance health mechanisms in a coherent and effective manner:

- Ordinary people living in wealthier states would be willing to support a Global Fund for Health not (only) because of the legal obligation to do so, but because the reliable funds from a Global Fund for Health would be an incentive for people in poorer states to push their leaders to adopt the SPF. A Global Fund for Health could be the first step towards a Global Social Protection Fund that could become the cornerstone of a global social protection regime.
- Ordinary people in all states of the world would want their governments to comply with the SPF, because that is the only way to avoid a race to the social bottom in slow motion. It may result in slower but more equitable economic growth. For states and their people that are at present desperately trying to fuel economic growth because they cannot afford the most essential levels of social protection, the Global Fund for Health would be there to assist them.

Incremental steps

Like Bob Deacon, we believe that ''steps towards a formal system of global redistribution that might eventually involve a Global Tax Authority and a Global Social Affairs Ministry will build upon firstly existing ad hoc mechanisms and secondly proposals for such mechanisms that are already within the global policy debate'', and that ''[a]mong existing mechanisms for international redistribution are the ones used by the Global fund to Fight AIDS, TB and malaria''.[18]

A first step would be for the Global Fund to become a Global Fund for Health. In a recent paper, Mark Dybul, Peter Piot, and Julio Frenk highlight the absence of a 'mechanism to finance integrated national health strategies', and argue that ''[o]ptions include creating something new, or transforming current institutions to meet the demands of the 21st century''.[19] Considering that Dybul is the former US Global AIDS Coordinator, and that Piot is the former executive director of UNAIDS, this call for a non-disease-specific global fund carries considerable political weight, and is consistent with our ideas.[20]

While Dybul, Piot, and Frenk call for a 'Bretton Woods like meeting' to create this mechanism, such a mechanism, together with an agreement on minimum levels of social protection, will also require political pressure from the ordinary people of richer and poorer states, rather than just another meeting of heads of states pursuing an agenda with limited input from diverse global stakeholders. To these ends we support the Joint Action and Learning Initiative on National and Global Responsibilities for Health, which proposes a campaign for a Framework Convention on Global Health.[21] Both initiatives are compatible, however, and both are rooted in human rights, serving as a guide for true partnership between people across borders, rather than merely a set of norms imposed upon states.

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Recommended reading

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