Leigh Haynes, JD, MPH, is a member of the global steering council of the PHM.

David Legge, MD, is Scholar Emeritus in the School of Public Health at La Trobe University in Melbourne, Australia. He is one of two co-chairs of the PHM.

Leslie London, MD, MB ChB, is a Professor of Public Health in the School of Public Health and Family Medicine at the University of Cape Town, South Africa, is head of its Health and Human Rights program, and is a member of the PHM South Africa.

David McCoy, is a medical doctor and an academic based at the Centre for Primary Care and Public Health at Queen Mary University London. He is active in the PHM.

David Sanders, is Emeritus Professor and founding Director of the School of Public Health at the University of the Western Cape, South Africa, is a past chairperson of the PHM South Africa, and is a member of the global steering council of the PHM.

Claudio Schuftan, MD, is a member of the global steering council of the PHM.

Please address correspondence to the authors c/o Leigh Haynes, email: leigh.kamore@gmail.com.

Competing interests: None declared.

Will the struggle for health equity and social justice be best served by a Framework Convention on Global Health?

Leigh Haynes, David Legge, Leslie London, David McCoy, David Sanders, Claudio Schuftan

Abstract

The idea of a Framework Convention for Global Health (FCGH), using the treaty-making powers of the World Health Organization (WHO), has been promoted as an opportunity to advance global health equity and the right to health. The idea has promise, but needs more thought regarding risks, obstacles, and strategies. The reform of global health governance must be based on a robust analysis of the political economy out of which the drivers of inequality and the denial of the right to health arise. Some of the published commentary has focused on using the proposed FCGH to institutionalize a paradigm change regarding international aid for health care, i.e., reconceptualizing such aid as obligatory, based on human solidarity rather than strategic considerations, based on global stability and national security. We warn against limiting the project to questions of inter-governmental financial transfers because of the risk of neglecting the underlying structural determinants of health injustice. Such neglect would help to legitimize an unjust and unsustainable global economic regime. We raise further questions about the strategic logic informing any campaign for a FCGH. The governments of the United States and Europe have put considerable effort into weakening WHO through tight donor controls, and it would require heavy pressure to persuade them to sign on to a FCGH. Generating such pressure would require strong popular mobilization around the local and diverse priorities of different communities across the globe, and recognition of a common need for effective regulation at the global level. We argue for a broad-based campaign from which the need for more effective global health regulation (and a FCGH) would emerge as a common theme arising from myriad more specific claims. This type of campaign would respond to local needs, and would also be understood within a global, political, and economic perspective.

Introduction

There is a clear need to reform the rules, structures, and power relations of global governance to address the urgent global health challenges we face. This has been well documented, not least in the report of the Commission on Social Determinants of Health.[1] Globalization (in particular, increasing global economic integration and the growth in power of unaccountable transnational corporations) is contributing to a rolling global crisis, manifest in climate change, financial instability, unemployment, food insecurity, and widening inequalities in health.[2] It is also eroding democracy and national sovereignty. Economic integration, on terms favorable to rich countries and their corporations, is being driven through preferential trade and investment agreements. Gleeson has pointed out how the US agenda for the proposed Trans Pacific Partnership Agreement threatens access to medicines through tighter intellectual property protection and higher prices, and also threat-

ens to obstruct regulation for public health through investor state dispute settlement.[3] Tighter intellectual property protection and investor state dispute settlement are both designed to maximize the profits and security of US corporations and to maximize export earnings and profit repatriation to the US. There is extensive literature on the risks to health of such agreements.[4] Reforming the existing global governance structures is a necessary part of any response to the global health crisis.

In this context, the treaty-making powers of the World Health Organization (WHO) are potentially of great significance.[5] Until now, WHO has used its powers to form an internationally binding treaty to promote health on only two occasions: the Framework Convention on Tobacco Control and the International Health Regulations.[6] Recently, however, there have been calls for WHO to develop a Framework Convention on Global Health (FCGH).[7] Such a convention could form the basis for binding rules and obligations that could advance equity and global health.

Currently, the most prominent supporters of an FCGH consist of academics and health activists participating in the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI).[8] A manifesto, which sets out the rationale and context for an FCGH, asserts that such a convention could "give true force to international law and extend its reach into the communities where we live, to create the conditions for health and wellbeing for everyone." It further states that an FCGH could "transform people's health and wellbeing by empowering people everywhere to claim their rights." The manifesto goes on to note that an FCGH could "create a framework for more effective global health structures and processes, ones that place the needs and demands of communities above powerful economic and political interests."[9]

The People's Health Movement (PHM) supports these aspirations, shares the view that the WHO should be empowered to act on its mandate to promote global health, and recognizes that this should include legally binding global rules and obligations. However, certain aspects of the current campaign in support of an FCGH require critical discussion.

Some proposals for an FCGH conflate the need for a regulatory framework for global health with a much more specific proposal for mandating intergovernmental financial transfers to support health improvement in poor countries.[10] There may be merit in reconceptualizing development assistance from being a discretionary act of 'charity' (often used to support donor interests) to being an obligation, reflecting global human solidarity rather than as a strategy for global stability and national security. However, limiting an FCGH to this objective risks neglecting disparities in wealth and power and the social, political and economic dynamics which underlie the widespread denial of the right to health. Ultimately, failing to address these dynamics runs the risk of legitimizing the prevailing political and economic regime.

Any prospect for WHO to adopt a truly progressive and transformative FCGH has limited plausibility at the present time, given WHO's current lack of vigor and the chokehold that some donors exercise over the organization's agenda. The political dynamics (and considerable social mobilization) required to yield a worthy FCGH need closer consideration.

Large scale social mobilization around a relatively abstract concept—an FCGH—may be limited if a campaign to promote an FCGH fails to assure civil society actors that such a framework would ultimately help to address the particular, diverse, and urgent priorities that local activists are facing. The prospects for such assurance are not necessarily good. However, there are many areas of global health that need binding, global regulations that an FCGH could potentially help develop. A campaign for an FCGH that includes the need for regulatory strategies around the issues that communities are facing could help build the momentum needed to achieve an effective FCGH.

Addressing the social, political, and economic determinants of global health

The proponents of an FCGH are a heterogeneous group with different visions concerning both process and outcomes. Some proponents emphasize the regulatory potential of an FCGH and are exploring

the different fields of global health where effective and binding regulations are needed.

Other proponents center on the creation of an obligatory (and conditional) system of financial transfers from rich to poor countries whereby rich countries would allocate 0.1% of their gross national income to development assistance for health care, while poor countries would commit to spending in excess of 15% of their national budget on health.[11] These are seen as working suggestions aimed at establishing the principle of mandatory conditional financial transfers between countries. It is argued that such an arrangement would help to bring health care expenditure in the least developed countries to a minimal standard of $60 per head per year (on the order of 1% of per capita health care expenditure in the US).

While higher and more reliable allocations of funding for health care would be welcome, the focus on health care financing involves a relatively limited view. It fails to challenge the prevailing political and economic order, which prevents economic development for many countries, and drives the transfer of value from the South to the North.[12]

Increases in official development assistance disconnected from any challenge to the prevailing economic dispensation will function to legitimize that dispensation. The dramatic increase in official development assistance from 2000 onwards was in large part a response to the threat to the legitimacy of the global economic order arising from civil society campaigns around global debt (for example, Jubilee 2000) and against the Trade-Related Aspects of International Property Rights (TRIPS) Agreement (in particular, the Treatment Access Campaign).[13] In 2001, the WHO Commission on Macroeconomics and Health commented that globalization was "on trial as never before."[14] Even the Ministerial Council of the World Trade Organization in 2001 saw the need to issue a reassurance to the effect that "the TRIPS Agreement does not and should not prevent members from taking measures to protect public health."[15]

We do not argue that an FCGH should provide a solution for all the problems associated with the global political economy (tax avoidance, transfer pricing, banks which are too big to fail, and other problems). Rather, we argue that such a convention should be developed and campaigned for in a way that contributes to highlighting and rectifying underlying structural problems, and should not sustain or legitimize these dynamics by allowing them to be ignored. An exclusive focus on mandatory conditional financial transfers would suggest that aid is an appropriate and, perhaps, sufficient solution to the health problems arising from an inequitable and unstable global economy.

Indeed, it would be better if international aid for health care was recognized as an obligation arising from global solidarity rather than as an instrument for achieving global stability and national security. However, failing to challenge the underlying power relations between the givers and the receivers, and failing to consider who decides how such transfers are governed and managed, will not serve the broader purpose of building solidarity around health for all.

The practicability of a campaign toward an FCGH

The idea of an FCGH is a bold and potentially powerful one. However, there is a sharp contradiction between the proposition that the WHO might adopt an FCGH and the significant influence some donors exert over the WHO. Around 80% of WHO's budget is conditional and extra-budgetary, leaving donors with huge influence to determine the organization's activities.[16] Assessed contributions have been deliberately frozen, partly in order to prevent WHO from acting on various excellent resolutions adopted by the Assembly including the Trade and Health Resolution of 2006 and other resolutions on the rational use of medicines.[17] Under these circumstances, the adoption of an effective FCGH is not likely.

If there was sufficient pressure for adopting a convention, it would be convenient for the great powers to fall back on one focused solely on aid flows for health care financing (leaving the US and Europe free to pursue trade agreements which drive much larger resource flows from the South to the North). The failure to arrive at an effective Framework Convention on Climate Change is salutary in this regard. In the desperation to achieve a modicum of progress in UN negotiations, the Framework Convention on Climate Change was so watered down to suit the interests of powerful countries and their corporations that hardly anything was left of the original policy intentions. A similar outcome for an FCGH could be predicted

unless it is driven by a strong global social movement around the right to health.

Social mobilization around a Framework Convention on Global Health

Some proponents of an FCGH see it as an opportunity to facilitate, build, and organize advocacy for the right to health within civil society, and a strong rights-based campaign rooted in social movements could certainly influence the outcome of negotiations around an FCGH.[18] However, the experience of the PHM is that campaign initiatives that are structured around relatively abstract and distant reforms, such as an FCGH, have limited inspirational power in terms of movement-building, even if cast in terms of the right to health.

Campaign initiatives that inspire community activists are focused on the priorities of their communities, promise a direct response to those problems, and offer real access to the levers of change. If such campaigns are also to redress the injustices embedded in the global structures, they must be guided by a strong analysis that articulates the links between local problems and global structures.

PHM's recent Cape Town Call to Action, developed through continuing consultations during the Third People's Health Assembly, calls upon people around the world to "[build] social and political power amongst people and communities" to "[create] and [communicate] alternative visions, analyses, discourses and evidence."[19] The Call to Action highlights the need for global campaigning and also recognizes that PHM circles will determine their level of engagement on the basis of local priorities and local capacity: acting locally while thinking globally.

PHM envisions a global movement under the right to health umbrella, based on many different streams of action coming together as local or more narrowly focused movements come to understand their shared global context and are inspired by the power of global solidarity. Such a global movement under the right to health would be part of an even larger group of movements bringing together concerns about employment, environment, indigenous rights, gender equity, and many other streams. We are not persuaded that a campaign focused solely on the need for an FCGH would be able to mobilize this kind of global movement.

Human rights are born out of struggles for social justice.[20] They arise when people come together to say, "This is wrong!" The envelope of human rights entitlements has been gradually enlarged because of popular pressure to ensure that the most marginalized can redress the conditions of their vulnerability, and to press the state to accept and recognize obligations to those who do not have economic or political power.[21] While the institutions of law have codified such rights, and popular struggles have made use of such laws through successful campaigns for progressive legislation and winning important victories through litigation, such legal strategies require ongoing social movement pressure to be effective.[22]

The rights discourse is powerful in community mobilization because it affirms that the situation the community confronts is wrong. The rights discourse loses its inspirational and rhetorical power when it is distanced from the wrongs that people are actually facing. A campaign structured mainly around a legislative strategy operating at the global level may have legal logic, but it will need considerable practical, inspirational, and rhetorical power to build and sustain a mass social movement.

Campaigning around regulatory strategies for global health

Any campaign for an FCGH needs to ensure that a preoccupation with institutional reform at the global level does not obscure the conditions for progressive popular mobilization. Some proponents of an FCGH argue that even if the overt goal is not achieved, the journey— affirming the right to health—would yield valuable gains. However, this is not necessarily so. If the campaign is structured around slogans that fail to inspire enthusiasm, or if the proposals for an FCGH represent an inadequate challenge to current power relations, very little will be achieved.

Movement building around an FCGH would be best served by locating the need for effective regulation for global health in relation to all of the other campaigns under the right to health umbrella. This would enable different stakeholder groups to see the logic of global health regulation in relation to their own struggles and the common need for an effective instrument for such regulation.

For example, there is a powerful social movement around breastfeeding and a widespread recognition that the voluntary Code of Marketing of Breast-Milk Substitutes has failed to effectively regulate the marketing practices of infant food manufacturers. Accordingly, a campaign for a binding protocol (under an FCGH) on the marketing of breast milk substitutes would attract a great deal of interest. Likewise, there is widespread disillusion regarding the Political Declaration on Non-Communicable Diseases (NCDs) and the US insisting that policy initiatives aimed at controlling the marketing of junk food to children be limited to voluntary commitments from transnational food corporations.[23] Across the NCDs constituency, there would be considerable interest in a binding protocol (under an FCGH) aimed at limiting children's access to junk food. Binding regulation is also needed in control of antimicrobial resistance, quality use of medicines, and public funding for research and development in Type II and III diseases.

If the purpose of an FCGH is to put in place a framework within which more specific protocols or agreements can be negotiated, it would make sense to explore the immediate priorities for regulation of global health. This would firmly locate the initiative in the context of globalization and contribute to building a broad constituency to demand a framework convention that would achieve this purpose.

Conclusion

The discussion of a proposed FCGH has directed renewed attention to the treaty-making powers of WHO and the need for stronger regulation for global health. This is to be welcomed, and PHM is committed to continuing this discussion.

A focus on mandatory, but conditional, financial transfers for health care funding would be too narrow for an FCGH. Likewise, we warn against any illusions regarding the immediate likelihood that the great powers will allow WHO to adopt an effective FCGH, particularly one with potential for enacting effective regulation on transnational corporations. A strong global social movement is needed to drive the adoption of such a convention. Building such a movement needs to happen from the bottom up, connecting the local to the global in our diverse but shared struggles for social justice and the right to health.

References

1. K. Lee, D. Sridhar, and M. Patel, "Bridging the divide: Global governance of trade and health," *Lancet* 373/9661 (2009), pp. 416-422; N.Y. Ng and J.P. Ruger, "Global health governance at a crossroads," *Global Health Governance* 3/2 (2011), pp. 1-37; J. A. Camilleri and J. Falk, *Worlds in transition: Evolving governance across a stressed planet* (Cheltenham UK/ Northampton, MA: Edward Elgar Publishing, 2009); K. Buse, W. Hein, and N. Drager (eds), *Making sense of global health governance: A policy perspective* (Basingstoke, UK: Palgrave Macmillan, 2009); D. V. McQueen, M. Wismar, V. Lin et al. (eds), "Intersectoral governance for health in all policies: Structures, actions and experiences." *Observatory Studies Series* 26 (Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies, 2012); Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health* (Geneva: WHO, 2008).

2. R. Labonté, C. Blouin, M. Chopra, et al., *Towards health-equitable globalisation: Rights, regulation and redistribution* (Ottawa: WHO Commission on Social Determinants of Health, Globalization Knowledge Network, 2007).

3. D.H. Gleeson, K.S. Tienhaara, and T.A. Faunce, "Challenges to Australia's national health policy from trade and investment agreements," *Medical Journal of Australia* 196 (2012), pp. 1-3.

4. Lee et al. (see note 1); J.E. Stiglitz, "Trade agreements and health in developing countries," *Lancet* 373/9661 (2009), pp. 363-365; C. Andrew, L. Bouchard, R. Labonté, and V. Runnels (eds), *Trade, growth and population health: An introductory review. Transdisciplinary Studies in Population Health Series* 2/1 (Ottawa: Institute of Population Health, 2010).

5. International Health Conference, Constitution of the World Health Organization (1946). Available at http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf.

6. WHO, Framework Convention on Tobacco Control (2003). Available at http://whqlibdoc.who.int/publications/2003/9241591013.pdf; WHO, *International Health Regulations*, 2nd edition (Geneva: WHO, 2005).

7. L.O. Gostin, "A framework convention on global health: Health for all, justice for all," *Journal of the*

American Medical Association 307/19 (2012), pp. 2087-2092.
8. Joint Action and Learning Initiative on National and Global Responsibilities for Health, Who We Are. Available at http://www.jalihealth.org/about/who-we-are.html.
9. Joint Action and Learning Initiative on National and Global Responsibilities for Health, "Health for all: justice for all, a global campaign for a Framework Convention on Global Health." Available at http://www.jalihealth.org/documents/Manifesto5-11-12.pdf.
10. Gostin (see note 15).
11. Ibid., p. 2089.
12. Labonté et al. (see note 7); People's Health Movement, Medact, Health Action International, et al., *Global health watch 3: An alternative world health report* (London/New York: Zed Books, 2011). pp. 9-42; Ibid.,. pp. 61-82; M. Koivusalo, T. Schrecker, and R. Labonté, "Globalisation and policy space for health and social determinants of health," in R. Labonté, T. Schrecker, C. Packer, and V. Runnels (eds), *Globalization and health: Pathways, evidence, and policy* (New York/UK).
13. R. Naiman, "IMF takes $1 billion in two years from Africa as official report reveals five new reasons to drop the debt," (April 13, 1999). Available at http://archives.econ.utah.edu/archives/pen-l/1999m04/msg00561.html; M. Heywood, "South Africa's treatment action campaign: Combining law and social mobilization to realize the right to health," *Journal of Human Rights Practice* 1/1 (2009), pp. 14-36.
14. WHO Commission on Macroeconomics and Health, *Macroeconomics and health: Investing in health for economic development* (Geneva: WHO, 2001), p. 15.
15. Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/2 (November 14, 2001). Available at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.pdf.
16. D.G. Legge, "Future of WHO hangs in the balance," *British Medical Journal* 345 (2012), p. e6877.
17. Ibid. International Trade and Health: Report by the Secretariat, UN Doc. No. A59/15 (April 24, 2006). Available at http://apps.who.int/iris/bitstream/10665/21100/1/A59_15-en.pdf; WHO, *The pursuit of responsible use of medicines: Sharing and learning from country experiences* (Geneva: WHO, 2012). Available at http://apps.who.int/iris/bitstream/10665/75828/1/WHO_EMP_MAR_2012.3_eng.pdf.
18. E. Friedman and L.O. Gostin, "Pillars for progress on the right to health: Harnessing the potential of human rights through a framework convention on global health," *Health and Human Rights: An International Journal* 14/1 (2012), pp.1-16.
19. Cape Town Call to Action, Third People's Health Assembly, Cape Town, July 6-11, 2012.
20. See, for example, A. Hughes, J. Wheeler, and R. Eyben, "Rights and power: The challenge for international development agencies," *IDS Bulletin* 36.1 (2005), pp. 63-72; C. A. Odinkalu, "Why more Africans don't use human rights language," *Carnegie Council on Ethics and International Affairs Human Rights Dialogue* 2/1 (1999), pp. 3-4. Available at http://www.carnegiecouncil.org/publications/archive/dialogue/2_01/articles/602.html; F. L. S. Valente, "From the campaign against hunger to the human right to food and nutrition in Brazil: Civil society mobilization and changing governing mechanisms," in United Nations Development Program, *Human development and human rights: Report of the Oslo symposium* (Norway: October 2–3, 1998), pp.179-185.
21. L. London, "'Issues of equity are also issues of rights:' Lessons from experiences in Southern Africa," *BMC Public Health* 7/14 (2007).
22. L. London, "What is a human-rights based approach to health and does it matter?" *Health and Human Rights: An International Journal* 10/1 (2008), pp. 65-80. Available at http://www.hhrjournal.org/index.php/hhr/article/view/25/108; R. Labonté and T. Schrecker, "Globalization and social determinants of health: Introduction and methodological background (part 1 of 3)," *Globalization and Health* 3/5 (2007); Heywood (see note 25); A. Kapczynski, "The access to knowledge mobilization and the new politics of intellectual property," *Yale Law Journal* 117 (2008), pp. 804-885.
23. Prevention and Control of Non-Communicable Diseases: Report of the Secretary-General, UN Doc. No. A/66/83 (2011). Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/66/83&Lang=E; D. Cohen, "Will industry influence derail UN summit?" *British Medical Journal* 343 (2011), p. d5328; D. Stuckler, S. Basu, and M. McKee, "UN high level meeting on non-communicable diseases: An opportunity for whom?" *British Medical Journal* 343 (2011), p. d5336.