Correcting Globalisation in Health: Transnational Entitlements versus the Ethical Imperative of Reducing Aid-Dependency

Gorik Ooms* and Rachel Hammonds
Institute of Tropical Medicine, Antwerp

*Corresponding author: Gorik Ooms, Department of Public Health, Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerp, Belgium. Tel.: +32-3-247.66.66, Fax: +32-3-216.14.31, E-mail: gooms@itg.be

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

There is growing tension between arguments for increasing foreign assistance to achieve the Millennium Development Goals and arguments for reducing foreign assistance so as to avoid a new form of colonisation. This essay argues that the impact of the global economy on access to healthcare in developing countries requires global corrective measures. It acknowledges the risk of foreign assistance being used for illegitimate purposes, but argues that if foreign assistance were provided within a human rights framework of rights-holders and duty-bearers, this risk can be mitigated. It analyses the current development aid paradigm, and how the fight against AIDS has begun to change it. It also examines why access to essential healthcare is a human right creating national and transnational entitlements and argues that foreign assistance responding to these entitlements is not a matter of discretionary spending; it is a matter of meeting legal obligations. It explores the legal implications of the core content of the right to health and its relationship with the obligation to provide assistance. It concludes with a review of two different but complementary proposals to create a global approach to the realisation of the right to health: the Global Health Fund and the Health Impact Fund Initiative.

The Ethical Imperative of Reducing Aid-Dependency?

'Needless to say, that apart from fanning corruption, aid plays to the advantage of the giver—the richer nations of the world which keep the poor mineral-rich countries dependent and in many ways, economically colonized' commented Moses Sserwanga (2007) of *The Monitor* (Kampala, Uganda) calling for the November 2007 Commonwealth Heads of Government Meeting to endorse and pursue fair trade, not aid as the route to human development.

Sserwanga is not alone in this view. Captured by the slogan 'Trade, Not Aid', the ethical imperative of reducing aid-dependency is increasingly supported by well-intended voices from the so-called 'global South' as well as from the 'global North' (Jenkins, 2002; Vidal, 2002; Preble and Tupy, 2005). Development aid is perceived as undesirable, at best as a necessary evil that should be consigned to the history books as soon as possible.

We also support efforts to make international trade 'fairer'. However, we do not understand why both claims are linked and treated as mutually exclusive: why 'trade, not aid' instead of 'trade, and aid'? Is there anything intrinsically wrong with global, transnational solidarity, loosely defined as the ethical responsibilities of all human beings towards one another? Does all aid deserve to be termed 'economic colonisation'?

The ethical imperative of reducing aid-dependency is not benign. In the absence of an alternative domestic source of financing, reducing the aid-dependency of developing countries' health sectors simply means reducing health expenditure, which decreases access to healthcare for most of the population and in particular for poor and vulnerable groups. It leads to extremely difficult ethical choices for health practitioners in developing countries, such as withholding lifesaving treatment from some people because the same amount of money can 'buy' more human lives if spent on cheaper treatments for other

doi: 10.1093/phe/phn018
Advance Access publication on 30 May 2008
© The Author 2008. Published by Oxford University Press. Available online at www.phe.oxfordjournals.org

diseases (and other people). Of course, those choices exist in developed countries as well, but in countries with an annual government health budget of less than US$15 per person, they take a far crueller form than in developed countries where governments' annual health budgets exceed US$2000 per person.

Those who oppose aid-dependence will argue that they do not want people to be denied access to healthcare or life-saving treatment and consequently die. In fact, their arguments probably do not address the issue of African AIDS patients becoming dependent on open-ended assistance to finance their treatment. They concern themselves with African states becoming dependent on foreign assistance. As such, they limit the scope of 'fairness' in transnational interactions to economic transactions only: once economic fairness has been established, the well-being and the dignity of individual people is a purely national or domestic matter. Solidarity between people is thus confined to the borders of the state.

We do not share this view. Firstly, we believe that the ethical responsibility of human beings towards one another transcends national borders. Furthermore, as economic globalisation has an impact on the well-being and the dignity of all people, corrective measures must be taken at a global level as well. But we acknowledge that foreign assistance can take the form of economic colonisation, whereby, for example, donor countries obtain favourable conditions for exporting mineral resources from a recipient country in return for much needed assistance in fighting deadly epidemics. While we do not endorse the ethical imperative of reducing aid-dependency as such, we do endorse the ethical imperative of avoiding a new form of colonisation.

We acknowledge the tension between the ethical imperative of avoiding new forms of colonisation and promoting the well-being of all human beings, wherever they live. We can overcome this tension by understanding foreign assistance as a transnational legal obligation and providing it as such, not as condition-laden charity. The risks of economic colonisation can be mitigated by rooting foreign assistance in the ethical imperative of transnational solidarity and administering it within a human rights framework with ensuing transnational duties and entitlements, creating rights-holders and duty-bearers, rather than the dominant aid framework of discretionary giving.

The evolution from condition-laden discretionary giving to a new aid paradigm based on duties and entitlements is already taking place, but it requires both further theoretical deepening and the development of tools for practical implementation.

In this essay, we will:

- Examine how globalisation affects health in developing countries, and why the impact of the global economy on access to healthcare in those countries requires global corrective measures;
- Explore the health development paradigm and its failures, and how the fight against AIDS has started changing it;
- Examine the right to health as an international right; the core content of the right to health and its relationship with the obligation to provide assistance;
- Analyse two different but complementary proposals to create a global approach to the realisation of the right to health: the Global Health Fund and the Health Impact Fund Initiative.

The Impact of Globalisation on Health in Developing Countries

We have heard that the world is becoming a global village so many times that it is becoming a meaningless truism. Yet for the Mozambican woman picking cashew nuts from the few trees she owns, globalisation is a reality. She used to pick, roast and peel the nuts. Now she does not roast and peel any more because World Bank economists have convinced her government that her comparative advantage is not to roast and peel nuts.

As the BBC (Loyn, 2003) reported: 'The new winds of economic reform were designed to enable Mozambique to enter the world economy, winning debt forgiveness and new international funding. But the result instead was that 10,000 people who were directly employed by the [cashew] industry lost their jobs, another million nut collectors lost an income, and Mozambique remains resolutely close to the bottom in league tables of world poverty.'

One million Mozambican nut collectors lost an income (McMillan *et al.*, 2002; De Renzio and Hanlon, 2007). But that is not the only way in which globalisation affected their lives. Most of them have children and, like all children, they get sick and need treatment.

About 40 per cent of Mozambican households do not seek treatment when a family member gets ill because either the nearest health centre is too far away, or they cannot afford the user fees (Chao and Kostermans, 2002). Those who seek treatment might find a health centre without appropriately trained staff. According to estimates by the Joint Learning Initiative, and endorsed by the World Health Organization (WHO), 'countries with fewer than 2.5 health care professionals (counting only doctors, nurses and midwives) per 1000 population failed

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

to achieve an 80 per cent coverage rate for deliveries by skilled birth attendants or for measles immunization' (World Health Organization, 2006). Mozambique, with its population of about 20 million people, would need 50,000 health professionals. In 2004, it had 514 doctors; 3974 nurses and 2236 midwives: a shortage of more than 86 per cent, or more than 43,000 health professionals (WHO, 2007a). Here, globalisation plays a role as well. There is a free and open global market for trained health workers: a Mozambican nurse will compare the salary offered by the Health Ministry with the salary offered by the South African or British public health systems. Fortunately, for Mozambicans seeking healthcare, the damage from this aspect of globalisation remains limited. Most Mozambican health workers speak their native language and Portuguese, not English. But this is probably a temporary protection, as English conquers the world as the lingua franca, future generations of Mozambican health workers will be attracted by the pull factors of globalisation.

Now imagine the former nut collector, out of a job, fortunate enough to live close to a health centre, fortunate enough to live close to a health centre with a trained health worker and fortunate enough to be able to pay the fee. Chances are that she will not receive the appropriate medicines for her children. This might well be a consequence of globalisation too. Until recently, Mozambique did not offer patent protection for medicines. The Mozambican Health Ministry purchased most medicines from India, where patent protection for medicines did not yet exist either and manufacturers produced cheap generic versions of new and effective medicines.

Nowadays, the heralds of a global unrestricted market want medicines available in India and Mozambique to be available in Europe and North America as well. At the same time, they want the extraordinary profits generated by new medicines—which depend on patent protection and the legal monopolies they create; the opposite of an unrestricted market—to be protected; they do not want generic medicines manufactured in India to be sold on European and North American markets. Rather than strengthening barriers between rich and poor markets, they have tried to ban generics from the poor markets. And, to a large extent, they have succeeded. To become or to maintain membership in the World Trade Organization (WTO), countries like India and Mozambique were required to adopt patent protection for medicines.

As globalisation rendered many poor Mozambicans poorer, and health workers and medicines more expensive, one might expect the heralds of globalisation to promote corrective or protective global solutions to Mozambique's health crises. The opposite is true. When it comes to healthcare—and other social services—the heralds of globalisation suddenly plead national self-reliance or the importance of local solutions. Global interdependence is good when it comes to trade, but when it comes to healthcare it is undesirable aid-dependency.

The Current Aid Paradigm, and how the Fight against AIDS has Started Changing it

In a global market, the provision of social services requires a global approach as well. Yet, to take one example, at present the International Monetary Fund (IMF) is unwilling or unable to imagine open-ended global financing mechanisms for social services. The IMF believes its role is to 'prepare countries for an orderly exit from long-term reliance on aid' (International Monetary Fund, 2007a: 7).

The consequences of aiming for 'an orderly exit from long-term reliance on aid'—national self-reliance or reducing aid-dependency—are quite dramatic. Primarily, it creates a type of mental brake on increasing foreign assistance for social services: if the ultimate aim is national self-reliance, too much aid could hinder or delay the achievement of this goal. Some will argue that the real reason for insufficient foreign assistance is selfishness on behalf of wealthier countries, and that the aim of national self-reliance is at best a weak excuse for reduced aid. But this seems to be contradicted by the fact that billions of dollars of presently available foreign assistance are not used to improve health or educational services but are instead used to increase developing countries' dollar reserves.

According to Terry McKinley of the United Nations Development Program (UNDP), 'significant proportions of [Official Development Assistance] have been diverted into reserves, aborting the transfer of real resources into developing countries' (McKinley, 2005: 8). In sub-Saharan Africa alone, the total amount of dollar reserves increased from US$32 billion in 2000 to US$58 billion in 2004.

Although McKinley blames this phenomenon on the fear of aid-induced 'Dutch disease', the IMF has gradually replaced 'Dutch disease' warnings as with the concept of 'fiscal space' or 'fiscal sustainability' as the new rationale for recipient countries to stockpile and not use foreign assistance. What is fiscal space or fiscal sustainability? According to Pablo Gottret and George Schieber of the World Bank it is 'a country's capacity to accommodate expenditures financed with aid within the domestic budget constraint in a reasonable period of time' (Gottret and Schieber, 2006: 139).

What happens when donors are willing to fund expenditures that are higher than what the 'domestic budget

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

constraint in a reasonable period of time' allows? Rather than refusing the 'excess' foreign assistance, governments might be tempted—and are encouraged by the IMF—to accept this assistance, but to divert it to dollar reserves and not spend it improving health or education services.

Thus it appears that the aim of sustainability at the national level is the main obstacle to a substantial increase in foreign assistance for healthcare: it inhibits donor countries' willingness to increase foreign assistance, and even if they did, chances are the additional assistance would not be spent. However, if we view foreign assistance for healthcare in the same way as we view social security transfers within a country then we would not have to concern ourselves with calculating when and if developing countries will develop the capacity to finance basic healthcare without foreign assistance. Instead we would accept that many developing countries need to rely, to varying degrees, on continued financial assistance for several decades. At the very least this change in mindset may allow for the full use of the foreign assistance that is currently available, rather than diverting substantial parts to dollar reserves.

We believe that the fight against AIDS has already created a new aid paradigm. The low-income countries highly affected by AIDS are unable to finance AIDS treatment themselves. Recognising this the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund, 2007: Section 4.5.5) has abandoned the conventional approach to sustainability: 'Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term' (Global Fund, 2007: Section 4.5.5).

Furthermore, AIDS activists from wealthy countries are pushing their governments to finance the Global Fund in accordance with an 'equitable contributions framework', based on the relative size of their economies (France *et al.*, 2002). This effort has had some success, and has turned the Global Fund into an embryonic global social security mechanism (with a limited mandate): high-income countries contribute in accordance with their wealth; low-income countries obtain entitlements in accordance with their needs.

Finally, grants from the Global Fund come without political strings attached. Proposals are reviewed by the Global Fund's Technical Review Panel, composed of independent experts, and are approved for funding by the Board of the Global Fund, composed of representatives of donor and recipient countries, United Nations agencies and civil society.

Mead Over, former Lead Health Economist of the World Bank's Development Research Group and currently a Senior Fellow at the Center for Global Development, attributes the 'single-minded focus on AIDS treatment and prevention' to the success of AIDS activists in transforming foreign assistance from charity (or 'discretionary spending') into entitlement spending. 'By effectively converting foreign assistance from discretionary to entitlement spending, the "success" of existing AIDS treatment programs has already locked us into a new aid paradigm. To the extent that the international community heeds the UNAIDS' call, entitlement spending will greatly increase in the next few years, both in absolute terms and, unless total assistance expands at the same phenomenal rate, as a percentage of total assistance' (Over, 2007). We agree with Over on this point: AIDS activists have helped usher in a new aid paradigm by transforming what was perceived as charitable, discretionary spending into entitlement spending.

In the next sections of this essay, we will argue that this new aid paradigm is firmly rooted in the right to health and in the national and transnational entitlements it creates. As such it is a way in which high-income countries can move towards complying with their international obligations with regard to the right to health in the developing world. It should not remain the exception applicable only to the fight against AIDS, tuberculosis and malaria: it should become the standard for global health aid and for other global aid to realise essential social rights whenever the aim of sustainability at national level is unrealistic.

The Right to Health

Ethics and values lie at the heart of the formal framework of international human rights law. The relationship between ethics and human rights is complex and has already been richly explored by many others (Archer, 2003). In this essay, we only aim to explore the extent to which the formal framework of international human rights law provides a foundation for an alternative aid paradigm, in which foreign assistance becomes a duty, responding to an entitlement, thus avoiding foreign assistance being used as a new form of colonisation.

The 1948 Universal Declaration of Human Rights (United Nations, 1948) (UDHR) is the foundation of the modern human rights movement, and although not a legally binding document in itself, later multilateral international human rights treaties elaborating the content of the UDHR do give rise to legally binding obligations on governments. The two key treaties arising from the UDHR, the International Covenant on Civil and Political Rights (United Nations, 1966a) (ICPR) and the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966b) (ICESCR) contain legally binding obligations for the states that ratify them.

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

The artificial split and elaboration in two different covenants has led some commentators to claim that one set of rights should be prioritised. One critique of social rights like the right to health stems from the fact that they require state action to be implemented. The perception that civil and political rights can be secured without state action or funding and simply require that the state not abuse its power is clearly erroneous, and is not a persuasive argument for favouring one set of rights over the other. The legitimacy of claiming a right to health has also been questioned by commentators who challenge the justiciability of all economic, social and cultural rights, claiming they are 'merely' programmatic rights (Vierdag, 1978). This justiciability critique is rebutted by numerous commentators (Arambulo, 1999). The political and academic debates surrounding the two different sets of rights continue despite the fact that human rights experts and the international community have affirmed that human rights are indivisible and cannot be fulfilled in isolation from one another.[1]

Article 12 of the ICESCR defines the right to health as 'the right to the highest attainable standard of physical and mental health' and corresponding state obligations encompass the provision of medical services and the underlying preconditions necessary to health. This bare bones definition has been affirmed and expanded on in later international conventions (United Nations, 1979, 1989) and other national and international legislation. The nature of states' obligations in achieving economic, social and cultural rights, including the right to health, has been specified more precisely by the United Nations Committee on Economic, Social and Cultural Rights (the Committee), as will be discussed below.

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 (Örücü, 1986). The concept of 'core content' was endorsed by the Committee in General Comment No. 3 (Committee on Economic, Social and Cultural Rights, 1990). It clarified that there are limits to the compromises that states can make with regard 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.

Toebes' work defining the core content of the right to health classified the elements that contribute to the health status of persons dividing them into two sub-groups: elements of healthcare and the underlying preconditions for health (Toebes, 1999). One year later, the Committee's General Comment No. 14 on the right to health affirmed the existence of a minimum essential level of the right to health (Committee on Economic, Social and Cultural Rights, 2000a).

Like Toebes, the Committee 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 marginalised groups (Committee on Economic, Social and Cultural Rights, 2000a: para. 43).

The Committee 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 (Committee on Economic, Social and Cultural Rights, 2000a).

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 54 low-income countries, as classified by the World Bank, public health expenditure was less than US$10 per person per year in 2004 (Ooms *et al.*, 2006). The inadequacy of this level of spending is glaring when compared with the Commission on Macroeconomics and Health's (CMH) estimate of US$38 per person per year in 2015, needed for an adequate package of healthcare interventions including AIDS treatment (Commission on Macroeconomics and Health, 2001).

In light of this shortfall, at a May 2000 Committee 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 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.' (Committee on Economic, Social and Cultural Rights, 2000b:

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

para 27) Later, in reporting on his Mozambique mission Hunt re-emphasised this point stressing that financial and technical assistance is an international responsibility under the ICESCR and the International Convention on the Rights of the Child. (Hunt, 2006).

However, as Skogly argues, the legal force of obligations of international cooperation in human rights instruments has not been settled. It is debated 'whether there is an obligation to provide international assistance (as in official development assistance) by rich countries, and on the other hand, whether there is a right to receive international assistance on part of the poorer countries.' (Skogly, 2006).

We argue that the principle of international cooperation is becoming part of customary international law as evidenced in 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.' (World Health Organization, 1946). Article 2(1) of the ICESCR creates an obligation on States parties to provide international assistance and cooperation to the maximum of their available resources (United Nations, 1966b). Further, in General Comment No. 3, the Committee clarified that the ICESCR's drafters 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 (Committee on Economic, Social and Cultural Rights, 1990).

In debating the nature of international obligations, Philip Alston argues that repeated inclusion of these commitments in international institutions will demonstrate their status as customary law. 'It will be difficult for countries to insist that they have persistently objected to such an evolution if they continue to affirm in so many contexts their commitment to assisting developing country governments to achieve targets as tangible and clearly achievable as the MDGs. The correlative obligation would, of course, be confined to situations in which a developing country had demonstrated its best efforts to meet the Goals and its inability to do so because of lack of financial resources '(Alston, 2005: 778).

In our opinion, even more important than the 'reiteration of such commitments' is the fact that some countries cannot realise the core content of the right to health, having demonstrated their 'best efforts' and their 'inability to do so because of lack of financial resources'. 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 fulfill their obligations.

The Right to Health and Access to Essential Medicines

In recent years attempts by civil society activists to improve access to essential medicines for disadvantaged and vulnerable groups, in particular the world's poor, have further energised the debate surrounding the right to health. The issue of access to essential medicines is an excellent example of how local and international factors interact and essentially shape local market access. It is an unfortunate example of how failure to respect the core obligation to provide essential medicines, on the part of both developing nations and those in a position to assist, costs the lives of millions of the world's disadvantaged and vulnerable people.

The 2005 Montreal Statement on the Human Right to Essential Medicines (the Montreal Statement) (Pogge, 2005), adopted by a group of experts, academics and international organisations, reiterated that access to essential medicines has a key role to play in realising the right to health. It is pertinent here because it addresses the effect that lending, trade and aid policy, and the international organisations involved in these fields, have on access to essential medicines in the developing world and consequently the right to health.

Articles 9 and 10 of the Montreal Statement are explicit about the direct link between policies advanced by the developed world, through bilateral and multilateral action (e.g. through the IMF and World Bank), and the impact on health in the developing world. Article 11 calls on states to place the right to health above trade concerns and notes 'that States are entitled and obliged to take all reasonable and feasible steps to enable access to essential medicines, including adopting trade practices and using trade flexibilities and safeguards, such as compulsory licensing and parallel importing.' Article 13 calls on international institutions and their members to comply with their duty to respect and actively promote the right to health by ensuring that international agreements

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

relating to the protection of intellectual property are in conformity with human rights obligations.

The Political Declaration by Governments, adopted at the June 2006 United Nations General Assembly High Level Meeting on AIDS (marking the fifth anniversary of the adoption of the Declaration of Commitment on HIV/AIDS by the United Nations General Assembly (United Nations, 2001)) echoed Article 11 of the Montreal Statement. It included the proclamation 'that access to medication is one of the fundamental elements to achieve the right to health, and the WTO TRIPS Agreement does not and should not prevent States from taking measures now and in the future to protect public health.' (United Nations, 2006).

Transforming a Collective Obligation into Individual Transnational Entitlements: The Global Health Fund

We have argued that an alternative global health aid paradigm, based on legal entitlements and duties, can overcome the tension between the ethical imperatives of avoiding a new form of colonisation and of promoting the well-being and the dignity of all human beings. However, when trying to move from theory to practice, we are confronted with a complex scheme of rights-holders and duty-bearers. We have argued above that developing countries have a right to assistance to achieve the core content of a right when they can prove that they have made their 'best effort' but cannot achieve the core content of a right due to financial constraints. But who must assist whom? There are many countries in need of assistance and many countries in a position to assist. The correlative duties need to be distributed among states in some way.

Perhaps an international court of social justice, where low-income states could make high-income states comply with their duties, would solve the problem. Such a court could apply principles of equity and fairness to establish individual states' entitlements and duties. However, no such court exists. This is a problem, but not an insurmountable one. For example, AIDS activists pressured the international community to create the Global Fund, which—when viewed through a human rights lens—is nothing other than a tool for compliance with the transnational obligation to fulfill an essential part of the core content of the right to health. The existence of the Global Fund exerted pressure on governments of states in need of assistance to develop AIDS treatment plans and on governments of states in a position to assist to provide the needed assistance. It created individual states' entitlements, and to some extent—the 'equitable contributions framework' already mentioned—individual states' duties.

But it is difficult to achieve progress in the fight against a single disease (or even three diseases) without addressing the fragility of public health systems in developing countries. To address this fundamental problem the world needs a Global Fund to fight poor health, including AIDS treatment but not excluding other essential healthcare, or a Global Health Fund to realise the core content of the right to health. What would be required to transform the Global Fund into a Global Health Fund, firmly rooted in a human rights approach, or a 'Framework Convention on Global Health' (Gostin, 2008)?

First of all, a Global Health Fund would have to acknowledge that the primary responsibility for realising the right to health remains with the state. It would have to establish a benchmark for the domestic contribution to healthcare that can be expected from developing countries. That would in fact require a double benchmark:

- One benchmark to estimate the amount of domestic resources a developing country can reasonably mobilise for government expenditure;
- A second benchmark to estimate the share of its domestic resources a developing country can reasonably allocate to healthcare.

We examine these benchmarks below, but before looking at the details and the figures, we want to emphasise that we are looking for a method, not for precise estimates. The figures need only be sufficiently realistic to demonstrate the feasibility of a Global Health Fund, as a method to transpose collective entitlements and duties into individual states' entitlements and duties, and not to provide precise estimates.

In order to make a realistic proposal for the first benchmark, we examined present levels of government revenue excluding grants in low-income countries of Sub-Saharan Africa, as estimated by the IMF in its Regional Economic Outlook report for Sub-Saharan Africa of October 2007 (International Monetary Fund, 2007b: 51). These countries managed to increase government revenue excluding grants from 15.6 per cent of GDP in 2003 to 17.8 per cent of GDP in 2008. This is an increase of 0.44 per cent of GDP per year. At this rate, by 2015, government revenue excluding grants could be 20 per cent of GDP.

For the second benchmark, we propose using the pledge made by African Heads of State and Government in the 2001 Abuja Declaration (Organisation of African

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

Unity, 2001) according to which 15 per cent of the budget should be allocated to health.

The combination of these two benchmarks leads to a general benchmark: low-income countries should mobilise and allocate to healthcare the equivalent of 3 per cent of their GDP before they can say they have made all reasonable efforts to realise the core content of the right to health.

How well are low-income countries performing against this combined benchmark? When we calculate present (figures for 2004) government expenditure on health, the median result is 1.9 per cent of GDP. The weighted average, however, is only 1.1 per cent GDP. India, whose economy accounts for more than half of the combined GDP of low-income countries and whose government expenditure on health is only 0.9 per cent of GDP, brings the average down. Without India, the weighted average would be 1.5 per cent of GDP. But even if we exclude India, low-income countries would have to double their government health expenditure, on average, before they can claim foreign assistance.

Even if this increase in expenditure would double or triple domestic resources for health, it would not be sufficient to realise the core content of the right to health. When we look at IMF estimates about real GDP per capita for the same countries, and assume that 3 per cent of GDP is how much governments of these countries can spend on health without foreign assistance, none of them can spend even half of the US$38 per person per year target recommended by the CMH. In as much as we can consider this US$38 per person per year target an indicator of what these countries need to spend to realise the core content of the right to health, we can consider the difference between US$38 and 3 per cent of real GDP per capita as these countries' entitlement from a Global Health Fund, per inhabitant. These 52 countries together (excluding Somalia and the Democratic Republic of Korea, for which no reliable figures are available) would have an entitlement of about US$51 billion to a Global Health Fund: *not* a collective entitlement, but the sum of 52 *individual* states' entitlements. India alone would have an entitlement of US$21 billion; the other 51 countries would together have an entitlement of US$30 billion.

From where would a Global Health Fund obtain its funding? Again, following human rights logic, 'states in a position to assist' have a duty to assist the countries mentioned in Table 1. But which states are 'states in a position to assist'? At the very least, the 30 member states of the Organisation for Economic Co-operation and Development (OECD) have, by joining the OECD admitted that they are states in a position to assist. How much assistance should they provide? On this question, the Committee provides some guidance. In its concluding observations, the Committee regularly commends states for their level of foreign assistance if it exceeds the equivalent of 0.7 per cent of their GDP, and encourages states to allocate a bigger part of their budget to foreign assistance if the state in question does not attain the level of 0.7 per cent of GDP. For example, Denmark was commended for achieving the target, and on the same day Italy was encouraged to improve its performance (Committee on Economic, Social and Cultural Rights, 2004a,b). The 0.7 per cent of GDP target was first affirmed in a 1970 UN General Assembly Resolution (United Nations, 1970: para. 43). It has since been regularly reaffirmed in international documents and increasing the number of countries committed to reaching this target is central to achieving the UN Millennium Development Goals (UN Millennium Project website). The 0.7 per cent of GDP target was first affirmed in a 1970 UN General Assembly Resolution (United Nations, 1970: para. 43). It has since been regularly reaffirmed in international documents; increasing the number of countries committed to reaching this target is central to achieving the UN Millennium Development Goals (UN Millennium Project website).

We can therefore assume that states in a position to assist have an obligation to allocate the equivalent of 0.7 per cent of their GDP to foreign assistance. However, health is not the only human right for which they have an obligation to provide assistance. What share of foreign assistance would be available for global health aid? We assumed that if states in need of assistance should allocate 15 per cent of their domestic resources, states in a position to assist should also allocate 15 per cent of foreign assistance to health. That would mean 15 per cent of 0.7 per cent of GDP, or 0.1 per cent of GDP. This approach allows us to calculate individual states' duties to a Global Health Fund. As the combined GDP of OECD member states was about US$30,000 billion in 2004, the sum of their duties would be about US$30 billion.

How are 'states in a position to assist' performing against this benchmark? In 2004, global health aid stood at US$12 billion, while it should have been at least US$30 billion, if OECD member states had allocated 0.1 per cent of their GDP to global health aid. It appears that when measured according to the above criteria 'states in a position to assist' are performing as badly as 'states in need of assistance'. As with 'states in need of assistance' those 'states in a position to assist' would almost have to triple their domestic resource allocation to health. If low-income countries increased their government health expenditure to 3 per cent of GDP, and if OECD members increased their foreign assistance for health to 0.1 per cent would there be enough financial resources to realise the

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

Table 1. Government health expenditure in low-income countries

A Low-income countries	B Total health expenditure, percentage of GDP (World Health Organization, 2004)	C Government health expenditure, percentage of total health expenditure (World Health Organization, 2007b, estimates for 2004)	D Government health expenditure, percentage of GDP (calculation by authors)	E GDP, billion US$ (International Monetary Fund, 2004)	F Government health expenditure, million US$ (calculation by authors)	G GDP per capita (International Monetary Fund, 2004)	H Government health expenditure, per capita, if it were 3% of GDP, in US$ (calculation by authors)	I Foreign assistance needed to achieve government health expenditure of US$38 per capita per year; millions US$ (calculation by authors)
Somalia	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
São Tomé and Principe	11.5	86.2	9.9	0.1	7.1	706.8	21.2	1.7
Malawi	12.9	74.7	9.6	2.6	253.0	208.2	6.2	400.3
Timor-Leste	11.2	78.9	8.8	0.3	30.0	353.8	10.6	26.2
Solomon Islands	5.9	94.5	5.6	0.3	14.8	566.4	17.0	9.8
Rwanda	7.5	56.8	4.3	1.8	78.2	213.6	6.4	271.4
Mongolia	6.0	66.6	4.0	1.8	72.6	716.8	21.5	41.8
Liberia	5.6	63.9	3.6	0.5	16.5	137.4	4.1	113.5
Zimbabwe	7.5	46.1	3.5	4.7	162.5	400.7	12.0	304.8
Zambia	6.3	54.7	3.4	5.4	187.5	480.4	14.4	267.1
Kyrgyz Republic	5.6	59.8	3.3	2.2	74.2	435.2	13.1	127.0
Burkina Faso	6.1	54.8	3.3	5.1	171.0	399.4	12.0	333.2
Mali	6.6	49.2	3.2	4.9	160.5	405.3	12.2	315.2
Papua New Guinea	3.6	84.3	3.0	3.9	119.2	695.5	20.9	96.8
Korea, Dem. Rep.	3.5	85.6	3.0	n/a	n/a	n/a	n/a	n/a
Bhutan	4.6	64.2	3.0	0.7	20.9	944.3	28.3	7.3
Haiti	7.6	38.5	2.9	3.5	103.3	431.6	12.9	204.9
Ghana	6.7	42.2	2.8	8.9	250.8	435.6	13.1	507.8
Mozambique	4.0	68.4	2.7	5.9	161.5	308.7	9.3	549.8
Ethiopia	5.3	51.5	2.7	9.5	258.9	133.5	4.0	2,414.9
Benin	4.9	51.2	2.5	4.1	101.7	564.3	16.9	151.4
Uganda	7.6	32.7	2.5	6.8	169.4	245.1	7.4	852.6

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

Senegal	5.9	40.3	2.4	8.0	190.8	704.8	21.1	191.9
Uzbekistan	5.1	46.6	2.4	12.0	285.2	464.0	13.9	622.8
Niger	4.2	52.5	2.2	2.9	64.0	238.2	7.1	375.9
Mauritania	2.9	69.4	2.0	1.5	30.1	542.0	16.3	60.0
Sierra Leone	3.3	59.0	1.9	1.1	20.9	202.0	6.1	169.7
Yemen, Rep.	5.0	38.3	1.9	13.9	265.7	682.4	20.5	356.3
Gambia	6.8	27.1	1.8	0.3	5.0	184.0	5.5	47.8
Madagascar	3.0	59.1	1.8	4.4	77.3	240.4	7.2	558.3
Eritrea	4.5	39.2	1.8	0.6	11.2	140.4	4.2	152.8
Kenya	4.1	42.7	1.8	16.2	284.5	495.3	14.9	759.3
Tanzania	4.0	43.6	1.7	11.3	197.8	309.0	9.3	1,054.5
Cambodia	6.7	25.8	1.7	5.3	92.3	393.9	11.8	354.8
Comoros	2.8	56.9	1.6	0.4	5.8	604.7	18.1	11.9
Chad	4.2	36.9	1.5	4.4	68.5	501.5	15.0	202.4
Central African Republic	4.1	36.8	1.5	1.3	19.8	325.4	9.8	113.6
Vietnam	5.5	27.1	1.5	45.5	678.9	555.2	16.7	1,750.8
Nepal	5.6	26.3	1.5	6.8	99.5	292.1	8.8	676.4
Sudan	4.1	35.4	1.5	21.7	314.7	629.0	18.9	659.5
Nigeria	4.6	30.4	1.4	71.5	1,000.3	501.4	15.0	3,274.9
Guinea-Bissau	4.8	27.3	1.3	0.3	3.5	175.5	5.3	50.4

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

Table 1. (Continued)

A Low-income countries	B Total health expenditure, percentage of GDP (World Health Organization, 2004)	C Government health expenditure, percentage of total health expenditure (World Health Organization, 2007b, estimates for 2004)	D Government health expenditure, percentage of GDP (calculation by authors)	E GDP, billion US$ (International Monetary Fund, 2004)	F Government health expenditure, million US$ (calculation by authors)	G GDP per capita (International Monetary Fund, 2004)	H Government health expenditure, per capita, if it were 3% of GDP, in US$ (calculation by authors)	I Foreign assistance needed to achieve government health expenditure of US$38 per capita per year; millions US$ (calculation by authors)
Togo	5.5	20.7	1.1	1.9	22.1	323.9	9.7	169.4
Congo, Dem. Rep.	4.0	28.1	1.1	6.5	73.5	117.1	3.5	1,926.1
Tajikistan	4.4	21.6	1.0	2.1	19.7	328.8	9.9	177.4
Côte d'Ivoire	3.8	23.8	0.9	15.5	140.2	867.4	26.0	214.1
Bangladesh	3.1	28.1	0.9	59.1	515.0	392.8	11.8	3,946.4
India	5.0	17.3	0.9	666.3	5,763.5	617.5	18.5	21,012.8
Burundi	3.2	26.2	0.8	0.7	5.6	90.5	2.7	258.9
Lao PDR	3.9	20.5	0.8	2.5	20.1	433.0	13.0	144.9
Afghanistan	4.4	16.9	0.7	6.0	44.4	541.5	16.2	239.9
Guinea	5.3	13.2	0.7	3.9	27.6	437.9	13.1	223.6
Pakistan	2.2	19.6	0.4	98.1	423.0	655.5	19.7	2,743.9
Myanmar	2.2	12.9	0.3	10.8	30.6	198.6	6.0	1,739.9
Total				1,176.0	13,214.3			51,238.7
Total excluding India				509.7	7,450.8			30,225.9

n/a, not available.

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

core content of right to health on a global scale. At first sight, there would not. A Global Health Fund would need US$51 billion, and OECD member states would have to contribute 'only' US$30 billion. However, between 2004 (the year on which these estimates are based) and 2015 (the year in which the US$38 health expenditure level should be achieved), economies will continue to grow. 'States in need of assistance' will need less than US$51 billion, and 'states in a position to assist' will have to contribute more than US$30 billion.

We can debate at length the appropriateness of all the percentages used. We can debate the definitions of states in need of assistance and states in a position to assist. We can debate the US$38 per person per year target. Furthermore, as the details of a Global Health Fund would take years to be agreed upon, and more years to be implemented, economies will grow (both the economies of states in a position to assist and states in need of assistance), populations will grow, and new diseases might appear or new medicines might be invented. These would all be factors that would change the parameters of a Global Health Fund. We simply want to offer a method that allows for transforming collective duties and entitlements into individual states' duties and entitlements.

Transforming a Collective Obligation into Individual Transnational Entitlements: The Health Impact Fund (HIF) Initiative

As explained above, developing countries had somewhat easier access to new medicines because many of them did not grant patent protection to new medicines. As soon as a new medicine reached the market, pharmaceutical companies in India and elsewhere could start reverse engineering and produce generic copies. Countries like Mozambique were then able to buy the cheaper generic version rather than the expensive original.

This situation was far from satisfactory. Private pharmaceutical companies do not have a legal obligation to fulfil the right to health (they do have an obligation to respect the right to health). However, public institutions funding research and development (R&D) based in states in a position to assist do have a transnational obligation to fulfil the right to health. A Médecins Sans Frontières (MSF) report argues that the pressure to pursue the commercialisation of research findings is increasing in the developed world (Médecins Sans Frontières, 2001: 20). The same report notes that basic research leading to the discovery of potential drug leads generally occurs at publicly funded universities, in-house government facilities or research institute in North America, Europe and Japan. At the very least, they should allocate a part of their research and development budgets to diseases that are common in the developing world, even if uncommon in their own countries. But they do not.

Of the 1393 new drugs approved between 1975 and 1999, only 13 were specifically indicated for tropical diseases and, of these 13, five were by-products of veterinary research and two had been commissioned by the military (Médecins Sans Frontières, 2001; Trouiller *et al.*, 2002). An additional three drugs were indicated for tuberculosis. The next five years brought 163 new drugs of which five were for tropical diseases and none for tuberculosis, which together account for 12 per cent of the total disease burden (Chirac and Torreele, 2006).

To make matters worse, globalisation forced developing countries to adopt stringent intellectual property protection measures in their national legislation, as a condition for attaining or retaining WTO membership. Although this was clearly not in their interest or to their advantage, losing the benefits of WTO membership might have been worse. Furthermore, Joseph Stiglitz describes it as follows: 'As the [Trade Related Aspects of Intellectual Property Rights (TRIPS)] agreement was being negotiated in Geneva in 1993, the Council of Economic Advisers and the Office of Science and Technology Policy in the White House tried to make American negotiators understand our deep reservations. What the United States was asking was, we thought, not in the interests of the advancement of science, and was certainly not in the interest of developing countries. But American and European negotiators adopted the positions of the drug and entertainment industries, and others who simply wanted the strongest intellectual property rights' (Stiglitz, 2006: 116).

Nonetheless, the TRIPS Agreement came into force, allowing little or no real leeway for developing countries. If a new medicine is brought to the market today—and if it is a real innovation—it can be protected by a patent in all countries that have the capacity to produce generic copies for at least 20 years. Developing countries are thus at the mercy of pharmaceutical companies, which may or may not offer them an affordable price.

From a human rights and entitlements point of view, if the new medicine treats a common disease effectively—for example it cures tuberculosis after a week's treatment—patients needing this medicine could legitimately claim it as part of the core content of their right to health. If they live in a state in need of assistance, their government could 'pass the buck' to states in a position to assist. Rather than aiming for a US$38

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

per person per year expenditure level, the Global Health Fund might then have to aim for US$45, for example, and the annual bill for states in a position to assist would increase accordingly.

Unfortunately, the Global Health Fund does not exist, and even if it existed, it is unlikely that it would automatically increase its grants simple because a new medicine has been developed. A simple reality check shows that the Global Fund continued to fund the highly ineffective chloroquine treatment for several years despite the existence of a more effective treatment—artemisinin-based combination therapy or ACT, which was not even patent-protected. In answering critics of this policy the Global Fund claimed that it continued to fund chloroquine treatment if a country specifically requested it arguing that it was a funding mechanism that relied on the WHO for technical support. Critics claimed that the Global Fund was doing a poor job of peer-reviewing proposals and that the WHO was failing to provide the appropriate technical leadership (Yamey, 2003).

Therefore, even a Global Health Fund as ambitious as that proposed above is unlikely to be a sufficient solution allowing us to realise the core content of the right to health. A different and complementary solution will have to be found to finance the research and development of new medicines, especially medicines relevant to developing countries.

Sharing the costs of existing medicines is an intervention at the end of the cycle of the development of medicines. Increasing the health sector budgets of developing countries, even quadrupling them, would create a new market for medicines, but it would remain a small market. North America, Europe and Japan accounted for 80 per cent of the world pharmaceutical market in 2002 (with a total projected world value of $406 billion), while Africa, Asia, Latin America and the Middle East, representing 80 per cent of the world's population, accounted for only 20 per cent of the pharmaceutical market (Médecins Sans Frontières, 2001).

From a human rights perspective, we are looking for a mechanism that values all human lives as equal. One Disability-Adjusted Life Year (DALY) saved in Mozambique should be honoured with the same reward as one DALY saved in India, the European Union or the USA. The burden of paying for those rewards should be shared among states in accordance with their capacity to share it, or their relative wealth. Even if we can make the case that states in a position to assist share a collective obligation to foster the development of new medicines needed by people living in developing countries, and that individuals living in developing countries have an entitlement allowing them to claim global investments in the development of medicines they need, we are again confronted with the dilemma of collective obligations. It is easier to say that states in a position to assist share a collective obligation to invest in new medicines most needed by all human beings, than to translate this into measurable obligations for each state.

No matter how utopian this may sound, a solution that addresses both of the abovementioned dilemmas—valuing all human lives as equally important, and sharing the burden in accordance with relative wealth—has already been 'invented'. As the HIF Initiative will be presented elsewhere in this issue of Public Health Ethics, we will limit ourselves to quoting this brief description: 'We propose a complement to the current patent system, a Health Impact Fund, that rewards innovators in proportion to the global health impact of their interventions via treaty-backed payments. To access this payment stream, holders would allow the open manufacture, distribution and sale of their products. With this option in place, diseases that do great harm mainly among the poor become profitable targets of R&D. By choosing this option for a specific medicine, innovators make it immediately available for competitive manufacture, which reduces its price to near marginal cost of production. Patients benefit further from additional incentives a registered innovator has to collaborate with generic producers and to help upgrade health services in poor areas.' (Incentives for Global Health, 2007).

Under article 31 of the TRIPS Agreement, states can allow the use of patent-protected innovation without the permission of the patent-owner 'if, prior to such use, the proposed user has made efforts to obtain authorization from the right holder on reasonable commercial terms and conditions and that such efforts have not been successful within a reasonable period of time' (World Trade Organization, 1994: 333). This is such an ambiguous statement that the patent-owner can easily argue that the proposed conditions are unreasonable. But article 31 also foresees an exceptional remedy: 'This requirement may be waived by a Member in the case of a national emergency or other circumstances of extreme urgency or in cases of public noncommercial use'. This is the essence of compulsory licenses: in case of 'national emergency', governments can allow a pharmaceutical manufacturer to make a generic equivalent of the much needed but unaffordable medicine.

But how to decide if a situation is a national emergency? A lot of situations will be clear-cut: either the medicine is not essential (the medicine does not treat or cure a common disease, or there are other medicines available), or the medicine is essential (the medicine does treat or cure a common disease, and there are no other

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

medicines available). But there is an overlap—situations in which there is an obvious public health need, but perhaps not important enough to call it a national emergency—which could also be considered as a gap. In some situations, neither the customary solution (patent protection), nor the exceptional remedy (compulsory license) is appropriate: patent protections leads to unaffordable prices, while the systematic use of compulsory licenses would become a strong counter-incentive for pharmaceutical companies to invest in the research and development of medicines that might be of use in developing countries, and therefore likely to be hit by a series of compulsory licenses.

Here, the HIF would fill a gap. Pharmaceutical companies investing in the research and development of medicines that might be of use in developing countries would have an alternative for the 'double or nothing' gamble that applying for a patent would mean: double if the patent stands, nothing if it is overruled by a series of compulsory licenses. The HIF option would provide them with a reasonably rewarding alternative: not 'double', not 'nothing'.

The existence of an alternative might also facilitate the use of compulsory licenses. At present, a patent-owner hit by a compulsory license is generally perceived as a victim: a rightful owner of intellectual property who has been robbed. But if the patent-owner had the alternative of obtaining a reasonable reward through the HIF, and decided not to use it, then the exceptional remedy of a compulsory license would seem more equitable.

Thus the HIF would provide a solution to the dilemma of essential but patent-protected medicines. As they are essential medicines, states have an obligation to provide them, and if states in need of assistance cannot afford them, then states in a position to assist have an obligation to provide assistance. As they are patent-protected, the patent-owner can charge exorbitant prices, knowing that states have a legal obligation to purchase these medicines. But if patent-owners had a reasonable alternative, and chose not to use it, the solution is simple: any essential medicine not registering with the HIF could immediately be hit with a worldwide series of compulsory licenses.

Furthermore, even if the treaty (or treaties) backing the HIF would be based on voluntary contributions, it is highly probable that the size of the contributions would be in accordance with the relative wealth of participating states. All countries would benefit from this proposal—as some new medicines registered with the HIF would also benefit patients in high-income countries—but the countries with the greatest needs would benefit most. As such, the HIF would also create a form of a global social security mechanism and fit within the alternative global health aid paradigm, creating transnational entitlements, rather than aiming for reduced aid-dependency.

Finally, the benefits of the HIF would also come without political strings attached. Developing countries would be able to purchase the new medicines, at a much lower price than if they were patent-protected, without having to return favours to donor countries.

Conclusion

Does all aid deserve to be termed 'economic colonisation'? We do not think so. If foreign assistance is based on charity only, with no obligation for donor countries other than to satisfy the moral obligations of their constituencies, it may come with strings that primarily serve the donor countries' own interests. Then foreign assistance might well be deserving of this characterisation. However, if foreign assistance is based on transnational entitlements rooted in international human rights, and perceived and considered as such by both states in a position to assist and states in need of assistance, it is not economic colonisation. It is merely a correction to economic globalisation and in that sense is needed to transform economic globalisation from colonisation to interdependency.

The proposals explained in this essay illustrate the feasibility of a new global health aid paradigm; they might not be the best solutions but at least they promote some much-needed thinking 'outside of the box'. Although some development experts might regret it, the new global health aid paradigm is already a reality. And it needs to be further developed.

Notes

1. The indivisibility of all human rights means that an analysis based on a single right is artificial and limited. We acknowledge the limitations of our approach, as it is clear that aggregate improvements in funding will do little to improve the health status of individuals subject to racial or gender discrimination or social exclusion. The merit of our approach is that the focus on a single right helps to simplify the case for a new aid paradigm.

Acknowledgements

The authors wish to thank Paul Hunt and Thomas Pogge for their useful suggestions on improving their arguments.

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

References

Alston, P. (2005). Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals. *Human Rights Quarterly*, **27**, 755–829.

Arambulo, K. (1999). *Strengthening the Supervision of the International Covenant on Economic, Social and Cultural Rights*. Antwerpen/Groningen/Oxford: Intersentia/Hart.

Archer, R. (2003). *Duties sans Frontières: Human Rights and Global Social Justice*. Versoix: International Council on Human Rights Policy.

Chao, S. and Kostermans, K. (2002). Improving Health for the Poor in Mozambique: The Fight Continues. World Bank, *HPN Discussion Paper*. Available: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627–10956981-40167/Chao-ImprovingHealth-whole.pdf [accessed December 31, 2007].

Chirac, P. and Torreele, E. (2006). Global Framework on Essential Health R&D. *Lancet*, **367**, 1560–1561.

Commission on Macroeconomics and Health. (2001). *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO. Available: http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf [accessed December 31, 2007].

Committee on Economic, Social and Cultural Rights. (1990). *General Comment No. 3. The Nature of States Parties Obligations*. Geneva: Office of the High Commissioner for Human rights. Available: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR±General±comment±3.En?OpenDocument [accessed December 31, 2007].

Committee on Economic, Social and Cultural Rights. (2000a). *General Comment No. 14. The Right to the Highest Attainable Standard of Health*. Geneva: Office of the High Commissioner for Human rights. Available: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument [accessed December 31, 2007].

Committee on Economic, Social and Cultural Rights. (2000b). *Summary Record of the 10th Meeting*. Geneva: Office of the High Commissioner for Human Rights. Available: http://www.unhchr.ch/tbs/doc. nsf/(Symbol)/d8711da53e337f75802568d90-03bc930?Opendocument [accessed December 31, 2007].

Committee on Economic, Social and Cultural Rights. (2004a). *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Denmark*. Geneva: Committee on Economic, Social and Cultural Rights. Available: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.102.En?Opendocument [accessed December 31, 2007].

Committee on Economic, Social and Cultural Rights. (2004b). *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Italy*. Geneva: Committee on Economic, Social and Cultural Rights. Available: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.103.En?Opendocument [accessed December 31, 2007].

De Renzio, P. and Hanlon, J. (2007). Contested Sovereignty in Mozambique: The Dilemmas of Aid Dependence. Oxford University, Department of Politics and International Relations, *Global Economic Governance Programme Working Paper*. Available: http://www.globaleconomicgovernance.org/docs/Derenzio%20and%20Hanlon_Mozambique%20paper%20rev%20120107.pdf [accessed December 31, 2007].

France, T., Ooms, G. and Rivers, B. (2002). The GFATM: Which Countries Owe, and How Much? *IAPAC Monthly*, **8**, 138–141. Available: http://www.hawaii.edu/hivandaids/IAPAC%%202002.pdf [accessed December 31, 2007].

Global Fund to Fight AIDS, Tuberculosis and Malaria. (2007). *Proposal Form–Round 7*. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria. Available: http://www.theglobalfund.org/en/files//R7_Proposal_Form_en.doc [accessed December 31, 2007].

Gostin, L. (2008). Global Health: Meeting Basic Survival Needs of the World's Least Healthy People: Towards a Framework Convention on Global Health. *Georgetown Law Journal*, **96**, 331–392.

Gottret, P. and Schieber, G. (2006). *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: The World Bank. Available: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing /HFRFull.pdf, December 31, 2007.

Hunt, P. (2006). *Report of the Special Rapporteur, Paul Hunt, to the Sixty-fist session of the Commission on Human Rights Council. Addendum: Mi*: United Nations, Economic and Social Council. Available: http://www2.essex.ac.uk /human_rights_centre /rth/docs/mozambique.pdf [accessed December 31, 2007].

Incentives for Global Health, HIF Initiative. Website. Available http://www.patent2.org/files/a_page_on_track2.doc [accessed December 31, 2007].

International Monetary Fund. (2007a). *Fiscal Policy Response to Scaled-Up Aid*. Available: http://www.imf.org/external/np/pp/2007/eng/060507.pdf [accessed December 31, 2007].

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

International Monetary Fund. (2007b). *World Economic and Financial Surveys: Regional Economic Outlook, Sub-Saharan African*. Available: http://www.imf.org/external/pubs/ft/reo/2007/AFR/ENG/sreo-0407.pdf [accessed December 31, 2007].

Jenkins, S. (2002). *Don't Patronize Africa, Give Trade Not Aid*. Available: http://www.thirdworldtraveler.com/Africa/Don't_Patronize_Africa.html [accessed December 31, 2007].

Loyn, D. (2003). Mozambique's Lost Cashew Nut Industry. *British Broadcasting Corporation*. Available: http://news.bbc.co.uk/2/hi/africa/3082316.stm [accessed December 31, 2007].

McKinley, T. (2005). *Why is 'Dutch Disease' Always a Disease? The Macroeconomic Consequences of Scaling Up ODA*. New York: United Nations Development Programme. *United Nations Development Programme Working Paper*. Available: http://www.undp.org/povertycentre/newsletters/Working-Paper10.pdf [accessed December 31, 2007].

McMillan, M., Rodrik, D. and Horn Welch, K. (2002). *When Economic Reform Goes Wrong: Cashews in Mozambique*. Cambridge, MA: John F. Kennedy School of Government. *Faculty Research Working Papers Series*. Available: http://ksgnotes1.harvard.edu/research/wpaper.nsf/rwp/RWP02–028/$File/rwp02_028_rodrik.pdf [accessed December 31, 2007].

Médecins Sans Frontières. (2001). *Fatal Imbalance: The Crisis in Research and Development for Drugs for Neglected Diseases*. Geneva: Médecins Sans Frontières. Available: www.msf.org/source/access/2001/fatal/fatal.pdf [accessed December 31, 2007].

Ooms, G., Derderian, K. and Melody, D. (2006). Do We Need a World Health Insurance to Realise the Right to Health? *PLoS Med*, **3**: e530.

Organisation of African Unity. (2001). *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. Available: http://www.un.org/ecosocdev/geninfo/afrec/vol15no1/151aids5.htm.

Örücü, E. (1986). The Core of Rights and Freedoms: The Limits of Limits. In Campbell, T. (ed.), *Human Rights: From Rhetoric to Reality*. New York:Blackwell.

Over, M. (2007). *AIDS Treatment as an International Entitlement: Are We Ready for a Global Welfare Paradigm*? Center for Global Health Policy. Available http://blogs.cgdev.org/globalhealth/2007/09/aids_treatment_as_an.php [accessed December 31, 2007].

Preble, C. and Tupy L. (2005). Trade, Not Aid. *Reason Online*, Available: http://www.cato.org/pub_display.php?pub_id=3873 [accessed December 31, 2007].

Pogge, T. (2005). *Montréal Statement on the Human Right to Essential Medicines*. Statement by the participants of the International Seminar on Human Rights and Access to Essential Medicines, Montréal, Canada, September 30–October 2, 2005. Available: http://www.ethics.harvard.edu/download/pogge2.pdf [accessed December 31, 2007].

Skogly, S. (2006). *Beyond National Borders: States' Human Rights Obligations in International Cooperation*. Antwerpen/Oxford: Intersentia.

Sserwanga, M. (2007). Uganda: CHOGM We Want Fair Trade, Not Aid. *The Monitor (Kampala)*, Available: http://allafrica.com/stories/200711191593.html [accessed December 31, 2007].

Stiglitz, J. (2006). *Making Globalization Work*. London: Penguin Books.

Toebes, B. (1999). *The Right to Health as a Human Right in International Law*. Antwerpen/Groningen/Oxford: Intersentia/Hart.

Trouiller, P., Olliaro, P., Torreele, E., Orbinski, J., Laing, R. and Ford, N. (2002). Drug Development for Neglected Diseases: A Deficient Market and a Public-Health Policy Failure. *Lancet*, **359**, 2188–2194.

United Nations. (1945). Charter of the United Nations. Available: http://www.un.org/aboutun/charter/ [accessed December 31, 2007].

United Nations. (1948). Universal Declaration of Human Rights. UN Doc. A/810 at 71 (1948). Available: http://www.un.org/Overview/rights.html [accessed December 31, 2007].

United Nations. (1966a). International Covenant on Civil and Political Rights. UN Doc. A/6316 (1966). Available: http://www.unhchr.ch/html/menu3/b/a_cpr.htm [accessed December 31, 2007].

United Nations. (1966b). International Covenant on Economic, Social and Cultural Rights. UN Doc. A/6316 (1966). Available: http:// www.unhchr.ch/html/menu3/b/a_cescr.htm [accessed December 31, 2007].

United Nations. (1970). General Assembly Resolution 2626 (XXV) October 24, 1970. Available: http://www.un-documents.net/a25r2626. htm [accessed December 31, 2007].

United Nations. (1979). Convention on the Elimination of All Forms of Discrimination against Women. U.N. Doc. A/34/46, at 193 (1979). Available: http://www.ohchr.org/english/law/cedaw.htm [accessed December 31, 2007].

United Nations. (1989). Convention on the Rights of the Child. U.N. Doc. A/44/49, at 166 (1989). Available: http://www.ohchr.org/english/law/crc.htm [accessed December 31, 2007].

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024

United Nations. (2001). Declaration of Commitment on HIV/AIDS. General Assembly Special Session Resolution A/RES/S-26/2 of June 27, 2001. Available: http://www.un.org/ga/aids/docs/aress262.pdf [accessed December 31, 2007].

United Nations. (2006). Political Declaration on HIV/AIDS. Available: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60-262_en.pdf [accessed December 31, 2007].

United Nations Millennium Project Website. Available: http://www.unmillenniumproject.org/press/07.htm [accessed December 31, 2007].

Vierdag, E. (1978). The Nature of the Rights Granted by the International Covenant on Economic, Social and Cultural Rights. *Netherlands Yearbook of International Law*, **9**, 69–105.

Vidal, J. (2002). Trade Not Aid. *The Guardian*, Available: http://www.guardian.co.uk/globalisation/story/0,7369,722865,00.html [accessed December 31, 2007].

World Health Organization. (1946). *Constitution of the World Health Organization.* Geneva: World Health Organization. Available: http://www.searo.who.int/LinkFiles/About_SEARO_const.pdf [accessed December 31, 2007].

World Health Organization. (2006). Working Together for Health. Available: http://www.who.int/whr/2006/whr06_en.pdf [accessed December 31, 2007].

World Health Organization. (2007a). 'Core Health Indicators: Mozambique.' Geneva: World Health Organization. Available: http://www.who.int/whosis/database/core/core_select_process.cfmcountry=moz&indicators=healthpersonnel [accessed December 31, 2007].

World Health Organization. (2007b). 'National Health Accounts.' Geneva: World Health Organization. Available: http://www.who.int/nha/country/Annex1&2,%20March%205,%202007.xls [accessed December 31, 2007].

World Trade Organization. (1994). The Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). Available: http://www.wto.org/English/docs_e/legal_e/27-trips.pdf [accessed December 31, 2007].

Yamey, G. (2003). Malaria researchers say global fund is buying 'Useless Drugs.' *BMJ*, **327**, 1188. Available: http://www.pubmedcentral.nih.gov/articlerender.fcgi? artid=300784 [accessed December 31, 2007].

Downloaded from https://academic.oup.com/phe/article/1/2/154/1449261 by guest on 10 April 2024