

## National and global responsibilities for health

Lawrence O Gostin,<sup>a</sup> Mark Heywood,<sup>b</sup> Gorik Ooms,<sup>c</sup> Anand Grover,<sup>d</sup> John-Arne Røttingen<sup>e</sup> & Wang Chenguang<sup>f</sup>

Preventable and treatable injuries and diseases are overwhelming sub-Saharan Africa, the Indian subcontinent and other impoverished areas of the world. Every year, 8 million children die before they reach the age of 5, more than 300 000 women die in pregnancy or childbirth, and more than 4 million people die of AIDS, malaria, or tuberculosis. By 2005, 80% of deaths from noncommunicable diseases were in developing countries. Healthy life expectancy in Africa is 45 years, a full quarter-century less than in high-income countries.<sup>1</sup>

Why are health outcomes among the world's poor so dire, even when international health assistance has quadrupled over the past two decades? The World Health Organization (WHO) perceives health to be "a shared responsibility,"<sup>2</sup> but global health actors often act out of self-interest rather than adopting harmonized approaches.

We are establishing the Joint Learning Initiative on National and Global Responsibilities for Health to articulate an overarching, coherent framework for sharing the responsibility for health that goes further than the United Nations Millennium Development Goals. The Initiative forges an international consensus around solutions to four critical challenges: (i) defining essential health services and goods; (ii) clarifying governments' obligations to their own country's inhabitants; (iii) exploring the responsibilities of all governments towards the world's poor; and (iv) proposing a global architecture to improve health as a matter of social justice.

The first challenge for the Joint Learning Initiative is to determine essential health services and goods that every person has a right to expect. Without articulating these, it is impossible to define each state's obligations to its own inhabitants, as well as the duties of high-income countries towards low- and middle-income countries.

The international human right to the highest attainable standard of health offers a starting point for ascertaining this essential level, including: WHO's "building blocks"

for health services (e.g. workforce, information and financing); essential vaccines, medicines and technologies; and basic survival needs (e.g. sanitation, nutrition, potable water, vector control and tobacco control). The right to health requires these services to be universally available, acceptable, accessible and of good quality.<sup>3</sup>

States hold the primary responsibility to fund and ensure all the essential goods and services under the right to health. WHO estimates the minimum annual cost at US\$ 40 per person,<sup>4</sup> excluding basic survival needs. In 2001, in Abuja, Nigeria, African heads of state pledged to devote at least 15% of national budgets to the health sector.<sup>5</sup> Yet, in 2007, the average per capita government health investment in Africa is US\$ 34, with a mean 9.6% budget allocation (compared with US\$ 1374 and 17.1% in the Americas).<sup>1</sup> This includes 15 African countries that invest as little as US\$ 2–10 per capita, which cannot begin to meet the population's health needs.<sup>6</sup> Many low- and middle-income countries, moreover, reduce domestic health spending for every dollar they receive in foreign health assistance.<sup>7</sup>

States also have a responsibility to govern well – honestly, transparently and accountably – with the full participation of civil society. Yet, health systems among low-income countries are among the most poorly governed.<sup>8</sup>

What do all countries owe to the world's least healthy people? Framing global health funding as "aid" is fundamentally flawed because it presupposes an inherently unequal benefactor–dependent relationship. Rather, global collaboration requires a collective response to shared risks and fundamental rights, where all states have mutual responsibilities. "Charitable giving" usually means that the donor decides how much to give, for what and to whom. Consequently, "aid" is not predictable, scalable or sustainable. It undermines the host country's "ownership" of – and responsibility for – health programmes.

Yet high-income countries have not come close to fulfilling their pledge made

in 1970 to spend 0.7% of their gross national product per annum on Official Development Assistance.<sup>9</sup> Four decades later, their average contribution stands at 0.31%.<sup>10</sup> Finding innovative ways to ensure adequate and enduring funding, with agreed-upon priorities, will be vital in ensuring that poor countries gain the capacity to fulfil the right to health.

Global health governance is essential because states will not accept international norms without genuine partnerships, equitable burden sharing and efficient programmes that improve health outcomes. Yet, political, legal and economic challenges impede effective governance. Countries face serious problems of fragmentation, duplication, and even confusion, among the deluge of global health actors and initiatives. Health ministries often lack basic knowledge of, and control over, foreign-supported programmes. We need a system of governance that fosters effective partnerships and coordinates initiatives to create synergies and avoid destructive competition.<sup>11</sup>

Importantly, global governance should reinforce the leadership and normative role of WHO which, as a United Nations agency, must have the legitimacy, authority and resources to support all countries in guaranteeing the right to health.

The Joint Learning Initiative aims to launch a wide participatory process involving all major stakeholders, including international organizations, governments, industry, philanthropists and civil society. The most transformative changes in global health have come from "bottom-up" social movements, such as campaigns to ban landmines or to fight HIV/AIDS. Civil society is now moving rapidly towards an agenda based on broad health rights and social justice, embracing the human right to health as a focal point for innovative global health governance. ■

### References

Available at: <http://www.who.int/bulletin/volumes/88/10/10-082636>

<sup>a</sup> O'Neill Institute for National and Global Health Law, Georgetown University, 600 New Jersey Avenue NW, Washington, DC, 20001, United States of America.

<sup>b</sup> SECTION27, Johannesburg, South Africa.

<sup>c</sup> Institute of Tropical Medicine, Antwerp, Belgium.

<sup>d</sup> United Nations Special Rapporteur on the Right to Health, Mumbai, India.

<sup>e</sup> Norwegian Knowledge Center for the Health Services, Oslo, Norway.

<sup>f</sup> Tsinghua University, Beijing, China.

Correspondence to Lawrence O Gostin (e-mail: [gostin@law.georgetown.edu](mailto:gostin@law.georgetown.edu)).

## References

1. World Health Organization. *World health statistics 2010*. Geneva: WHO; 2010. Available from: [http://www.who.int/whosis/whostat/EN\\_WHS10\\_Part2.pdf](http://www.who.int/whosis/whostat/EN_WHS10_Part2.pdf) [accessed 2 September 2010].
2. About WHO [Internet site]. Geneva: World Health Organization; 2010. Available from: <http://www.who.int/about/en/> [accessed 2 September 2010].
3. Committee on Economic, Social and Cultural Rights. *The right to the highest attainable standard of health*. Geneva: Office of the United Nations High Commissioner for Human Rights; 2000 (E/C.12/2000/4, CESCR General Comment 14). Available from: [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En) [accessed 1 September 2010].
4. Carrin G, Evans D, Xu K. Designing health financing policy towards universal coverage. *Bull World Health Organ* 2007;85:652. doi:10.2471/BLT.07.046664 PMID:18026615
5. *Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases*. Abuja, Nigeria: Organization of African Unity; 2001. Available from: [http://www.un.org/ga/aids/pdf/abuja\\_declaration.pdf](http://www.un.org/ga/aids/pdf/abuja_declaration.pdf) [accessed 1 September 2010].
6. African Civil Society. *Letter to July 2010 African Union Summit on upholding African health and social development commitments* [Internet site]. EQUINET [Regional Network on Equity in Health in Southern Africa]; 2010. Available from: <http://www.equinet africa.org/newsletter/index.php?id=7411> [accessed 1 September 2010].
7. Lu C, Schneider MT, Gubbins P, Leach-Kemon K, Jamison D, Murray CJL. Public financing of health in developing countries: a cross-national systematic analysis. *Lancet* 2010;375:1375–87. doi:10.1016/S0140-6736(10)60233-4 PMID:20381856
8. Transparency International. *Global corruption report 2006: corruption and health*. London: Pluto Press; 2006. Available from: [http://www.transparency.org/publications/gcr/gcr\\_2006](http://www.transparency.org/publications/gcr/gcr_2006) [accessed 2 September 2010].
9. *The 0.7% target: an in-depth look* [Internet site]. New York: United Nations Millennium Project; 2005. Available from: <http://www.unmillenniumproject.org/press/07.htm> [accessed 1 September 2010].
10. Development Cooperation Directorate. *Development aid rose in 2009 and most donors will meet 2010 aid targets* [media release]. Paris: Organisation for Economic Co-operation and Development; 2010. Available from: [http://www.oecd.org/document/11/0,3343,en\\_2649\\_34447\\_44981579\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/11/0,3343,en_2649_34447_44981579_1_1_1_1,00.html) [accessed 1 September 2010].
11. Gostin LO, Mok EA. Grand challenges in global health governance. *Br Med Bull* 2009;90:7–18. doi:10.1093/bmb/ldp014 PMID:19376802