Meeting the Survival Needs of the World's Least Healthy People

A Proposed Model for Global Health Governance

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INTERNATIONAL HEALTH ASSISTANCE IS PROVIDED IN AN INeffective way that does not enhance the capability for human functioning.[1] Most funding is driven by emotional, high-visibility events, including large-scale natural disasters such as the Asian tsunami; diseases that capture the public's imagination such as the human immunodeficiency virus and AIDS; or diseases with the potential for rapid global transmission such as hemorrhagic fever, severe acute respiratory syndrome, or pandemic influenza. These funding streams skew priorities and divert resources from building stable local systems to meet everyday health needs.

A relatively small number of wealthy donors currently wield considerable influence in setting the global health agenda. Although well intentioned, rich countries and philanthropists often set priorities that do not reflect local needs and preferences. Sometimes donors exert control over the use of funds that discourages local leaders from taking ownership over programs. Conditions attached to funding can even be detrimental to the public's health, such as the President's Emergency Plan for AIDS Relief requirement that 33% of prevention funds must be spent on chastity and fidelity, whereas no funding can be used for clean needle programs.[2] Similarly, for years, development banks have encouraged or required poor countries to cap internal spending on health as a condition of loans or debt relief.[3]

Donor countries often fund politically popular projects, rather than what is most likely to improve global health, leading some experts to conclude, " . . . funding is skewed towards what people in the West want to deliver."[4] International health assistance, moreover, is fragmented and uncoordinated. Nongovernmental organizations and relief agencies often establish programs that compete with each other and, still worse, compete with local government and businesses. Rather than integrating policies and programs within local hospitals, clinics, and health agencies, they set up state-of-the-art facilities that overshadow and detract from government and private efforts. Foreign philanthropists can offer salaries and amenities that are far more generous than those that can be offered locally. As a result, local innovation and entrepreneurship are stifled; talented individuals in business, health care, and community development migrate to foreign-run programs; and the local health industry cannot profit or easily survive.[5]

In addition, massive infusion of humanitarian assistance into very poor countries can lead to reliance and dependency. If charity is the main vehicle for health improvement, local government and businesses lose the desire and ability to solve problems on their own. When the infusion of foreign cash, clinics, medicines, and aid workers ends, the least healthy will be no better and perhaps worse off, unless they gain the capacity to meet their own basic health needs.

Host countries also bear responsibility for the failure of international development assistance. Many poor countries spend a minute percentage of their gross domestic product on health, preferring to spend on military or other perceived needs. At the same time, some governments misappropriate foreign health assistance, whether by excessive bureaucracy, incompetence, or corruption. The World Bank estimates that roughly half of all foreign health funds in sub-Saharan Africa are not used for health services, but are spent on payments for nonexistent services, counterfeit drugs, equipment diverted to the illicit market, or bribes.[6]

Basic Survival Needs

What is truly needed, and what richer countries instinctively (although not always adequately) do for their own citizens, is to meet what can be called "basic survival needs." Basic survival needs include sanitation and sewage, pest control, clean air and water, diet and nutrition, tobacco reduction, essential medicines and vaccines, and well-functioning health systems. Survival needs are laid out in the United Nations' Millennium Development Goals, which call for major improvements in maternal and child health, and the prevention of AIDS, malaria, and other diseases.[7] Meeting everyday survival needs may lack the glamour of high-technology medicine or dramatic rescue, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disability across the globe.[8] Mobi-

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lizing the public and private sectors to meet basic survival needs, comparable to a Marshall Plan, could radically transform prospects for improving health among the world's poorest populations.

Meeting basic survival needs can be disarmingly simple and inexpensive and should rise to the top of the the agenda of the world's most powerful countries. It does not take advanced biomedical research, huge financial investments, or complex programs. Vast human benefits would accrue from highly cost-effective interventions. For instance, vaccine-preventable diseases are virtually extinct in developed countries but still account for millions of deaths annually in poorer regions. Basic sanitation and water systems would vastly improve global health at minimal cost, such as clean water kits costing as little as $3.[9] An insecticide-treated bed net, which costs roughly $5, is highly effective in reducing malaria, river blindness, elephantiasis, and other insectborne diseases among children.[10] But only about 1 in 7 children in Africa sleep under a bed net,[11] and only 3% of children in sub-Saharan Africa use a net impregnated with insecticide.[12]

The single most important way to ensure basic survival is to build enduring health systems in all countries. Health systems include public health agencies with the capacity to identify, prevent, and ameliorate health risks in the population—disease surveillance, laboratories, data systems, and a competent workforce. They also include primary health care, bringing basic medical services (eg, maternal and child health, family planning, and medical treatment) as close as possible to where people live and work. Primary care promotes individual and community self-reliance and participation in the planning, organization, operation, and control of health services, making fullest use of local and national resources. What poor countries need is to gain the capacity to provide essential health services.

Proposal for a Framework Convention on Global Health

If meeting basic survival needs can truly make a difference for the world's population, and if this solution is preferable to other paths, can international law structure legal obligations accordingly? Extant health governance has been lamentably deficient, and a fresh approach is badly needed.[13,14]

The World Health Organization [WHO] Constitution grants the agency formidable powers, but its potential has never been realized.[15] In 60 years of existence, WHO has enacted only 1 significant regulation (the International Health Regulations)[16] and 1 treaty (the Framework Convention on Tobacco Control).[17] There is, however, a much larger body of international law that powerfully affects global health in areas ranging from food safety, arms control, and the environment to trade and human rights. The WHO should be a leader in creating, or at least influencing, this body of international law, but that has not happened.[18,19] The agency has shied away from rulemaking because it has seen itself principally as a scientific, technical agency.

As a result, social activists increasingly have turned to the language of human rights to articulate their aspirations for global health. But recasting the problem of extremely poor health as a human rights violation does not help.[20] The legal obligation to protect the public's health falls primarily on each state (ie, nation-state), but poor countries lack the capacity to do so. Although the International Covenant on Economic, Social, and Cultural Rights[21] posits that all states have duties to cooperate, there are no specific requirements for assisting other countries.

If law is to play a constructive role, new models will be required. One model would be a Framework Convention on Global Health (FCGH). An FCGH is a global health governance scheme that incorporates a bottom-up strategy that strives to do the following: build capacity, so that all countries have enduring and effective health systems; set priorities, so that international assistance is directed to meeting basic survival needs; engage stakeholders, so that a wide variety of state and nonstate participants can contribute their resources and expertise; coordinate activities, so that programs among the proliferating number of participants operating around the world are harmonized; and evaluate and monitor progress, to ensure that goals are met and promises kept.

The framework convention-protocol approach refers to a process of incremental regime development. In the initial stage, participating states would negotiate and agree to the framework instrument, which would establish broad principles for global health governance. In subsequent stages, specific protocols would be developed to achieve the objectives set forth in the original framework. These protocols, organized by key components of the global health strategy, would create more detailed legal norms, structures, and processes. The framework convention-protocol approach has considerable flexibility, allowing participating states to decide the level of specificity that is politically feasible now, saving more complex or contentious issues to be built in later protocols.

The framework convention-protocol approach is becoming an essential strategy of powerful transnational social movements to safeguard health and the environment. In addition to the Framework Convention on Tobacco Control, a series of international environmental treaties serve as models for global health governance, such as the Vienna Convention for the Protection of the Ozone Layer[22] and the United Nations Framework Convention on Climate Change.[23] These framework conventions recognize that a collective effort is necessary to mitigate the threat that humans pose to health and the environment. Although far from perfect, health and environmental conventions offer inventive approaches to global governance.

An FCGH would represent a historical shift in global health, with broadly imagined global governance. The initial framework would establish the key modalities, with a strategy for subsequent protocols on each of the most im-

portant governance parameters. It is not necessary, or perhaps even wise, to specify in detail the substance of an initial FCGH, but the broad principles might include:

- *Statement of a mission*—convention parties seek innovative solutions for the most pressing health problems facing the world in partnership with nonstate actors and civil society, with particular emphasis on disadvantaged populations;
- *Development of objectives*—create enduring health system capacities, meet basic survival needs, and reduce global health disparities;
- *Engagement and coordination*—find common purposes among a variety of state and nonstate participants, set priorities, and coordinate activities;
- *State party and other stakeholder obligations*—forms and levels of assistance (eg, incentives, financial aid, debt relief, and technical support);
- *Empirical monitoring*—data gathering, benchmarks, and leading health indicators, such as maternal, infant, and child survival;
- *Enforcement mechanisms*—inducements, sanctions, and dispute resolution; and
- *Ongoing scientific analysis*—scientific research and evaluation on cost-effective health interventions, such as the creation of an intergovernmental panel on global health, comprising prominent medical and public health experts.

The framework convention-protocol approach has a number of advantages. The incremental nature of the governance strategy allows the international community to focus on a problem in a stepwise manner, avoiding potential political bottlenecks over contentious elements. The process of creating international norms and institutions also provides an ongoing and structured forum for states and stakeholders to develop a shared humanitarian instinct on global health. A high-profile forum for normative discussion can help educate and persuade participating states, and influence public opinion, in favor of decisive action. And it can create internal pressure for governments and others to actively participate in the framework dialogue. The creation of such a normative community, therefore, may be an essential element of building an international consensus. The imperatives of global health cannot be framed just as a series of isolated problems in far-off places, but rather as a common concern of humankind.

This approach, however, will not be a panacea and cannot easily circumvent many of the seemingly intractable problems of global health governance including the domination of economically and politically powerful countries; the deep resistance to creating obligations to expend, or transfer, wealth; the lack of trust in international legal regimes; and the vocal concerns about the integrity and competency of governments in many of the poorest regions.

But given the dismal nature of extant global health governance, an FCGH is a risk worth taking. It will, at a minimum, identify the genuinely important problems in global health: targeting the major determinants of health, prioritizing and coordinating currently fragmented activities, and engaging a broad range of stakeholders. It also will provide a needed forum to raise visibility for one of the most pressing problems facing humankind.

Fair Terms of International Cooperation on Global Health

If the international community wants to make a genuine difference in the lives of the world's least healthy people, it needs an innovative international mechanism to bind themselves and others to take an effective course of action. Amelioration of the enduring and complex problems of global health is virtually impossible without a collective response. No state or stakeholder, acting alone, can avert the ubiquitous threats of pathogens as they rapidly migrate and change forms. If all states and stakeholders voluntarily accepted fair terms of cooperation through an FCGH, then it could dramatically improve life prospects for millions of people. But it would do more than that. Cooperative action for global health, like action to address global warming, benefits everyone by diminishing collective vulnerabilities.

The alternative to fair terms of cooperation through an FCGH is that everyone would be worse off, particularly those who have compounding disadvantages.[24] Absent a binding commitment to help, rich states might find it politically or economically easier to withhold their fair share of global health assistance, hoping that others will take up the slack. Major outbreaks of infectious disease, including extensively drug-resistant forms, would become increasingly more likely. Even if the economically and politically powerful nations escaped major health hazards, they would still have to avert their eyes from the mounting hardships and health problems among the poor. They would have to live with their consciences knowing that much of this physical and mental anguish is preventable.

If the global community does not accept fair terms of cooperation on global health soon, there is every reason to believe that affluent states, philanthropists, and celebrities simply will move on to another cause. When they do, the vicious cycle of poverty and endemic disease among the world's least healthy people will continue unabated. That is a consequence that no one should be willing to tolerate.

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EDITORIAL

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Genetics and Genomics
A Call for Papers

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THE OCTOBER 15, 1997, ISSUE OF *JAMA*[1] WAS DEVOTED to genetics and featured articles on genomic screening in late-onset familial Alzheimer disease, *BRCA1* sequence analysis, hereditary prostate cancer 1 locus, chromosome 19 single locus, and multilocus haplotype associations with multiple sclerosis, cancer incidence after retinoblastoma, prenatal genetic carrier testing, molecular diagnosis and carrier screening for β-thalassemia, genetic testing in hereditary colorectal cancer, molecular neurogenetics, family history and genetic risk factors, and preparing health professionals for the genetic revolution.

During the past decade, there has been an explosion of progress in genetics and genomics including the sequencing of the human genome.[2,3] In March 2008, *JAMA* will devote an entire theme issue to practical applications of genetics and genomics that are or might become clinically important. We invite authors to submit manuscripts reporting the results of original research, especially clinical trials; systematic reviews including meta-analyses; special communications; and commentaries. Evidence-based articles will be given priority.

Topics of particular interest include genetic diagnosis including prenatal tests, genetic testing especially for illnesses for which presymptomatic intervention is possible, pharmacogenomics, gene therapy, evolutionary medicine such as genotypes with proven adaptive responses to emerging infections, genetic counseling, and ethical issues surrounding genetics.

Manuscripts received by November 1, 2007, will have the best chance for consideration for this theme issue. All manuscripts will undergo our usual rigorous editorial review process. High-quality submissions not accepted for the theme issue may be considered for other issues of *JAMA* or, with the authors' permission, for consideration by one of our *Archives* specialty journals, which are also devoting a March theme issue to this topic.

Authors are encouraged to consult the *JAMA* Instructions for Authors[4] for guidelines on preparing and submitting manuscripts.

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