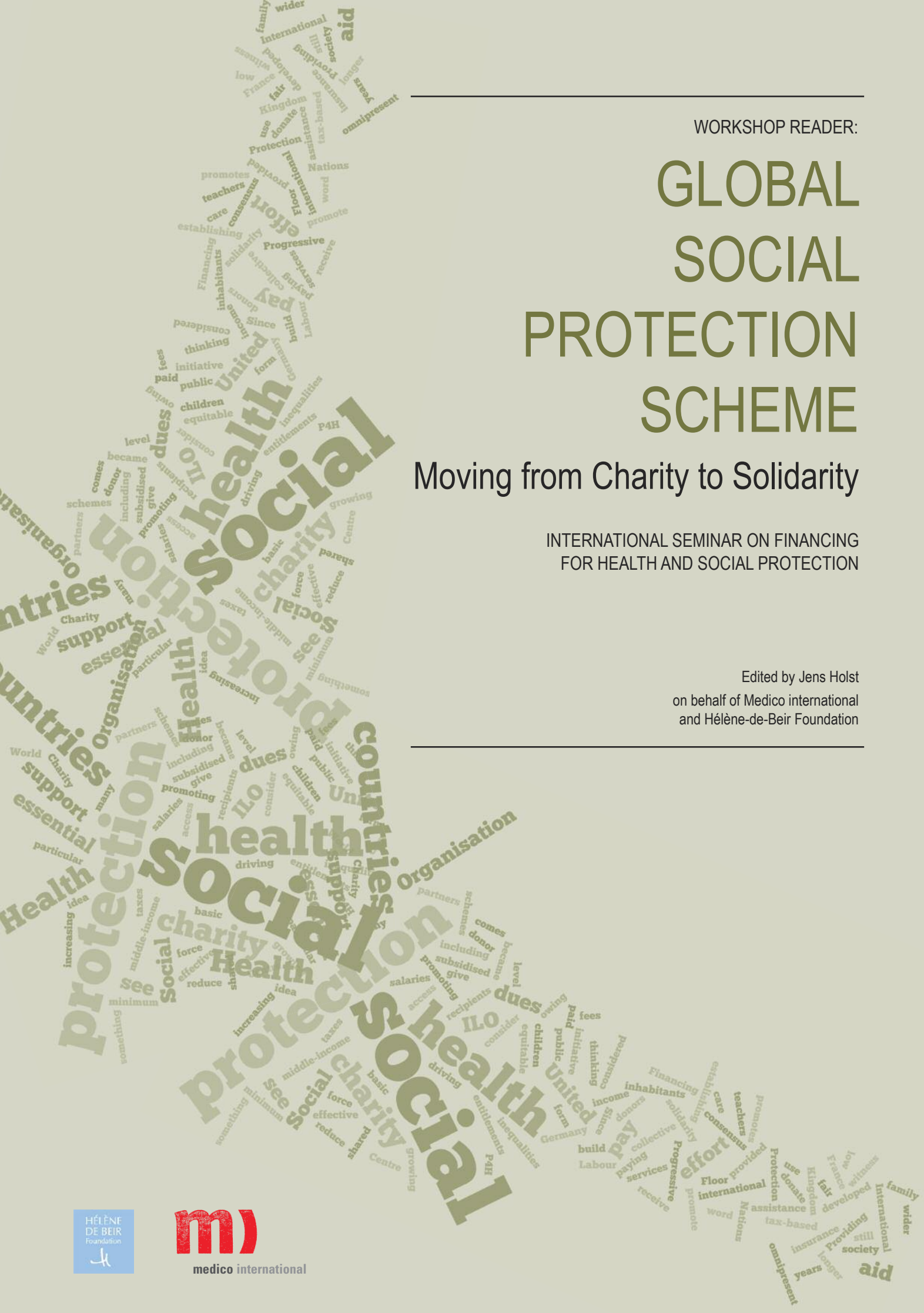
WORKSHOP READER:

GLOBAL SOCIAL PROTECTION SCHEME

Moving from Charity to Solidarity

INTERNATIONAL SEMINAR ON FINANCING
FOR HEALTH AND SOCIAL PROTECTION

Edited by Jens Holst
on behalf of Medico international
and Hélène-de-Beir Foundation



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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AMC	Advance Market Commitments
ASEAN	Association of Southeast Asian Nations
BMGF	Bill and Melinda Gates Foundation
BRICS	Brazil, Russia, India, China and South Africa
CAFTA	Central-American Free Trade Association
CMH	Commission on Macroeconomics and Health
DC	Developing Countries
DESA	Department of Economic and Social Affairs (United Nations)
ECF	European Cohesion Fund
ECLAC	Economic Commission for Latin America and the Caribbean
EFRD	European Fund for Regional Development
ESF	European Social Fund
EU	European Union
FCGH	Framework Convention on Global Health
FTT	Financial transaction tax
G20	Group of 20
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNI	Gross National Income
GSP	Global social protection
HHA	Harmonization for Health in Africa
HIV	Human immuno-deficiency virus
IDU	Intravenous drug users
IFFIm	International Finance Facility for Immunisation

ILO	International Labour Office
IMF	International Monetary Fund
IMR	Infant mortality rate
JALI	Joint Action and Learning Initiative
LDC	Least developed countries
MDG	Millenium Development Goals
MERCOSUR	Mercado Común del Sur / Southern Common Market
MSF	Médecins sans Frontières
MSM	Male who have sex with male
NAFTA	North-American Free Trade Association
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
P4H	Providing for Health
PEPFAR	President's Emergency Plan for AIDS Relief
PHI	Private health insurance
PPP	Public-private partnership
(PRODUCT)RED	Fighting for an AIDS-Free Generation
SHI	Social health insurance
SPF	Social Protection Floor
SRI	Socially responsible investments
UN	United Nations
UN/DESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations Children's Fund
UNITAID	Increasing Treatment Coverage for HIV/AIDS, Malaria and TB Through Market Solutions
US$	United States Dollar
WHO	World Health Organization

FINANCING GLOBAL SOCIAL PROTECTION – MOVING FROM CHARITY TO SOLIDARITY

The idea of charity is still omnipresent in thinking about international assistance. The word 'donor' is a witness of that: some countries 'donate' or give; they do not see themselves as owing something to other countries or their inhabitants; nor do they see themselves as partners in a shared effort.

Charity once was a driving force of what became social protection. It no longer is. Social protection is not about charity. When we pay our taxes or social insurance fees, we are not donors of aid, we are paying our dues; when we receive support in the form of subsidised health care or teachers for our children whose salaries have been paid, we are not recipients of aid. We pay our dues and we use our entitlements, and we consider it a collective effort to build a fair and equitable society. That is solidarity, not charity.

There is a growing consensus that effective public social protection schemes are essential to reduce health and other social inequalities. Since many years and with increasing support from the wider United Nations family, the International Labour Organisation (ILO) promotes a Social Protection Floor: a minimum level of social protection, including basic income and access to essential social services, to be provided by all countries. When it comes to health in particular, Germany and France, with the ILO and the World Health Organisation (WHO) developed the "Providing for Health" or P4H initiative, promoting social health protection in low- and middle-income countries. The United Kingdom considered to establishing a Centre for Progressive Health Financing to promote tax-based social health protection.

What the above-mentioned efforts have in common – so far rather unfortunately – is that they do not intend to apply the principles of social protection – solidarity, not charity – at the global level. They try to promote permanent redistribution of income within countries, not between countries.

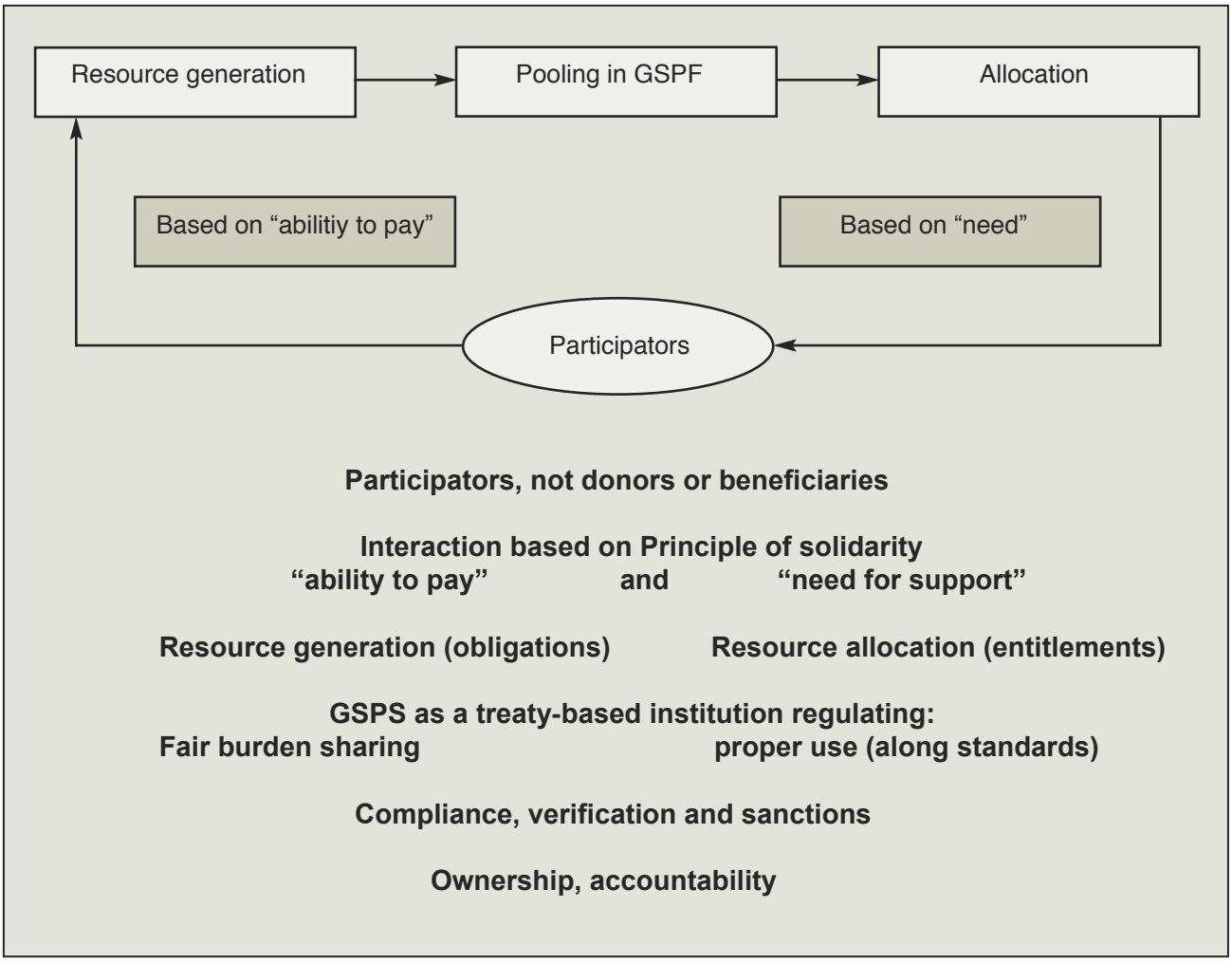
The idea of applying the principles of social protection that exist between people living in the same country to people living in different countries may seem odd, but has a precedent. When confronted with the HIV/AIDS epidemic, the international community accepted that health is a global issue that requires mutual and shared responsibility beyond borders. Even if some countries were (and still are) too poor to provide AIDS treatment, and will rely on international assistance during decades to come, the international community decided to support the provision of AIDS treatment to all people who needed. As that required international assistance during many decades, it could not rely on charity – it had to be based on solidarity. Thus, the creation of the Global Fund to fight AIDS, Tuberculosis and Malaria can be seen as the beginning of a new paradigm of global social protection. However, an approach tackling only three diseases is inadequate for redressing health inequalities in the longer term, and furthermore intrinsically

contradictory with the idea of solidarity: if we work together for a fair and equitable global society, sharing particular health risks cannot be the basis for solidarity – not if it comes at the detriment of other health risks that are not shared.

Can we imagine a funding mechanism for Global Social Protection between people living in different countries, relying on each other and supporting each other, contributing to a fair and equitable global society? – medico international and the Hélène de Beir Foundation can. We think that most people can adhere to the principles of Global Social Protection. We do not aim for a global social protection scheme that replaces national social protection schemes; we think that national social protection schemes will benefit from a global scheme. We think we can learn from social protection equalisation schemes, like they exist within and among many high-income countries (Australia, Belgium, Canada, Germany, and others). Particularly the German "Risikostrukturausgleich" that balances economic gaps within the social health insurance system, and the "Länderfinanzausgleich" among the federal states, are of interest.

The objective of a three days expert workshop on Financing Global Social Protection is to challenge the metaphorical devil in the detail. We know we must move from global charity to global solidarity. The question is: how? ■

FIG. 1: MODEL OF A GLOBAL SOCIAL PROTECTION SCHEME



PREFACE

In recent years, social health protection has climbed high up the international political agenda; universal coverage even has the potential to become a Millennium Development Goal. The World Health Report 2010 "Health Systems Financing – The Path to Universal Coverage" has definitely pushed forward international awareness on universal health coverage. Many developing countries and even countries in transition are still a long way from providing their populations with universal coverage, i.e. giving everyone access to a reasonable array of preventive, curative and rehabilitative health services when needed, under equal access conditions and with a high level of financial risk protection. According to World Health Organization (WHO) estimates, about 100 million people fall into poverty every year because they cannot afford the cost of essential health care.

While globalisation is rapidly progressing and economic linkages around the world become closer and closer, social protection is still primarily considered a national responsibility. It is long overdue to assess the paradigm of exclusively national responsibility for social protection in a globalised world, particularly because a number of least developed countries will be unable to fund universal social systems from domestic resources alone. Thus, to effectively globalise the concept of universal coverage, innovative financing mechanisms are required that allow for reliable redistribution of resources and shared responsibility at international level.

International aid programmes and development cooperation are currently putting much emphasis on improving social protection in poor countries, and particularly on helping them to move closer to universal coverage. But international assistance is still governed by a rather charity-based understanding where rich countries voluntarily 'donate' something to other nations in order to support their development. 'Donor' countries do not perceive themselves as partners in shared responsibility and joint efforts to overcome worldwide poverty and inequity. Even less do they see themselves in a position where they are obliged to offer something to poor countries and societies because their wealth is at least partly based on the poverty of others or on the fact that a significant proportion of humanity is deprived of the social rights enjoyed by others.

Various approaches exist, including the WHO's endeavours towards universal coverage as documented in the World Health Report 2010 on "Health Systems Financing – The Path to Universal Coverage", the Social Protection Floor Initiative of the International Labour Office (ILO), and the Providing-for-Health (P4H) initiative created by France and Germany together with ILO and WHO to promote social health protection in low- and middle-income countries. There is no doubt that all these and many other programmes and strategies for expanding social health protection are necessary and instrumental. However, they still reflect the charitable understanding of international assistance and development aid that is still prevalent and quite apparent in the field of social protection and universal coverage. All efforts so far by multilateral and bilateral 'donors' show no intent to apply more equitable approaches or to operationalise

the core principle of existing social protection systems, namely solidarity. Existing experience in promoting and implementing income redistribution within countries has not yet been applied at the global level, although the growing inequality between countries calls for international solidarity as a requirement for achieving universal coverage.

The workshop on Global Social Protection held in Berlin from May 14th to 16th, 2012 brought together experts working in various fields related directly or indirectly to global health, such as the right to health, international taxation and financing mechanisms, and social protection. The objective was to identify and present ideas, concepts and strategies for converting the current paradigm of charity-based international aid for universal health coverage into rights-based and operational solidarity. This reader is a compilation of various papers emanating from the most important presentations held during the workshop. The reader sets out to preserve the contributions that reflect various approaches to global social protection (GSP); at the same time it is designed as a background document for a policy paper on GSP.

Thomas **Gebauer** from medico international provides an introduction in which he elaborates on the need to institutionalise solidarity for health, which is a global public good. The struggle to improve global health has to put an emphasis both on the social determinants of health, as the most influential factors for people's health, and on universal coverage providing effective healthcare for everybody. Relevant improvements of global health and health protection will be very difficult to achieve without clear policy decisions and without rejecting the currently predominant neo-liberal ideology. At the same time it is indispensable to improve the accountability of individual states. In order to set up GSP mechanisms and enhance financial risk protection worldwide, funds will have to be pooled at international level in a way that allows for the principle of solidarity to be operationalised. Several options for innovative funding for health exist and some of them are already being explored, but to create an International Fund for Health that is able to guarantee sustainable and socially fair worldwide universal coverage, a globalisation of the principle of solidarity is indispensable. This might appear utopian at first glance and in view of the current conditions, but a measure of utopia is required when it comes to achieving the objective of health for all.

Anand **Grover**, Special UN Rapporteur on the right to health, analyses the relationship between the right to health and health financing. He defines the meaning of the right to health and gives an overview of the existing international legislation on the right to health. Thereafter he presents and briefly analyses existing models of international funding from the perspective of a potential shift in the global paradigm of international assistance for health. Bringing down international legislation to human needs, Gorik **Ooms** from the Hélène De Beir Foundation elaborates three-and-a-half convincing arguments for global social protection in a very personal manner and based on his extensive field experience. Firstly, GSP for health is a humanitarian duty that derives from the obvious fact that so many people around the world are excluded from the most basic services, and even confront the international community with the dilemma of prioritising between emergency and disaster relief on the one hand and development assistance on the other. Secondly, GSP for health is required to operationalise the human right to health, which has to be translated from words on paper into daily practice and the lives of people all over the world. In addition to the more general rights approach as a whole, the fact that GSP for health is a matter of global social justice provides another half argument. And thirdly, GSP is a matter of enlightened self-interest to avoid a 'tragedy of the commons', meaning that under the given global economic rules and strong international competition countries tend

to attract economic activity from other countries at the cost of deterring other countries from raising taxes and other levies. In order to avert this detrimental race to the bottom, minimal social protection standards and a GSP fund have to be established.

The economist David **Woodward** approaches the general topic of social protection in the context of increasing income inequalities. He draws out some interesting comparisons with another crucial debate within the international community, namely climate change and the constraints it imposes on global growth, and explains the interrelation between the demand for oil, carbon-dioxide emissions and economic development. Moreover he illustrates the current global income inequalities and the benefits of economic growth, looking more specifically at the effects of global inequality on healthcare financing and considering the share of spending allocated to health in different countries and the distribution between public and private spending on health in order to derive some implications for a Global Social Protection scheme.

Thomas **Pogge** from Yale University raises the philosophical question as to whether the current international framework and the given conditions are violating the human rights of the world's poor. His contribution starts with a normative analysis of the meaning of violating a human right from non-fulfilment via the relation of human rights to law and morality to the path from non-fulfilment to violation of human rights. Existing evidence shows that basic social and economic human rights remain unfulfilled for around half the world's population, and the poorer half of humanity is suffering a rapid decline in its share of global household income. As the design of supranational institutional arrangements plays a major role in explaining the growing inequality, one might conclude that the global better-off are collectively violating the human rights of the global poor.

During the GSP workshop Aurelio **Fernández** presented the basic ideas and objectives of the ILO concept of the social protection floor for fair and inclusive globalisation. The executive summary depicts the underlying challenges, describes the idea behind the global social protection floor and explains why such a floor is urgently needed and how it can be implemented.

Health scientist Jens **Holst** analyses existing financial equalisation mechanisms with regard to their potential to generate lessons learned for implementing the organisation of a GSP scheme based on the principle of solidarity. Solidarity is not a woolly concept when it is operationalised in national and regional health financing systems where resource generation for healthcare is either organised through tax revenue or social insurance contributions. Beyond social protection, risk equalisation mechanisms exist within countries and beyond borders, mainly in free-trade agreements. Federal countries such as Germany as well as the European Union provide a series of interesting approaches to risk equalisation which might be used for setting up a GSP scheme.

The former minister of health from Mozambique, Francisco **Songane**, analyses the detrimental effects of traditional development assistance and appeals for a move from vertical and project funding to a systems-strengthening approach that addresses the development of countries in an effective and sustainable manner. Therefore the currently incoherent visions of funders and recipients of development aid have to be conciliated, and a new paradigm of development assistance has to be implemented. This will not be possible without achieving an international consensus, even though the considerations regarding the type and scope of social protection might vary from one country to another.

Tax-law professor Lieven **Denys** sees the potential of financial levies for globalising solidarity and setting up global social protection. There-

fore new mechanisms of resource generation are needed, and resources should best be generated where the highest benefit and profit rates exist. Globalisation has created enormous levels of wealth, particularly in the financial sector. Currently there is an increased use of global commons, for example in association with the liberalisation of capital and trade, and there is a growing consensus that national states are unable to cope with the financing of public goods at global level, particularly in view of shrinking domestic resources. Against this background, innovative taxes on the financial sector and particularly on international financial transactions have a huge potential for financing a GSP scheme through an adequately designed global solidarity levy.

In her contribution, the director of the Spanish NGO Salud por Derecho, Vanessa **López**, starts to refer to the right to health in her analysis of responsibilities and resources for financing global social protection. A development framework is required in order to build the will to assume responsibility at global level. The proposal consists in a universal social health insurance scheme based on certain principles such as solidarity and redistribution as preconditions for achieving the sustainable financing of GSP.

The lecturer on tax law and vice chair of the Tax Justice Network, Attiya **Waris** broaches the issue of the role of international and national taxation for achieving GSP. Innovative financing mechanisms include both fiscal and non-fiscal tax incentives. The historical development of national taxation is interesting because it links resources to human rights and, lately, to entitlement to social protection. Likewise, globalisation and increasing international resources require ade- quate taxation mechanisms in order to contribute to development and promote GSP.

German technical cooperation associate Jean Olivier **Schmidt** presents innovative approaches applied by the overseas development institutions in order to provide harmonised and target-oriented support to developing countries and countries in transition. There is a move from financing health services to supporting health financing. The international initiative Providing for Health (P4H) is an international instrument to support countries in their striving for universal health coverage. The global initiative to promote social health protection makes a difference and helps countries to develop sustainable systems.

Last but not least, Gorik **Ooms** raises the challenging relationship between the available fiscal space and the relevance of long-term and reliable international support and co-financing of social protection systems. The prevailing pressure on countries to reduce taxes and public services requires stable financial cross-subsidisation instead of donor-driven development assistance.

The topic of global social protection is increasingly high on the international agenda. In particular, it is worth mentioning that the essence of the GSP workshop contributions and conclusions have been reflected in the report of the Special Rapporteur on everyone's right to the enjoyment of the highest attainable standard of physical and mental health to the sixty-seventh session of the United Nations General Assembly in August 2012. In section 33 the Special Rapporteur, Anand Grover, who participated in the GSP workshop in May 2012, states the following: "In order to shift the global paradigm of international assistance for health from a donor-based charity regime towards an obligatory system based on the principle of solidarity, global pooling mechanisms should be founded upon international or regional treaties under which States incur legal obligations to contribute to the pool according to their ability to pay and through which funds are allocated based upon need. Such a shift is necessary in order to ensure the availability of sustainable international funding, as required by the right to health." ■

THE NEED TO INSTITUTIONALISE SOLIDARITY FOR HEALTH

THOMAS GEBAUER[1]

Abstract

For achieving the ambitious aim of Health for All in an increasingly globalised world a new paradigm is more needed than ever. International health policy has to deal essentially with two areas for improving people's health: The social determinants of health and fair health financing. While most determinants of health go beyond the scope of health policy, health financing is at its core the principle of solidarity. Health systems financing has to rely on the redistribution of wealth that can be achieved by effectively applying the principle of solidarity. Good will and charity are insufficient for protecting people in need. Everybody should enjoy legally binding rights to health and irremediable entitlements to social rights.

To be able to respond to the entitlements of people, mandatory and predictable funding mechanisms have to be implemented in a way that ensures fair burden sharing and proper use of funds. However, new international funding mechanisms are only the second best option. While they promise to be supportive to balance existing financial gaps, strengthening national capacities on the front line is even more important. The global south needs to regain control over its own resources.

It is necessary to have output in mind, but existent experiences and good practices should also be taken into account. There is quite a number of successfully implemented equalisation mechanisms in place showing that permanent redistribution and fair risk sharing are possible. However, for overcoming the neo-liberal hegemony strong civic action and public pressure are indispensable.

Health – a global public good

International health has recently achieved new attention in the political debate. All over the world policy makers, researchers and representatives of both business corporations and NGOs and the civil society as a whole tend to make reference to global health. The perceptions, concepts and interests, however, are extremely heterogeneous. Global health goes far beyond preventing pandemics, trade of health products, ranking health systems or reforming international health organisations. First of all the global-health concept reflects the need to rethink health under the premise of a globalised world. Health is an essential condition for human and social development. Hence, from the human-rights perspective global health refers to the responsibility to establish health as a global public good. In order to make this happen, the responsibility for health has to be shared at the international level.

The still ambitious goal Health for All is as old the World Health Organization (WHO) founded in 1948. The fact that this objective has not yet been achieved during the last over 60 years is sobering in view of the worldwide wealth and richness that has been generated during the last decades. However, Health for All should not be

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a dream any longer; and in fact it could have been achieved long ago. Realising the right to health for all human beings does not depend on creating more and more wealth; it is primarily an issue of fairly distributing the existing and ever increasing global income. The main challenge is the lack of political and public pressure for making everybody benefit from the abundant resources generated at global level.

The extremely unequal distribution of resources becomes especially evident in health. Indeed average life expectancy of the global population has constantly increased over the last decades; in Africa and some countries of the former Eastern world, however, it is declining. Likewise the infant mortality rate (IMR) illustrates the blatant inequalities that exist in today's health. While 99 children out of 1,000 live births in Chad die before their first birthday, infant mortality is just 2 in Sweden (WHO 2012: 52-59).

There is no doubt that the world has made considerable progress during economic globalisation. But at the same time the gap between the rich and the poor has increasingly widened. The neo-liberal paradigm that the poor would also benefit from the liberalisation of trade in goods and capital has long proven wrong in theory (Alesina & Rodrik 1994: 482ff) and practice (Machinea et al. 2006: 21ff; Perry et al. 2006: 59ff; cf. also Waris: The Role of International Tax in the Achievement of Global Social Protection in this reader: 122f). Instead of the expected trickle-down effect, global economic growth has rather corroborated poverty by a cynical hidden agenda: Take it from the needy, give it to the greedy. Today it does not only make a difference whether we are born in a prosperous country in Europe, North America or Australia or in the 'global south' of developing countries and countries in transition. It also matters more and more which social class we are borne in since social exclusion, poverty, and the denial of future perspectives has meanwhile reached wealthy societies.

The present health inequalities, however, are not as irremediable as they might appear, and sufficient resources are in principle available for providing all human beings with adequate social rights. But alternatives do not appear from nowhere, they can only be realised by facing the prevailing power relations that are responsible for the maintaining the status quo of unequal distribution of wealth. Health for all and change for better health require amendment to, or abolition of, the structural conditions that fuel persisting inequalities. Therefore social movements guided by a vision of a different world are indispensable.

The two areas of change for better health

The struggle for overcoming health inequalities has to focus both on the social determinants of health and universal coverage in health. Improving people's health will remain impossible unless social environments allow people to develop and activate their own health potentials. Appropriate living conditions are indispensable for achieving the ambitious goal of health for all, including access to income or land, adequate nutrition, housing, education, full participation in cultural life, and others. Action for global health has to emphasise the importance of social determinants of health. The struggle for better health will have to include the protection and recovery of fundamental common goods such as land (for nutrition), rivers (for clean water), environmental issues, but also knowledge (for access to medicine). While emphasis should be put on the social determinants of health as most influential factors for people's health all over the world, there is also a need for effective health care services. Even in a perfect world where social determinants of health are fully streamlined according to health requirements, people who fall ill and suffer accidents will need medical assistance. Thus, universal coverage has to complement the SDH approach. Universal coverage means that everyone has access to a broad array of preventive, curative and rehabilitative

health services when needed, under equal access conditions and with a high level of financial risk protection.

Without any intention to diminish or deny the relevance of social determinants of health, the following chapter will focus on universal health protection. It is quite obvious that the world is far from achieving universal access to the highest attainable standard of health care. The statistics are appalling:

- Every year 18 million persons die of diseases that could be prevented by sufficient nutrition, safe water, etc. or easy to treat with essential medicines, rehydration, etc. (Pogge 2008).

- Developing countries account for 84 % of global population and 90 % of the global disease burden, but only 12 percent of global health spending (Gottret & Schieber 2006: 2).

- 41 low-income countries are too poor to generate sufficient resources required to achieve the MDGs by 2015 (WHO 2010: xiii).

- Every year about 100 million people are pushed under the poverty line because they need to pay for health services (WHO 2010: 5).

Due to these scandalous global inequalities, the health of the majority of the world population remains insufficiently protected and promoted. Only a minority enjoys complete financial risk protection. The poorer the country, the larger the private share of health expenditure. In 2007, in 33 mostly low-income countries, more than 50 % of the total expenditure on health was direct out-of-pocket payments (OOP) payable at the point of service. OOP represent the most inequitable source of health financing and imply unforeseeable financial risks (WHO 2010: xiv).

In 2010, during the presentation of the World Health Report on Health Systems Financing – The path towards universal coverage in Berlin, WHO Director General Margaret Chan called for the abolition of out-of-pocket payments and particularly 'user fees'. Dr Chan has not had a good word to say for the latter. 'User fees' are punishing the poor, said the DG of the WHO (Gebauer 2011), in the presence of representatives of the World Bank, which in the late 1980s and 1990s, together with the International Monetary Fund (IMF), heavily promoted 'user fees' as part of the structural adjustment programmes forced on the developing world. It is worth mentioning that international politics again recognises the everlasting vicious circle of poverty and bad health. The close relationship between poverty and illness demands for giving high priority to social determinants of (bad) health. At the same time the vicious circle explains why universal access to health cannot be achieved by linking health care to individual purchasing power. He struggle for universal coverage comprises a minimum of five key actions:

First and foremost it is indispensable to challenge the neo-liberal paradigm of selfresponsiveness and entrepreneurship. Second, as a prerequisite for improving state accountability, there is a clear need for health governance reform. Third, out-of-pocket payments have to be reduced as far as possible by enhancing financial risk protection. Fourth, a broader system of risk pooling is required for spreading risks and sharing funds earmarked for health care, and - last but not least - the principle of solidarity has to be reactivated in order to replace market-driven concepts.

Rejecting the neo-liberal ideology

The struggle for universal coverage starts with questioning and attacking the still dominant neoliberal paradigm. Globalisation has widened health inequalities, but of course globalisation cannot be turned back. By contrast, the conditions of ongoing globalisation can definitely be changed and more emphasis given to the detrimental effects of privatisation. The transforming

of health services into commodities, the linkage of access to health care to individual's purchasing power, and the dismantling of public health systems have only been possible in the context of the predominance of a specific ideology. This ideology is usually denominated as neo-liberal, and the core concepts of this ideology have replaced social values and institutions such as solidarity and public goods by logic of self-responsibility and individual entrepreneurship.

In a recently published paper the well-known health economist Gavin Mooney (2012: 397f) summarises his findings quite drastically: "Neoliberalism kills. We need to find a better way…. The crucial issue, however, is to accept that public health must be political and that fundamental to any genuine progress in addressing poverty, inequality, and ill health at a global level is to recognise that, first, neoliberalism is at the root of these problems and, second, some alternative must be found." In fact, despite abundant evidence for health being primarily determined by the social environment, neo-liberalism has been extremely successful in pushing the responsibility for people's health away from society and public institutions to private actors and individuals. Even those spheres of societies that traditionally do not belong to the areas of action for business such as health, education, and culture have been increasingly penetrated by liberal market values and are considered mainly as fields of business and profit-oriented entrepreneurship.

Improving state accountability

Accountability of governments and public institutions shows an amazing fragmentation that has occurred in the international health landscape. On the one hand the rapid emergence of new actors, such as corporate and private foundations, multinational companies, public-private partnerships, has highlighted health as a priority; but at the same time it has also weakened mandated state institutions at all levels. Particularly ministries of health of many countries in the South have to navigate a verily maze in today's health governance. It is almost impossible to make a national health ministry accountable if it has to deal with dozens of private and international actors all pursuing their own interests. Similar problems afflict the WHO at the international level.

In order to stop wasting of resources, avoid duplications of activities, and support national ownership publicly mandated institutions have to be strengthened. It is encouraging that the debate on governance reform has intensively commenced. Ministries of health and the WHO have to get back into the 'driver's seat'. Only if mandated institutions serve as leading and coordinating authorities they can be made accountable: accountable, for example, for introducing financial risk protection schemes.

Enhancing financial risk protection

Financial risk protection means that the major source of health funding comes from prepaid and pooled resources rather than from fees and payments at the point of service. Universal coverage will only be possible if direct payments are progressively replaced by prepayment schemes. The most effective prepayment systems are tax-borne public health systems (e.g. UK, Scandinavian countries, Canada, Brazil, and Thailand) and legally binding, mandatory and universal social health insurance (SHI) systems (e.g. Austria, Belgium, France, Germany, Korea, and Costa Rica). Tax revenue and social-health-insurance contributions represent two forms of prepayment for health.

There is a long-standing debate about the advantages and disadvantages of the two public healthcare systems. It is obvious that tax-based systems ensure universal population coverage and tend to be more adequate for countries with a population share of informal-sector workers and poor who are unable to pay contributions on

a regular basis. However, fairness of financing is directly related to the effectiveness and progressiveness of the tax system. SHI systems have the potential to safeguard progressive financing for health but face major challenges for expanding social protection to the whole population; they may be better for wealthier countries since the funds collected through SHI schemes are earmarked for health and cannot be misused for other purposes in case of budget constraints.

Besides tax-based systems and SHI plans there are other options, such as private health insurance and health saving accounts (HSA) as individual saving plans for healthcare. With respect to achieving universal coverage such savings accounts are counterproductive and run contrary to the idea of health as a public good. They undermine social cohesion because they do not provide any risk sharing or redistribution. Instead of private insurance or savings, effective financing for health requires pooling funds and sharing risks.

Setting up pooled funds

Both tax-based health systems and social insurance schemes work on the basis of pooled funds. At its best, pooling of funds comprises all citizens of a country and is therefore large enough to cover the risks of all members. The smaller a pool, the more limited the funds available for healthcare and the more difficult to cover all risks. Only a sufficiently large number of contributing fund members can ensure all services needed and especially expensive treatments of some people.

Latest through its World Health Report on 'Health Systems Financing' WHO (2010) has established a more meaningful concept of universal coverage than ever. The concept of universality goes beyond mere population coverage and defines three dimensions that have to be reasonably met for achieving universal coverage: The question is not any longer only to expand the number of people covered; social health protection also requires expanding the scope of services and reducing out-of-pocket costs.

Different from ILO's Social Protection Floor WHO does not speak about some coverage or basic protection. It rather urges all states to do their utmost to set up pooled funds in order to provide equal access for everybody as an important step towards fully realising the right to health. Duty bearers, states, and all other stakeholders are required to present strategies and corresponding plans of action that allow to pave the way towards the overarching goal of universal coverage. The ultimate objective should be that all citizens of a country enjoy social health protection, with a comprehensive service package and without any extra payments. In the current debate such a vision seems to be utopian - but it is achievable by reactivating the concept of solidarity.

The principle of solidarity

Since everywhere in the world a certain population share is always too poor and/or too ill to sufficiently contribute to pooled funds for covering their own health needs, universal coverage requires the presence of a permanent and institutionalised system of risk sharing and redistribution. Poorer society members have to be subsidised by the better off who can afford higher prepayments for health. Effectively operationalising the principle of solidarity is perhaps the most important key to implementing a universal and fair healthcare system.

It does not matter whether a system is tax-financed or based on SHI contributions. Both are social funding mechanisms guaranteeing that even members who are not in a position to contribute at all will receive the same services as all the others members when they need them. While individual contributions in terms of taxes or in-

surance contributions depend on people's ability to pay, entitlement to and claiming of services is only determined by need. It is the principle of solidarity that disconnects access to health care from individual purchasing power. To make this happen, the wealthier have to subsidise the poorer, younger the elderly, and economically active children and pensioners.

It has to be pointed out that the principle of solidarity goes far beyond the usual understanding of solidarity as expression of empathy and charity. The principle of solidarity relies rather on institutionalising socially fair burden sharing and redistribution. 'Social infrastructure' of societies is fundamental and needs to be publicly regulated and funded like the hard infrastructure such as transportation, energy, administration, law enforcement, police, etc.. The term 'social infrastructure' stands for an ensemble of public goods including effective healthcare provision, proper education systems, social protection schemes, food security, and others. It refers to social institutions that are essential for the social cohesion of societies and should therefore be accessible to everybody, regardless of individual wealth and purchasing power. Otherwise societies run the risk of collapsing if they do not protect healthy relationships among their citizens and fair burden sharing. This is impossible to achieve without mandatory contributions since otherwise the rich will opt out. All over the globe business corporations tend to evade taxes (TUC 2008: 4ff) and the rich prefer private insurance. In order to generate sufficient funding for covering the needs of all citizens including the poor requires compulsory contributions to be effectively charged from everybody and especially from the rich.

Innovative funding for health

Proper health care depends on the availability of adequate financial resources. The existing health inequalities can only be reduced by increasing public spending, rather than continuing social cuts. In view of the global poverty affecting one third of the world's population, fiscal policy-making has to refocus on the redistribution of wealth. Even the World Health Report on 'Health Systems Financing' (WHO 2010) favours this radical-sounding idea inviting all WHO member states to introduce new fiscal measures in order to enhance government revenue available for healthcare. Taxation is seen as one of the key policy instruments to widen the fiscal space. As suitable options WHO proposes:

- A special levy on large and profitable companies;
- A levy on currency transactions;
- A financial transaction tax; and
- Taxes on tobacco, unhealthy food, etc. (WHO 2010: 29)

It is remarkable that the report does not mention public-private-partnerships (PPP) as a source of new funding opportunities. Resource generation from private foundations and corporations seems to be attractive for some international donors, but entails serious governance challenges and creates easily conflicts with adequate taxation. Against this background and in view of the need for reliable and fairly financed resources for safeguarding public goods and implementing the right to health for all, the call for tax justice through progressive taxation is back on the political agenda.

Societies should not allow governments to remain inactive just given the assertion that there are no or insufficient resources. In order to properly respond to the social needs of their populations, they have to be encouraged to widen the fiscal space. If the call for health as a common good in collective responsibility is not just dealing with nice words, health needs to be essentially seen in the context of adequate financing.

However, some of the poorest countries will not be able to raise sufficient funds to meet all the health needs even if their governments show the

political will for change and try to activate the necessary resources. Maybe because the domestic economy is too weak or the negative impact of the global economy too strong they fail to balance needs with capacities. In these countries governments have limited ability to collect taxes or SHI contributions because people simply are poor or working in the informal sector. As mentioned above, only eight out of 49 low-income countries will be able to finance the required level of services from domestic resources alone until 2015. In 2001 the WHO Commission on Macroeconomics and Health (CMH) estimated that even a very basic set of services for prevention and treatment would cost more than US$ 34 per person and year - but 31 countries spend less than US$ 35 per capita on health (Xu et al. 2007: 979).

Globalising the principle of solidarity

To bridge the existent gaps in the globalised world, an international financing mechanism for pooling and sharing risks at global level is required. For applying the principle of solidarity at international level rich countries will have to be forced to share the financial burden of poor countries and to contribute to their health budgets. The Universal Declaration of Human Rights provides the legal foundation for such obligations. Paragraph 28 states that everyone is entitled to a social and international order in which the rights and freedoms that are set forth in this Declaration can be fully realised. “The existing international institutional order fails this test, it aggravates extreme poverty”, says the Yale philosopher Thomas Pogge (2008: 3): “The rich countries (are) violating human rights when they, in collaboration with Southern elites, impose a global institutional order under which, foreseeably and avoidably, hundreds of millions cannot attain ‘a standard of living adequate for the health and well-being of himself and of his family (§ 25)’.” (cf. also Pogge: Are We Violating the Human Rights of the World’s Poor? in this reader: 60-76).

From a human-rights perspective, establishing a global institution for correcting the undesired effects of the current global order by redistributing wealth and health-related resources is not a matter of nice-to-have, but an obligation. Such an institution would have to manage two main tasks: Organise fair burden sharing between the countries providing the resources and ensure the proper use of funds by recipient countries. Such an institution could be seen as “a method to transpose collective entitlements and duties into individual states’ entitlements and duties” (Ooms & Hammonds 2008: 160).

Managing an International Fund for Health does not necessarily require a new big bureaucratic body – another Geneva based health actor with thousands of staff members centrally designing programmes and vertically dominating recipient countries. Gorik Ooms and Rachel Hammonds (2008: 160ff) propose to transform the existing Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) into a Global Health Fund by expanding the mandate from a limited vertical disease approach to horizontal strengthening of national health systems (ibid.). It would also be possible to create a small new authority that completely refrains from any operational activity and is just in charge of running a financial equalisation scheme.

Financial equalisation mechanisms exist at national, regional and even at international levels. They haven been successfully implemented in countries such as Australia, Belgium, Canada, Germany and Brazil. In these countries and elsewhere equalisation works horizontally between regions (federal states, provinces etc.) and are usually based on rather complex calculations taking into account regional tax revenue, demographic patterns, income level and others. Equalisation mechanisms often transfer considerable financial volumes and provide some regions with a relevant share of their overall revenue (see Holst: Implementing the Principle of Solidarity through Financial Equalisation in

this reader: 86-104). Existing evidence shows that interregional financial equalisation might provoke political controversies, but it occurs widely unperceived by the public through fully automatised processes based on adequate data entry by tax authorities (see e.g. BMF 2010).

Comparable schemes exit at supranational levels: the European Social Fund, for example, which was established to balance the needs of the different regions in the European Union and within countries in the context of education, unemployment benefits, and other social services, is currently allocating € 75 billion per year. And beyond regional trade or political agreements there is another remarkable example for an equalisation payment mechanism. It was established as a part of the Universal Postal Union founded in 1874. Back then the national postal authorities agreed on a treaty regulating the financial requirements arising from delivering letters and other postal items beyond national borders. The fee charged in one country has to also cover the due transportation and delivery costs in the destination and potentially in other countries.

Today, hardly anybody is aware of the existence of the Universal Postal Union. However, its set up was a crucial step towards allowing global communication, and it still works. Moreover, the Universal Postal Union proves that the best common goods are those that do their work without causing a fuss. If establishing such an international equalisation payment scheme was possible in the 19th century, why should it not be possible today in the context of global governance for health?

International Fund for Health

The lessons learned in the context of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) show the way to universal coverage. On one side the progress achieved in responding to HIV/AIDS demonstrates the effectiveness of international funding instruments, but it also makes clear that an approach focusing on just three diseases is inadequate to address the problems in the longer term. Ad-hoc success stories like these cannot last unless effective health systems are built up. Long-term results – and experience with the GFATM demonstrates this – require mandatory rather than voluntary contributions: there must be contractually guaranteed funding.

Therefore an International Fund for Health should be firmly based on a legally binding treaty. Both fair burden sharing among the countries that contribute to the fund as well as the claiming of access should be transparently regulated, based on a human rights approach. An international legal agreement could be arranged either by signing a treaty that just covers the global funding aspect or as an additional protocol to a Framework Convention on Global Health (FCGH), as proposed by Larry Gostin et al. (2011: 1f) and the Joint Action and Learning Initiative (JALI).

Obviously an International Fund for Health would change the existing paradigm of international cooperation. One of the most important changes would be the transformation of official development assistance (ODA) from an interest-driven donor-recipient type of aid to a system of cooperation based on entitlements and shared responsibility. Since an International Fund for Health will not operate as a global body implementing vertical health programmes, the use of all transferred funds has to be legally bound by appropriate guidelines and principles. These guidelines already exist. First and foremost the International Covenant of Economic, Social and Cultural Rights plus the General Comments, the Primary Health Care Declaration of the WHO, the concept of universal coverage claiming equal access for all, and other such instruments. Undoubtedly there is sufficient knowledge of how to achieve health for all. And there are already internationally agreed principles. All

what is missing are the institutions to set the knowledge and principles into force.

Financing an International Fund for Health would be feasible since there is enough money available for providing health for all. The World Health Report talks about an annual amount of US$ 60 per capita needed to realise access to appropriate health care in today's poor countries. Below the line the total amount required would still be in the range of what is already promised by high-income countries. The costs to significantly improve health care funding in the least developed world would not exceed the 15 % margin of health out of the 0.7 % goal for ODA. In a perspective of global equity in health - and there is actually no good reason not to claim for equity and fair financing – an average per-capita spending on health in the range of US$ 700-800 would not require generating new funds. US$ 900-1,000 would certainly be a good start to enable all citizen of the world to enjoy health care protection without exceeding total global expenditures for health: In 2010 the world spent US$ 6.5 trillion for health, which amounts to US$ 948 per person and year (WHO 2011: 4).

Promoting the principle of solidarity at international level is not a matter of finding missing resources. It is rather a matter of the political will to create a new institutional norm ensuring that richer countries are mandated to transfer earmarked funds to poorer countries as long as these are lacking adequate fiscal capacity. However, this may raise another concern that has to be taken seriously. How to avoid internationally supplied resources displacing national efforts? In fact, today's international aid quite often implicates the effect that recipient countries reduce the allocation of domestic resources. having a closer look at the facts It is obvious, however, that this attitude is precisely due to the unreliability of today's international aid that prevents countries from allocating more of their own resources.

Setting up a proper health system in poor countries is certainly quite cost intensive. A government that is trying to do this by using international support provided for a short period of time could find itself left behind with unaffordable costs when funding from aboard stops. Under these circumstances countries may prefer not to invest in their healthcare systems. Thus, it is rather the long-term reliability of international co-financing that allows and motivates national planning based on a steady increase of internal resources.[2]

Appropriate utopia

An International Fund for Health may be considered as utopian, but change will not be possible without going beyond pragmatism. Looking to all what is happening in today's world in the name of realism, we see that 'realism' has long proven to be wrong-headed. There is currently a window of opportunity for change, and change can be successful if there is the "desire for change", actively expressed by an engaged international public: By social movements, community organisations, civil society creating a 'countervailing power'. Precisely such a strong public is needed to gain the 'diplomatic space' that allows the negotiation of new norms and the setting up of new institutions.

Globalisation has reached a point where, for the first time ever, signs of a world society are emerging. The creation of an International Health Fund firmly belongs on the political agenda. For the benefit of all in the globalised world, national solidarity institutions such as tax based health systems or mandatory social health insurance schemes will only survive if the principle of solidarity itself becomes globalised. That is the level where self interest meets ethics. ■

[2] Regarding the issue of reliability of international support see also Ooms: Fiscal Space and the Importance of Long Term Reliability of International Co-financing in this reader: pp. 135-139.

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THE RIGHT TO HEALTH AND HEALTH FINANCING

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The right to health

During the last decades, the international community has agreed upon a number of human rights instruments setting out the various principles and norms that constitute fundamental rights. Meanwhile, numerous international human rights instruments clarify and refine specific human rights norms. All states that decide to ratify a human rights convention are thereafter legally bound to the obligations imposed by the convention. The value of international conventions, commitments and recommendations is that they create a framework for a variety of actors to apply different strategies for promoting and protecting human rights. Moreover, international legal instruments convert abstract human rights into enforceable entitlements that are essential for people's wellbeing and welfare.

The right to health is not to be understood as a right to be healthy. At the international level, the right to health refers to the right of everyone to the highest attainable standard of physical and mental health. The highest attainable standard of health requires governments to create the conditions under which everyone can be as healthy as possible. Such conditions range from ensuring the availability, accessibility, acceptability and good quality of health facilities, goods and services to healthy and safe working conditions, adequate housing and nutritious good. Full realization of the right to health is contingent upon the availability of adequate, equitable and sustainable financing for health, at both the domestic and international levels.

The right to health has been articulated in numerous international and regional human rights conventions and treaties and enshrined in national constitutions all over the world. The following Table 1 provides an overview of the most important legal conventions related to health and the right to health.

TABLE 1: INTERNATIONAL CONVENTIONS ENFORCING THE RIGHT TO HEALTH

- WHO Constitution (1948)
- UDHR- Article 25 (1948)
- ICESCR- Article 12

- International Convention on the Elimination of All Forms of Racial Discrimination (Art. 5 (e) (iv) (1965)

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). (Art. 11(1)(f), 12, 14(2)(b) (1979)

- Convention on the Rights of the Child: Art. (24) (1989)

- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families: arts. (28, 43 (e), 45 (c)) 1990

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- Convention on the Rights of Persons with Disabilities: art. 25 (2006)
- The Charter of Fundamental Rights of the European Union (2000)

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is central to achieving and ensuring the right to health at global level. Its Article 12 reflects a comprehensive approach taking into account underlying determinants of health (United Nations 2000):

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall **include** those necessary for:

(a) The provision for the reduction of the stillbirth rate and of infant mortality and **for the healthy development of the child**;

(b) The improvement of **all aspects of environmental and industrial hygiene**;

(c) The **prevention, treatment and control of epidemic, endemic, occupational and other diseases**;

(d) The **creation of conditions**, which would assure to **all medical service and medical attention in the event of sickness**.[6]

In addition to the international instruments mentioned above, a number of other international and regional agreements and instruments exist, such as the Declaration of Alma Ata (1978), the European Social Charter (1961), the African Charter on Human and People's Rights (1981), and the Additional Protocol to the American Convention on HRs in the Area of Economic, Social and Cultural Rights (1988), that refer to the right to health. In General Comment No. 14 (2000), the Committee on Economic, Social and Cultural Rights articulates and elaborates the content of the right to health. The 1st paragraph underpins the high priority of health within human rights: "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realisation of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable" (United Nations 2000). Other agreements address particular health concerns, such as the Declaration of Commitment on HIV/ AIDS, which refers to the global epidemic and recognises "that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations 2001: 3). In addition to constitutional provisions that enshrine the right to health, a broad array of domestic laws creates statutory rights based on the right to health.

The right to health includes both freedoms and entitlements. Freedoms under the right to health include: the right to make health-related decisions free from state interference; the right to be free from medical experimentation and non-consensual testing and treatment; the right to privacy and confidentiality in health-related matters

[6] Highlighted by the author.

and information; and the right to informed consent. Entitlements refer to the availability and accessibility of health facilities, goods and services, a functioning, adequate health system, access to medicines and special provisions for vulnerable groups. The right to health also requires the participation of affected individuals and communities at all levels of health-related decision making, the monitoring of the realisation of the right to health at the national level, and the availability of effective judicial or other appropriate remedies for violations of the right at both national and international levels.

The right to health contains the following interrelated and essential elements: Availability, accessibility, acceptability, and quality. Availability refers to the existence of functioning health facilities, goods and services in sufficient quantity within a state. Accessibility means that health facilities, goods and services must be physically and financially accessible to everyone without discrimination and that people have the right to seek, receive and impart information and ideas concerning health issues. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. In addition to availability, accessibility, acceptability and quality, the right to health also includes the underlying determinants of health, including access to clean water and sanitation, and adequate housing and nutrition. Alongside these material determinants, the right to health includes social determinants such as poverty, inequality, and non-discrimination.

General Comment 14 establishes a series of core obligations:

(a) Right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;

(b) Minimum essential food which is nutritionally adequate and safe;

(c) Basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) Provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) Ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.

International experience shows that universal access ensuring universal access to good quality health facilities, goods and services will be impossible to achieve without public financing. Therefore, implementing adequate health financing systems is a prerequisite to meeting core obligations of the right to health. In practice, many states are unable to immediately meet all of their obligations under right to health obligations due to social, economic or developmental constraints; however, all states are required to meet **core obligations immediately**, such as the obligation to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs. In order to meet these core obligations, States must ensure adequate public financing for health.

At the domestic level, this means that states must prioritise financing for health in national

budgets. The obligation to ensure adequate funds are available for heath and to prioritise health financing is a necessary prerequisite to realisation of nearly every aspect of the right to health and required under States' obligation to make use of maximum available resources to ensure full realisation of the right. In order to make use of maximum available resources, States must therefore take all necessary steps to raise adequate revenue and mobilise resources for health. Budget prioritisation therefore requires states to set aside a significant portion of general government expenditures toward spending on health and to prioritise health along side other core funding commitments, such as spending on education, social security and defence.

States must also ensure the equitable allocation of health funds and resources toward achieving universal access to good quality health facilities, goods and services, in accordance with the principle of non-discrimination and with special attention to the needs of vulnerable or marginalised populations. Equitable allocation of funds and resources for health may be achieved through the pooling of health funds collected through prepayment schemes, wherein individuals contribute according to their ability to pay with exemptions for the very poor. Pooling promotes equitable financing for health by facilitating cross-subsidies from healthy to unhealthy and from wealthy to poor members of the pool and across the life cycles of individual members.

Within the multilateral framework, deficit domestic public funding for health can be met by international cooperation. It is quite clear that for diverse reasons a large number of developing countries (DC) and especially the least developing countries (LDC) are unable to finance the resources required for realising the right to health. Moreover, unidirectional, traditional development assistance by “donors” from wealthy states has not been able to meet the funding needs of DC and LDC states. The international community, and wealthy states in particular, thus has a responsibility to cooperate internationally in order to ensure the availability of sustainable international funding for health. In order to accomplish this, more innovative and efficient international mechanisms are required.

Existing models of international funding

Until the global HIV/AIDS epidemic, international funding based on needs rather than on donor priorities linked with conditions was a pipe dream. The unprecedented crisis in HIV, coupled with a strong community-led HIV movement, however, drove the international community to set up global funding mechanisms for HIV/AIDS. Three primary funds arose from this concerted multilateral effort: GFATM, PEPFAR and UNITAID. These models can be and should be evaluated for developing and implementing international funding mechanisms for ensuring the right to health. One of the most important criteria of the three funds is that financing is driven by needs of the situation and not tied to priorities of the donors.

The President’s Emergency Plan for AIDS Relief (PEPFAR) is the largest fund for global health with a financial volume of up to 4 billion US$. Funding is contingent of use of American goods, services and professionals. The United States of America (US) government has a high level of control over the programme and imposes a series of conditions such as the ban on needle syringe and the prostitution clause, which are undoubtedly counter productive for effectively fighting HIV/AIDS. PEPFAR is a widely medicalised programme with hardly any participation of the affected communities.

The GFATM is a multilateral body that is often seen as squeezing out UN bodies. Some confusion exists as to whether the Global Fund is a development or rather a banking institution. The financial volume managed by the GFATM peeked at approximately 3.5 billion US$ per year but came down to currently 1 billion US$ per year.

Such a significant reduction of overall funding has diminished the Fund's ability to impact global health and damaged one of its core principles concerning of predictability of funding. In order to eliminate inefficient funding, there is a need to refocus funding efforts to ensure that interventions, which have the greatest long-term impact, are prioritised. For example in Asia the GFATM allocates 20 % of its prevention resources in interventions aiming at the most-at-risk population among which 95 % of new infections occur. Moreover, many states want the GFATM to concentrate funding on young people and the general population rather than putting strategic emphasis on male who have sex with male (MSM), intravenous drug users (IDU) or sex workers even though interventions on these especially vulnerable groups are most promising to have impact. In contrast to PEPFAR, however, the GFATM attaches priority importance to transparency and participation of affected communities and private sector involvement is quite low.

UNITAID is an international drug purchase mechanism, established to provide long-term and predictable funding to increase access and reduce costs of quality medicines and diagnostics for the treatment of HIV/AIDS, malaria and tuberculosis in developing countries. UNITAID uses innovative financing methods to fund its operations. A tax on airline tickets levied by some member countries, referred to as the solidarity contribution, accounts for 70% of UNITAID's funding. This is complemented by multi-year contributions from member countries. A mechanism like UNITAID could go beyond its vertical approach towards selected health problems and be extended to the entire health sector. However, if such a mechanism is to play a role in ensuring the right to health at the global level, it depends entirely on the amount and predictability of funding that may be generated.

A first step towards tackling the challenges for implementing international health financing mechanisms and global social protection would be to critically analyse and evaluate the successes of and challenges faced by PEPFAR, GFATM, and UNITAID. In addition to adequate and sustainable funding, in order to realise the right to health globally, global health financing mechanisms must not attach conditionalities to the receipt of funds, their governance must be open and transparent, and all operations must be based on the participation of affected communities and civil society. Moreover, calculations of the resources required for strengthening health systems and providing basic health services in 49 low-income countries, calculated at 47 US$ per capita, must be reassessed (WHO 2009: 3).

The manner in which global funding mechanisms collect, manage and allocate funds is another key concern. These processes must be based on notions of fairness and solidarity: countries should contribute according to their ability to pay and funds should be allocated according to need. A number of ways to raise funds exist, including innovative financing mechanisms such as the airline tax discussed above.

At the moment, global funding for health in DC and especially LDC states depends to a large extent on the charitable impulses of the developed nations; there is no legal mechanism and thus no obligation in place to enforce contributions at the global level. An international agreement which lays the foundation for ensuring adequate and sustainable funding for global health is needed to address this deficit and facilitate international cooperation toward realising the right to health globally.

In order to shift the global paradigm of international assistance for health from a donor-based charity regime toward an obligatory system based on the principle of solidarity, global pooling mechanisms should be founded upon international or regional treaties under which states incur legal obligations to contribute to the pool according to their ability to pay and through

which funds are allocated based upon need. Such a shift is necessary in order to ensure sustainable international funding as required by the right to health. Toward this end, the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI), comprising a number of leading global health advocates, was established to seek international consensus around broadly imagined global health governance to meet the needs of the world's least healthy people and close unconscionable health gaps between the global rich and poor. JALI's key purpose is to explore the possibility of a Framework Convention on Global Health as a potential key strategy for supporting social move- ments around the world that are advocating for the full implementation of the human right to health. This objective is one worth fighting for. ■

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THREE AND A HALF ARGUMENTS FOR GLOBAL SOCIAL PROTECTION FOR HEALTH (A PERSONAL STORY)

GORIK OOMS[7]

Abstract

In this paper, I will try to give an overview of my main arguments for global social protection, and at the same time relate those arguments to some important events in my personal life. This is not what academics are expected to do, but this is not a purely academic publication.

My first argument is purely humanitarian – it is about saving lives. In 2000, in Mozambique, the Médecins Sans Frontières team I was leading and the Ministry of Health (MoH) were not able to save the lives of children with AIDS, because of an ideological belief: the belief that open-ended solidarity across borders – comparable to the open-ended solidarity we practice within countries – is wrong, that states must be or become financially autonomous, and that health-promoting efforts should therefore not cost more than what a country can afford without becoming dependent on assistance. This belief still kills millions of people every year. If global social protection for health, based on redistribution of income that is as reliable as it is within countries, would replace 'development assistance' as we know it, those lives could be saved.

My second argument is about human rights, about the right to health in particular. The international treaties may not as clear as they should be, and they may focus too much on national responsibility, which results in the right to health being quite different depending on the country one lives in. But they also conform that health is a human right; that every human being should have access to water, food, and essential health care; and that this a responsibility of humanity towards humanity. If access to water, food, and essential health care were not a responsibility of humanity towards humanity, health would not be a human right, but a privilege, for people born in the 'right' countries. This became the core argument of my doctoral thesis.

My next argument is about justice – it is not fundamentally different from the argument about the right to health, and therefore it only counts as half. Having appointed me as a 'Global Justice Fellow' at Yale, Thomas Pogge challenged me to explore why health is a human right, regardless to the treaties, as a matter of justice. My first answer is that human rights are translations of a pre-historical natural sense of justice, which demanded that members of a tribe acted as partners worthy of cooperation, and allowed each other to be partners – 'to allow' understood passively, but also actively, as in providing an allowance. Supporting each other in being or becoming healthy is an essential part of that, and it cannot be confined within country borders. My second answer is that within a free market mechanism, people may harm each other without knowing it, and without intention, because

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of 'bad inequality': the kind of inequality that allows the privileged to preserve their privileged positions. Social protection is a correction to that – a kind of insurance against unintended harm doing. As bad inequality works beyond borders, social protection should correct beyond borders too.

My third argument is about enlightened self-interest, from the perspective of the inhabitant of a high-income country. While I was looking for illustrations of increasing inequality between countries, what I found was increasing inequality within countries. Bad inequality is still working, not as much between countries – making rich countries richer and poor countries poorer – as it used to be, more between clans of people. The correction (social protection) is being eroded, because it is organised per country, and governments are obliged to adjust to the lower taxation and social protection standards of their neighbours. Social protection is succumbing to a kind of 'tragedy of the commons'; it will take cooperation and harmonisation between countries to protect it within countries.

FIG. 1: MULTI-LAYERED GLOBAL SOCIAL PROTECTION

Conclusion: global social protection is the logical next step in the geographical expansion of mutual support systems – from tribes to cities, and from cities to countries, and from countries to the planet. From Doctors Without Borders to Social Protection Beyond Borders requires only an incremental change.

Introduction

The first time I heard about the idea of global social protection was in a rather dramatic brainstorming session about AIDS treatment in Mozambique in 2000. (Many years later, I found out that Abram de Swaan (1994) had suggested it even earlier.) It was the medical coordinator of our Doctors Without Borders or Médecins Sans Frontières (MSF) team, Piet Corijn, who came up with it. The idea has never left my mind since then; gradually it became the essence of my work.

Over the years, my reasons for promoting global social protection have evolved, expanded and matured. Most of them have been published, but not in a coherent way. This reader gives me an opportunity to briefly describe three and a half arguments, with references to the papers where they are published in greater detail.

To be clear, our proposal is not to create a global social protection scheme that would replace national schemes, only to add a layer. Social protection schemes are not monolithic blocs. For example, the average inhabitant of a member state of the European Union pays taxes and participates in social protection at the level of the city he or she lives in. In many European Union member states, there are taxes at sub-national levels ('communities' or 'regions' in Belgium; 'Länder' in Germany). The largest amount of tax is levied at the national level. Finally, all member states of the European Union contribute financially to the running of the European Union, which now contains some mutual social protection, albeit very modest (cf Holst: Implementing the So-

lidarity Principle through Financial Equalisation in this reader: 86-104). Within the United States of America, the situation is similar. Most people pay taxes at the municipal level, i. e. to the city in which they live, at county level, at the state level (e.g. as income tax or sales tax) and then at the federal level. The idea is not to replace all of that with a single global scheme but to add a relatively modest global layer, as the illustration expresses.

First argument: global social protection for health is a humanitarian duty

If there is a single moment that defined the rest of my life, it would be the moment when I was told that out of about 40 children we – the MSF team, supporting the MoH – were treating for malnutrition in Chokwe, Mozambique, one did not have AIDS. The town of Chokwe had been flooded in February 2000. People lost their homes, harvests and reserves, and relied on food distributions. These food distributions are never perfect; there always is a group of households that will be excluded because they are not duly registered, for example. And some of these excluded households will wait until one or more of their children are extremely malnourished before seeking medical assistance. That is why setting up a therapeutic feeding centre is one of the standard responses after disasters like floods. The children receive the specialised and fortified milk or dairy products they need, and the families are included in food distributions.

It also is one of the most rewarding interventions: a series of Lazarus-like 'miracles' can be expected. When the children arrive they are weak and silent, as if they are just waiting to die. A few weeks later, they can leave, smiling, cheerful and making all sorts of noise. And we had our series of 'miracles' in Chokwe. But not enough. Some children did not get better. They remained weak and silent, they had diarrhoea, and too many died. After a month or three, we should have been able to close the centre: the households that had been excluded from the food distribution schemes should have been included by then, and the severely malnourished children should have recuperated. It did not make any sense. Then someone suggested that many of these children probably had AIDS, and that they were not malnourished because of the floods and the destroyed harvest, but because they had chronic diarrhoea – no matter how much they ate or drank, they would not recuperate.

Bringing up the hypothesis created a dilemma in itself. We had already discussed with the MoH the possibility of providing antiretroviral treatment and the answer was negative. The MoH did not want a foreign organisation to introduce a level of health care that it would not be able to continue or replicate, and in May 2000, we were still talking about a cost of US$2,000 per person per year. (None of the antiretroviral medicines we needed were patent-protected in Mozambique, but even the generic versions were expensive; the offer from CIPLA – an Indian manufacturer of generic medicines – of a 'cocktail' at US$1 per day came a year later.) And several 'donors' – I'll explain later why they are not really donors – had made it clear they would not support AIDS treatment. If we tested children and they turned out to be HIV positive, we had nothing to offer them except some palliative care, so why would we test them at all? To satisfy our curiosity? But if they really had AIDS, they would have gotten it from their mothers – who could have been HIV positive without having developed full-blown AIDS yet – and some of their siblings would probably be HIV positive too. In that case, keeping the children and their mothers in a feeding centre seemed a cruel thing to do. Eventually, we agreed with the MoH to do 'anonymous and unlinked' tests, meaning that blood samples were taken without any code that could link them to the individual children they were taken from, so we would know how many children were HIV positive, but we would not know

which children were and which ones were not. (Anonymous and unlinked testing was pretty uncontroversial at that time; that is no longer the case, and for good reasons (Rennie et al. 2009).)

I was in the feeding centre when the results came back: only one of the children was not HIV positive. It was worse than expected, and we had already decided beforehand – after heated discussions – what our reaction would be: to send all children home to die as peacefully as possible. That was not a consensual decision; some of our team members wanted to keep the children there, and start making a video documentary with the title 'World, Watch Them Die', or something similar. The whole situation was absurd: a few months earlier, 'donor' representatives had been willing to hire helicopters for rescue operations at ridiculously expensive prices – US$ 2,000 per hour or more. (If my memory is correct, one of our helicopters had come all the way from Bulgaria, because that was cheaper.) The very same people who had been willing to pay for that were now refusing to finance treatment at US$ 2,000 per year, for the very same children they had saved at US$ 2,000 per hour. I made a few phone calls to the MoH and to some of these 'donor' representatives, but they had not changed their minds. And then I watched mothers gathering their stuff, picking up their children, and going home silently – accepting their horrible fate.

It was not the first time I was confronted with this apparent contradiction between the 'exuberance' of relief and the stinginess of development assistance, provided by the same institutions. It is all about sustainability. If you want interventions to be sustainable, the countries where you want to have these interventions should be able to continue them with their own funding, at least in the long run – or so the theory goes. So you should not provide AIDS treatment in a country that has no real perspective of becoming wealthy enough, fast enough, to take over the financing. In a crisis situation, however, you can ignore sustainability, because the crisis is temporary by definition. It does not matter that the Government of Mozambique cannot afford helicopters for rescue operations, because we are assuming – wrongly, in all probability – that the floods will not return. It is not an entirely senseless theory. If we want to avoid some countries becoming dependent on others, international assistance should be limited, in volume or in time.

That is the pleasant narrative about the contradiction between emergency relief and development assistance: the international community is aiming for countries' autonomy, or emancipation. It is supported by many people and organizations; even people who strongly support increasing taxation as a matter of solidarity (between people within the same country) seem to object to long-term reliance on solidarity across national borders. For example, a senior political advisor at Christian Aid recently argued that the UK development secretary "must uphold UK aid spending while devising an exit strategy" and encourage developing countries to increase tax revenue to make aid redundant (Oyuela 2012). The less pleasant narrative is that international assistance is essentially charity, given by people and their representatives who feel that they do not 'owe' assistance to others who live in different countries. They are generous, but feel they should be allowed to end their generosity at any time.

In 2006, I wrote an article about this contradiction between emergency relief and development assistance (Ooms 2006). In Mozambique, in 2000, our pressing concern was not to examine or expose the contradiction, but to overcome it. Those were the circumstances in which our medical coordinator compared international assistance at the beginning of the 21st century with national assistance at the end of the 19th century: charitable, and therefore unreliable, and therefore not quite as useful as the same

amount of money could be, if given out of solidarity. And therefore, he argued, we should advocate in favour of global social protection.

We did not, I must admit; MSF did not take up advocacy for global social protection. We took the path we knew best; we called the epidemic of AIDS a global emergency and a humanitarian crisis, we called for relief, not for a better version of development assistance. It was a humanitarian crisis, we argued, and we got relief: for example, PEPFAR – the USA President's Emergency Plan for AIDS Relief that was launched by the end of 2002 – had both 'emergency' and 'relief' in its name. And we should not be ashamed of millions of people living many years longer because of a massive and unprecedented relief response; this also means millions of children becoming orphans at an older age. But in hindsight, we could have 'used' the AIDS epidemic to illustrate the failure of development assistance and to call for a better version of it; one based on solidarity, not charity. Perhaps it is not too late.

To be sure, calling for global social protection instead of development assistance, as we know it is not essentially about the volume of transfers – although the volume of transfers would definitely increase if development assistance became global social protection. It is essentially about accepting that people owe support to each other, within countries and beyond the borders of countries, as a matter of solidarity, not charity. And this is not a semantic discussion: assistance that is reliable in the long run can do things that unreliable assistance cannot do. For example, if you are an MoH staff member of a low-income country and you receive a grant of US$ 50,000, you could buy an ambulance or you could hire 50 nurses for a year. If you know the grant will be continued year after year, you will do better to hire 50 nurses, as they will save a lot more lives than an ambulance. But if you think the grant will not be repeated, you had better buy the ambulance, as it will not protest if it is 'fired' next year. As explained in a shorter technical paper for this reader, unreliability of international assistance in the long run is probably the most underestimated problem of international assistance (cf. Ooms: Fiscal Space and the Importance of Long Term Reliability of International Co-financing in this reader: 135-139).

Second argument: global social protection for health is required to realise the human right to health

In 2001, the attitude of the international community towards the epidemic of HIV/AIDS changed quite dramatically. The most notorious manifestation of this change was the 'Special Session on HIV/AIDS' of the General Assembly of the United Nations, better known as UNGASS (United Nations General Assembly Special Session), which ushered in the so-called 'Declaration of Commitment' (United Nations General Assembly 2001). It called the HIV/AIDS epidemic "a global emergency", and will be remembered for creating what became the Global Fund to fight AIDS, Tuberculosis and Malaria – or, as worded in the Declaration, for supporting "the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment." This was approved by the very same governments whose representatives had decided – 12 months earlier – to refuse treatment to the children with AIDS in Chokwe.

What had happened? In Mozambique, we were so happy about having a prospect of providing AIDS treatment that the question about the U-turn did not really matter. As the whole Declaration was engendering a sense of emergency, I could not help being worried, as I knew from experience that the international community's attention for emergencies can be as intense as it is short-lived. What if, after a couple of years, the international community once again felt the

same way as it did 12 months before the Declaration? Would we stop treating people? Even then, our medical team members argued, a few years of treatment is better than no treatment at all.

Furthermore, AIDS was not our only concern. In the north of the country we were running a project that provided training to traditional birth attendants; the results were disappointing and many of our team felt that we should focus on hospital-based emergency obstetric care, which required ambulances and a communication system between health centres. This was expensive – indeed, it was considered too expensive for Mozambique – but not quite as expensive as AIDS treatment. And there was a general problem with user fees to be paid by people needing healthcare; we knew that they excluded many people. It was unimaginable that people would be asked to pay for AIDS treatment – even if the fees were only a fraction of the real cost, it would cause people to discontinue their treatment as soon as they felt better. In a nutshell, it did not seem fair that caesarean sections would not become available in places where AIDS treatment was, or that people would have to pay for malaria treatment but not for AIDS treatment.

The Declaration of Commitment on HIV/AIDS not only referred to the 'global emergency' but also contained several references to human rights, and the right to health in particular. For example, it mentioned that "access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." But surely, that was equally valid for other essential medicines as for emergency obstetric care. If taken seriously, it also required ensuring that nobody would be excluded from healthcare merely because they were unable to pay the user fees.

This reference to the right to health seemed promising, as it could provide a basis for reliable international assistance: not temporarily, as long as richer countries' governments felt like it, but for as long as was necessary to realise the right to health. And it would apply to health in general, not to AIDS only. But there was something disingenuous about this statement, or so I felt. From my university days – I am a lawyer – I remembered that human rights define minimum levels of acceptable relationships between governments and the people under their jurisdiction; human rights are about what your government cannot do to you, or what it must do for you. They are not about what governments cannot do or should do for people living elsewhere, or so I remembered. And therefore it did not solve our problems in Mozambique, as it was too poor – and no person (or institution or government) can be obliged to do something it is unable to do.

So your human rights entitlements depend on what your government is able to do: if you happen to live in a wealthy country, your human rights entitlements are larger than they would be if you would live in a poorer country. That is what the reference to "achieve progressively the full realisation" in the Declaration of Commitment means. Surely, if you need AIDS treatment, it is an essential element of your right to health – your right to the enjoyment of the highest attainable standard of physical and mental health, as the International Covenant on Economic, Social and Cultural Rights defined it. But only if your government can afford it …

When I was reading the Declaration of Commitment for the first time, I remember how I had disliked – as a student – this concept of progressive realization. If human rights are truly human rights, rights one has because of being a human being, they should not depend on the wealth of the country one lives in. Imagine that slavery would be illegal only in countries where the circumstances permitted the abolition of slavery. But if that is what the international treaties pres-

cribe, a United Nations' declaration should not suggest otherwise – or it should improve the treaties.

So I decided to refresh my memory. I vaguely remembered that the International Covenant on Economic, Social and Cultural Rights refers to international assistance as a means to hasten the progressive realisation, and I easily found it, in article 2(1) of the Covenant: "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant." (United Nations Commissioner on Human Rights 1966). But it was easier to find than to understand. Does it mean that states have obligations to realise these rights for 'their' people, and to seek international assistance if they need it? Or does it mean that states have an obligation to realise these rights for all people, directly for their own inhabitants, and through international assistance for everyone else? If the latter interpretation was the correct one, then on what grounds would governments prioritise their inhabitants? Or shouldn't they; should they support the rights of all people equally? That latter – very egalitarian – interpretation was attractive, but not quite realistic; I could not imagine the people of Belgium – the country I am from – agreeing to share all their tax contributions with the entire world.

I then looked up the most recent 'concluding observations' about Belgium. For the readers who are not familiar with the role of the Committee on Economic, Social and Cultural Rights, that committee was created to monitor how states that have ratified the International Covenant are progressing (or not). These states write periodic reports and the Committee makes observations about the reports. The most recent I could find in 2001 were the concluding observations from November 2000, in which the Committee "notes with concern that, in 1998, Belgium devoted only 0.35 per cent of its gross domestic product (GDP) to international cooperation, while the United Nations recommendation in this regard is 0.7 per cent of GDP for industrialised countries." (Committee on Economic, Social and Cultural Rights 2000). Obviously, with 0.7 per cent of GDP, Belgium – or even all high-income countries together – could never attain in the rest of the world the same level of realisation of the right to health as at home; thus the Committee did not support the egalitarian interpretation of article 2(1). But if the other interpretation were correct – the one according to which states needing assistance have an obligation to seek assistance, while states that can provide assistance do not really have any obligation to do so – the 0.7 per cent recommendation was based on no substantial legal argument.

The Committee on Economic, Social and Cultural Rights does not only issue 'concluding observations' as explained above, but also writes 'general comments' on issues arising from the Covenant, which are somewhat authoritative interpretations. One of the first such comments – General Comment 3, issued in 1990 – was about "the nature of States parties' obligations". There I found this: "The Committee notes that the phrase "to the maximum of its available resources" was intended by the drafters of the Covenant to refer to both the resources existing within a State and those available from the international community through international cooperation and assistance." (Committee on Economic, Social and Cultural Rights 1990). But what does "those available from the international community" mean: those that happen to be available because of decisions voluntarily made by some wealthier states, or those that should be available because of legal obligations? This was not particularly helpful.

More helpful, in my opinion, was the comment – still in General Comment 3 of 1990 – about core obligations: "the Committee is of the view that a

minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party". This idea was further developed in subsequent general comments, including in General Comment 14 of 2000 about the right to health (Committee on Economic, Social and Cultural Rights 2000). General Comment 14 affirmed once again the idea I disliked as a student (and still dislike, by the way) – which is that social human rights are 'movable' and depend on the wealth of the state one happens to live in – in paragraph 9: "The notion of "the highest attainable standard of health" … takes into account both the individual's biological and socio-economic preconditions and a State's available resources." So, bad luck if you live in a poor country! But it also affirmed and described, in paragraphs 43 and 44, core obligations and "obligations of comparable priority".

The idea is that every human right, even though its full realisation depends on circumstances, has a core content that cannot be made dependent on circumstances, otherwise the right to health itself would be meaningless. For example, if in a particular country there are severe tensions between two different ethnic groups, the government could outlaw all public statements accusing groups of having certain characteristics – statements like "all these people are thieves" – and that could be an acceptable limitation of the freedom of speech. Depending on the circumstances, the Convention on the Prevention and Punishment of the Crime of Genocide would even oblige governments to take such measures. But if it were accepted that circumstances can justify criminalising any related critique of the government – statements like "our government is not dealing properly with theft" – then the right itself becomes meaningless.

There must be a core content of every human right: if there is not, then human rights are not really human rights but human privileges for those living under the adequate circumstances. And if there is a core content of every human right, there are corresponding core obligations. With regard to the right to food, the Committee defined the core content of that right as "availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture" (Committee on Economic, Social and Cultural Rights 1999); or in other words: whatever it takes to avoid starvation. If food is a human right, then every human being should at least have access to enough food to avoid starvation. (We know that this is not a reality yet, but there is a big difference between taking notice of a reality and qualifying a reality as justifiable because of circumstances. Even in the face of widespread slavery, one could affirm freedom from slavery as a human right.)

What would the core content of the right to health look like? Analogical to the right to food and avoiding starvation, the right to health could include whatever it takes to avoid… avoidable serious disease or death. That may have been the approach used by the Committee on Economic, Social and Cultural Rights (2000: 13) when it described the core obligations arising from the right to health:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population;
…

Each of these core obligations would, if unfulfilled, lead to avoidable serious disease or death. Of course, even if or where these obligations are fulfilled, people will still become sick and die, but the core obligations are about addressing the relatively easily avoidable causes of disease or death: providing water, food, sanitation, and primary health care. One could argue that according to these criteria, even the most expensive medicine or medical intervention that is life saving for a very limited number of people only is to be considered as being included in the core content of the right to health. But the reference to "essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs" cleverly avoids the problem, as the World Health Organization (WHO) provides a regularly updated 'model list', considering "minimum medicine needs for a basic health_care system, listing the most efficacious, safe and cost_effective medicines for priority conditions" (World Health Organization 2012).

Back in 2001, when the Declaration of Commitment on HIV/AIDS mentioned that "access to medication" is one of the fundamental elements of the right to health, the medication needed to treat AIDS still wasn't on the WHO Model List of Essential Medicines – it was included in 2002 (World Health Organization 2002), and MSF played an important role in making that happen. So when I received the Declaration of Commitment on HIV/AIDS in October 2001, I already knew that these medicines would be included in the Model List, and that access to these medicines would therefore be part of the core content of the right to health. By then, the cost had dropped to $ 365 per patient per year – in countries like Mozambique where generic versions were allowed, that was. But that still didn't fit into the budget of the Ministry of Health, which was about US$ 10 per inhabitant per year. Not everyone in Mozambique needed AIDS treatment. Given the adult HIV prevalence rate estimated at 15 per cent, we estimated that up to 30 per cent of the population would need AIDS treatment. (When you start providing effective AIDS treatment, HIV prevalence goes up simply because many HIV positive people who would have died no longer do.) Assuming that the cost of basic AIDS treatment would go down to US$ 100 per patient per year in the long run – which did happen – we still needed a budget of US$ 30 per inhabitant per year. Human right or not, core obligation or not, the Government of Mozambique could not afford it. But in its General Comment 14 of 2000 about the right to health, the Committee also clarified, in paragraph 45, that "it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" which enable developing countries to fulfil their core and other obligations." That made sense: a core content of the right to health, to which all human beings are entitled, and for which all human beings should support each other – through national and international solidarity.

And that meant that international assistance as we know it – essentially charity – is not good enough. We need reliable financial transfers within countries and between countries.

Although I wrote an opinion paper for a Belgian newspaper about the right to health and how it would lead to global social protection in December 2001, it took me until December 2006 before I wrote it as an academic paper, with Katharine Derderian and David Melody (Ooms et al. 2006). This argument became the cornerstone of my doctoral thesis (Ooms 2008), and, with Rachel Hammonds (Ooms &, Hammonds 2010), we

used it in an article taking up a challenge launched by Norman Daniels – who reasoned along the lines of the content of the right to health being limited by the resources available at the national level, but who, at the same time, judged "Strongly Statist Versions of Relational Justice" to be deeply unsatisfactory (Daniels N 2008).

When I finalised my doctoral thesis, the interpretation according to which states have obligations to provide assistance to other states – or to people living in other states – was still quite controversial. But in September 2011, at a gathering convened by Maastricht University and the International Commission of Jurists, a group of experts in international law and human rights adopted the 'Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights'. These principles confirm the existence of an obligation to provide international assistance, as part of a wider obligation of international cooperation (Group of experts 2011). As one of the members of that group, I felt as if we had competed a new logic that had started with General Comment 14 about the right to health of 2000, and that had become a reality with the Declaration of Commitment on HIV/AIDS of 2001 – a reality only for HIV/AIDS, however. The Global Fund to fight AIDS, Tuberculosis and Malaria was (and still is), in my opinion, the embryonic version of a global social protection scheme. To implement the Maastricht Principles on Extraterritorial Obligations a much more solid and wider global social protection scheme would be needed – building on the Global Fund, or something else.

Additional half argument: global social protection for health is a matter of global social justice

During my third year as executive director of MSF Belgium, in 2006, I started writing about the humanitarian and human rights arguments that are explained above. Professor Marleen Temmerman of the University of Ghent – a friend of our family who had helped my wife deliver both of our children – encouraged me to work on a doctoral thesis. I was not exactly bored in my job, but a bit frustrated – it felt as if I was creating an environment for everyone else to be innovative and creative, while not having time left to do any creative thinking myself. So I accepted Marleen's challenge, and obtained my 'Doctor of Philosophy' title in 2008.

One of the chapters that did not make it into my final thesis was about global justice. In 2003, James Orbinski, the former international president of MSF (who accepted the Nobel Peace Prize in 1999), had introduced me to Thomas Pogge – to the philosopher and to his thinking. Pogge's arguments seemed very close to the ones I was working on, but on a deeper level. When the time came to finalise my thesis, I had still not mastered the philosophical arguments well enough and left that chapter out.

In 2009, Pogge invited me to be the 'Global Justice Fellow' at the Whitney and Betty MacMillan Center for International and Area Studies at Yale, for the 2009-2010 year – an opportunity I could not refuse. Pogge's arguments are influenced by John Rawls' 'Theory of Justice' and Rawls' ideas about 'distributive justice' in particular, but Rawls himself had rejected the application of his theory at the international level suggested by Pogge. That reminded me of the paradoxical attitude (in my opinion) of many people involved in international assistance who seem to feel that solidarity within a country is something good while solidarity across borders is deeply problematic or even wrong. So this was a good opportunity to try and understand Rawls, and indirectly all those people who – with the best of intentions – argue against international solidarity in the long run.

On my arrival at Yale, Pogge asked me why I believed that health is a human right, and what that meant. My answer, as a lawyer, was simple:

health is a human right because there are human rights treaties in which health is mentioned as a human right, and what that means is mentioned – to some extent at least – in the treaties too. "So," I remember Pogge asking, "before the treaties were signed, health was not a human right?" After a year of chewing on that bone, I came up with two answers. Both of them were inspired by Rawls. Rawls became famous for his thought experiment known as 'the veil of ignorance'. It was intended to illustrate a way to identify "the principles that free and rational persons concerned to further their own interest would accept in an initial position of equality as defining the fundamental terms of their association" (Rawls 1999: 10.) – if you can find the principles these people would have adopted when designing their ideal society without knowing which positions of this society they would occupy, i.e. from behind 'a veil of ignorance', then you have the principles of a just society. In itself, this thought experiment never really convinced me, I must admit. But it is essentially a metaphor that unites several other concepts of justice, of which two are particularly enlightening, in my opinion. The first is about justice as fair and therefore stable cooperation. Simply put: a society should try to be a fair system of cooperation (Rawls 2005: 11); if the terms of cooperation are felt to be unjust by many participants, the cooperation will not work efficiently. So if a society is just it will be an efficient cooperation, and if it is not an efficient cooperation, it probably isn't just – a bit like the proof of the pudding being in the eating.

The second is about justice as doing no harm to each other – the idea at the core of Pogge's work, which Rawls may have rejected as too simplistic, but which shines through the cracks of his more sophisticated arguments. For example, when Rawls argues that "background institutions of justice must work to keep property and wealth evenly enough shared over time to preserve the fair value of the political liberties and fair equality of opportunity over generations" (Rawls 2003: 51), he is essentially arguing that wealth being distributed 'too unevenly' is a threat to equality of opportunity. Those who have too much wealth are harming others. Branko Milanovic, calls this 'bad inequality' or inequality that "provides the means to preserve acquired positions", as opposed to 'good inequality' or inequality that "is needed to create incentives for people to study, work hard, or start risky entrepreneurial projects" (Milanovic 2005: 12).

My first answer to Pogge was about justice as fair and stable cooperation, and inspired by the science of natural evolution – I prefer not to use the expression evolutionary theory. The science of natural evolution explains why human beings are inclined to observe limitations when they harm each other for their own interests, like fighting for food, and are also inclined to support the other who needs support to remain a valid member of the group. These are inclinations that allow the individual to thrive within a cooperative group. Readers who are familiar with the science of natural evolution may think I succumbed to the theory of 'group selection' – according to which certain inclinations or physical qualities spread because they make the group that has them fitter – and abandoned the more orthodox theory of 'gene selection' – according to which such inclinations and physical qualities are attached to genes, and genes only spread if they make their individual possessors fitter. But let me reassure them; I am a rather strict adept of gene selection. However, I think that 'kin selection' is a form of gene selection: genes spread if they make their possessors fitter, but that also happens if the behaviour of one possessor of a particular gene promotes the chances of survival and procreation of his or her sisters and brothers, who have about 50 per cent chances of possessing the same gene. A cluster of genes imposing inclinations to support each other and to observe limitations when harming each other could have been quite successful within a relatively small tribe of hunters and gatherers of which most members were cousins, if not siblings. A cluster of genes imposing exactly the

same inclinations, but only under a condition of reciprocity, would have been even more successful. And that reciprocity would mean that the occasional intruder not possessing these genes would not be able to exploit the cooperative inclinations of most members of the tribe.

Human rights, then, can be understood as translations of these genetic inclinations: when small nomadic tribes became settlements, settlements became cities, and cities became states, these inclinations needed to be formalised and codified. Instead of prescribing decent cooperative behaviour between individuals, human rights describe minimum standards of behaviour of networks of cooperation – societies – towards individuals. If human rights are still – according to the treaties – predominantly about what your government cannot do to you, or what it must do for you, it is because countries are still perceived as the main networks of cooperation. As long as governments of countries guarantee human rights to all inhabitants, it means that all cooperation happens according to minimum standards. The stronger person cannot enslave the weaker, as the government would interfere. The stronger person cannot use violence against the weaker, as a monopoly of violence has been given to the government, and the government most ensure fair trials before using violence. The stronger person can try to exploit the weaker, but the stronger will have to pay taxes that will provide food, healthcare and education to everyone, and so there are limits to the exploitation that can happen.

But the reality of countries being the main networks of cooperation is changing, rapidly. From the perspective of a small grower of coffee beans in Kenya, the main network of cooperation is not Kenya, not the People of Kenya nor the Government of Kenya, but the global coffee market. The traders, the buyers, and the consumers of coffee are the members of the 'global coffee tribe'. They 'cooperate', but have no institutions to make sure that the conditions of cooperation live up to minimum standards of decency. Each member of the global coffee tribe negotiates for the highest possible profits or benefits, often without realising that as a result of this uncorrected cooperation, many coffee growers cannot afford to take their children to a health centre when needed.

This kind of uncontrolled cooperation that causes huge profits for some and inhumanely low living conditions for others goes against the natural inclinations and expectations of the people who are losing out. They may accept uneven distribution of the products of cooperation, but not a distribution that is so extremely uneven that they are unable to feed their children. If they 'accept' the present situation, it is because they have no other choice, and that creates a very unstable basis for cooperation in other areas where the winners of global trade may be in a more vulnerable position. That is what I tried to explain in 'Why the West Is Perceived as Being Unworthy of Cooperation' (Ooms 2010). If we want to have smooth cooperation at the global level, we will have to make sure that everyone involved in it will benefit from it, accepting uneven distribution only within limits. As we do not always realise how very innocent choices – like going to one coffee shop because it is a bit cheaper than the next one – encourage the global market dynamics that lead to extremely uneven distribution of the products of cooperation, we need global social protection to correct those dynamics.

My second answer to Pogge was about justice as doing no harm to each other. Reading Rawls about "background institutions of justice" that "must work to keep property and wealth evenly enough shared over time to preserve the fair value of the political liberties and fair equality of opportunity over generations" (Rawls 2003: 51), reminded me about a phenomenon that Gunnar Myrdal had identified a few decades earlier, and called 'cumulative causation'. Centres of economic growth, like families, clans, cities, or even

countries, invest their profits in additional competitive advantages and becoming even stronger, while the periphery of these centres undergoes a 'backwash effect' and becomes even weaker (Myrdal 1957: 12). To illustrate that his theory of cumulative causation really is common sense, Myrdal referred to Matthew's Gospel: "For to the one who has, more will be given, and he will have an abundance, but from the one who has not, even what he has will be taken away" (Matthew 13:12). Later, the phenomenon became known as the 'Matthew effect' in economics (Rigney 2010). As mentioned above, Milanovic (2005: 12) calls the problem 'bad inequality' or inequality that "provides the means to preserve acquired positions", as opposed to 'good inequality' or inequality that "is needed to create incentives for people to study, work hard, or start risky entrepreneurial projects."

For the sake of simplicity, allow me to use 'bad inequality' as a generic expression that captures Myrdal's 'backwash effect' and the problem that Rawls described when arguing for 'background institutions for justice': that if property and wealth are not evenly enough shared over time, the value of the political liberties and fair equality of opportunity are jeopardised. Now, is bad inequality a form of doing harm – i.e. harm done by those who have the means to preserve their privileged positions, who use these means, and who by using these means fix others in their underprivileged positions? One can argue that as long as the people enjoying privileged positions have no intention to keep the others down, they are not causing harm: it is the situation that causes harm. But one can also argue that if people enjoying privileged positions understand 'bad inequality' and how it works, they should either change the situation or abandon their privileged positions. An intellectual middle ground could be to consider social protection as a kind of insurance against unintended, unidentifiable and unforeseeable harm-doing. Whenever we participate in cooperation, we do not really know if the uneven distribution of the products of cooperation will be the consequence of uneven effort or the consequence of uneven prior positions. To be sure that we do no harm, we accept that a share of the products of cooperation be redistributed in accordance with needs, and that all people keep certain freedoms, regardless of their poverty or wealth.

If 'bad inequality' is a real problem, then we should wonder if it remains confined within the borders of countries. Because of the nature of the problem, we really have no reason to believe it would remain confined within countries' borders, and therefore we need global social protection, as Hammonds and I argue in a chapter of a still unpublished book (Ooms & Hammonds forthcoming).

All in all, this probably isn't an additional argument, but it is a foundation for my second argument. Health is a human right, and at least for its core content, the corresponding duties fall on humanity. That is what justice requires, and we need global social protection to implement it.

Third argument: global social protection is a matter of enlightened self-interest, to avoid a 'tragedy of the commons'

Trying to answer Pogge brought me to read Myrdal's works again, and it brought me back to Myrdal's prediction that global economic integration would be bad for poorer countries: "On the international as on the national level trade does not by itself necessarily work for equality. It may, on the contrary, have strong backwash effects on the underdeveloped countries" (Myrdal 1957: 51-52). But Myrdal's predication was not entirely right. Until the end of the 20th century, global inequality evolved as Myrdal had predicted; rich countries became richer, and poor countries became poorer. Inequality between countries – measured by comparing the average income of each country (and ignoring the differences in income between people living in the same coun-

try) – rose. By the end of the 20th century, however, this trend reversed; inequality between countries has been falling ever since. According to Glenn Firebaugh (2003: xi) "income inequality across nations peaked in the last third of the twentieth century and is now declining", however, "[a]t the same time, inequality within nations – which had been declining over the first half of the twentieth century – has begun to rise".

What is going on here? In 1997, Dani Rodrik (1997: 69) warned against "social disintegration as the price of economic integration". In a later book he argued: "Governments today actively compete with each other by pursuing policies they believe will earn them market confidence and attract trade and capital inflows…" (Rodrik 2007: 201). Vic George and Paul Wilding argue along the same lines: "Concern about competitiveness has obviously put social security schemes under pressure given the way in which the debate about competitiveness has focused primarily on employment costs and levels of social benefits and taxation and the supposed damage they can do to competitiveness" (George & Wilding 2002: 70).

Most research about the consequences of the quest for competitiveness on social policy has focused on wealthier countries – countries with rather generous social protection mechanisms that are now under pressure. There is evidence, however, that poorer countries, while trying to establish their social protection, are hampered by the very same quest for competitiveness (Avi-Yonah 2001). The same author concludes: "it can be argued that given the need for tax revenues, developing countries would in general prefer to refrain from granting tax incentives, if only they could be assured that no other developing country would be able to grant such incentives" (ibid.).

If correct, than social protection has many features of a common-pool resource, and it may be argued that it is becoming the victim of a particular kind of 'tragedy of the commons': not over-exploitation but under-exploitation is the problem. By under-exploiting the potential for taxation and social protection, countries try to attract economic activity from other countries, which decreases these other countries' ability to raise taxes. The solution to a tragedy of the commons is regulation or self-regulation, and that is precisely what Pierre Pestieau (2005: 10) proposes: "[t]he only way to reverse such an expected outcome is to rely on cooperation between national governments".

What should this cooperation include? Somehow, it should oblige all countries to adopt certain minimum levels of social protection – and therefore minimum levels of taxation. When wealthier countries' governments will try to propose that, it seems inevitable that poorer countries' governments will argue that this is merely an attempt to end a recent trend – a trend of poorer countries capturing a bigger share of the global economy. Richer countries' governments could reply that minimum levels of social protection are required because of human rights, while poorer countries' governments could reply that, in this case, international assistance is required because of human rights, too.

This would lead to a global social protection regime, including a global social protection floor – minimum levels of social protection to be observed by all countries – and a global social protection fund, to channel transfers from richer to poorer countries. A global social protection regime would serve the interests of the common people of all countries. The common people of poorer countries would benefit from more reliable international assistance, and from the dampening of tax competition. The common people of wealthier countries would benefit from the dampening of tax competition. These arguments are being elaborated in a paper written with many others, to be published in 2013 (Ooms et al. forthcoming).

Conclusion

The more I think and write about it, the more it seems obvious: global social protection is the inevitable next step in a natural evolution that started when individual members of tribes of hunting and gathering humans understood they had to respect and support each other. The 20th-century translation of that understanding is the Universal Declaration of Human Rights and its two International Covenants, both focusing on duties of national governments towards the people under their jurisdiction. The 21st-century translation of that understanding will be a clarification of the Universal Declaration of Human Rights and its two International Covenants with regards to 'extraterritorial obligations' or, in other words, a clarification of the duties of humanity towards humanity. This is already taking shape in the 'Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights' (Group of Experts 2011), and, in the area of civil and political human rights, in the concept of the 'Responsibility to Protect' (International Commission on Intervention and State Sovereignty 2001).

All in all, my three and a half arguments are, essentially, a single argument. The idea of autonomous, self-containing and sovereign states has become an anachronism. The reality of the 21st century is that people are members of a global society. And therefore, they have humanitarian duties towards each other (across borders); they have duties of justice to support the realisation of each other's human rights (across borders); and they serve their own interests by supporting the realisation of each other's human rights (across borders).

In hindsight, the step from supporting Doctors Without Borders to supporting Social Protection Across Borders is only an incremental one. Let's take it. ■

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SOCIAL PROTECTION AS A WHOLE IN THE CONTEXT OF INCREASING INCOME INEQUALITIES

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Abstract

The major reductions in global carbon emissions required to control climate change will impose a binding constraint on global economic growth over the coming decades. Combined with the extreme inequality of global income distribution, and the still more unequal distribution of the additional income generated by global growth, this means that substantial progress towards poverty reduction will require a greater emphasis on redistribution at the global level, for example through a global social protection system. A particular case can be made for such a system to finance health services: excluding out-of-pocket spending, per capita spending on health is US$ 7.40 in low-income countries, compared with US$ 4,140 in high-income countries, despite substantially greater needs in the former. This disparity also contributes to the "brain drain" of health professionals from North to South, and skewed incentives in medical research and development. Together with the increasing emphasis placed on health by donor countries, this suggests that the health sector may be an appropriate entry point for a long-term process aimed at establishing a broader global social protection system.

Introduction

Concern about inequality – either as an intrinsic issue of social justice or instrumentally, as a cause of more tangible societal problems – has been a major driving force behind the development Social security and social protection systems at the national level. Such systems have unquestionably been an important factor limiting economic inequality in those countries in which they operate.

Inequality is much greater at the global level (Woodward and Simms 2006), and raises similar issues of social justice and global problems (e. g. in terms of environmental costs, health risks and security). However, the response – official development assistance – has been very different in nature (discretionary and based on non-binding norms rather than based on entitlements and obligations) and much more limited in scale (amounting to around 0.3-0.4 % of global GDP). Consequently, it has had relatively little effect on inequality or poverty.

The absence of any effective mechanism for redistribution at the global level has contributed to a strong emphasis on economic growth in developing countries as a means of poverty reduction. At the same time, globalisation and the associated increase in the outward orientation of national economies in the developing world (often as a result of conditionalities attached to aid) has led to greater reliance on global economic growth as an engine for national growth. However, global growth has in practice had relatively little impact on poverty in recent decades; and the growth-based model is now critically challenged, not only immediately by the current financial crisis, but also prospectively by

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increasingly binding constraints on global carbon emissions (Woodward & Simms 2006). These considerations greatly strengthen the case for a global system of social protection.

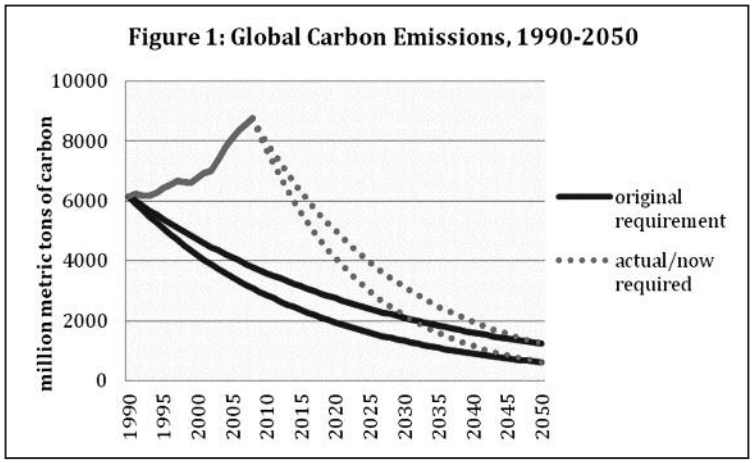
This paper first assesses the implications of global carbon constraints for global economic growth, and of distributional considerations for the effectiveness of such growth in reducing poverty. It goes on to assess the implications of global income inequality for the geographical distribution of health expenditure, and of this distribution for the availability of health care in developing countries. Finally, it draws conclusions for the desirability of a global social protection system, with particular reference to financing of health services.

Climate Change and the Constraints to Global Growth

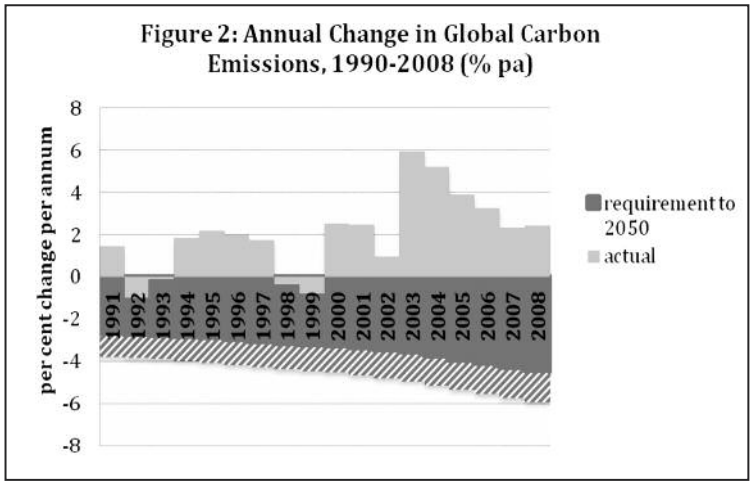
The growth rate of the global economy is increasingly constrained by the need to reduce carbon emissions sufficiently to stabilise the atmospheric carbon concentration at a level consistent with a rise in the global average temperature to 2° C above pre-industrial levels. This is generally considered to require a reduction of anthropogenic emissions by 60-80 % from the 1990 level by 2050.

However, as shown in Figures 1 and 2, actual emissions have continued to increase, actually accelerating sharply after 2002. This has increased the rate of reduction required considerably, by raising the starting point – emissions in 2008 being more than double that implied by a regular adjustment path even to the 60 % reduction target – while the period remaining to 2050 is reduced. By 2008, the rate of reduction required had increased from 2.6-3.8 % p. a. to 4.4-5.9 %. Moreover, the excess of actual and projected emissions over the original target levels implies a more rapid increase in atmospheric concentrations than envisaged in the regular adjustment path (indicated by the gap between the red and blue lines in Fig. 1), and hence a faster increase in global temperatures. Cumulative emissions between 1990 and 2008 are estimated at 133.4bn tonnes of carbon, a level that would not have been reached until 2021 in the 60 % reduction scenario, and 2034 in the 80% reduction scenario (Fig. 3). This suggests that climate change may already be between 13 and 26 years more advanced than had an orderly reduction in emissions begun in 1990.

Limiting global warming to 2° C may thus require the attainment of emissions reductions targets much sooner than 2050, further reducing the time available, and thus increasing the required rate of reduction substantially more. If (very simplistically) we assume that the target date is



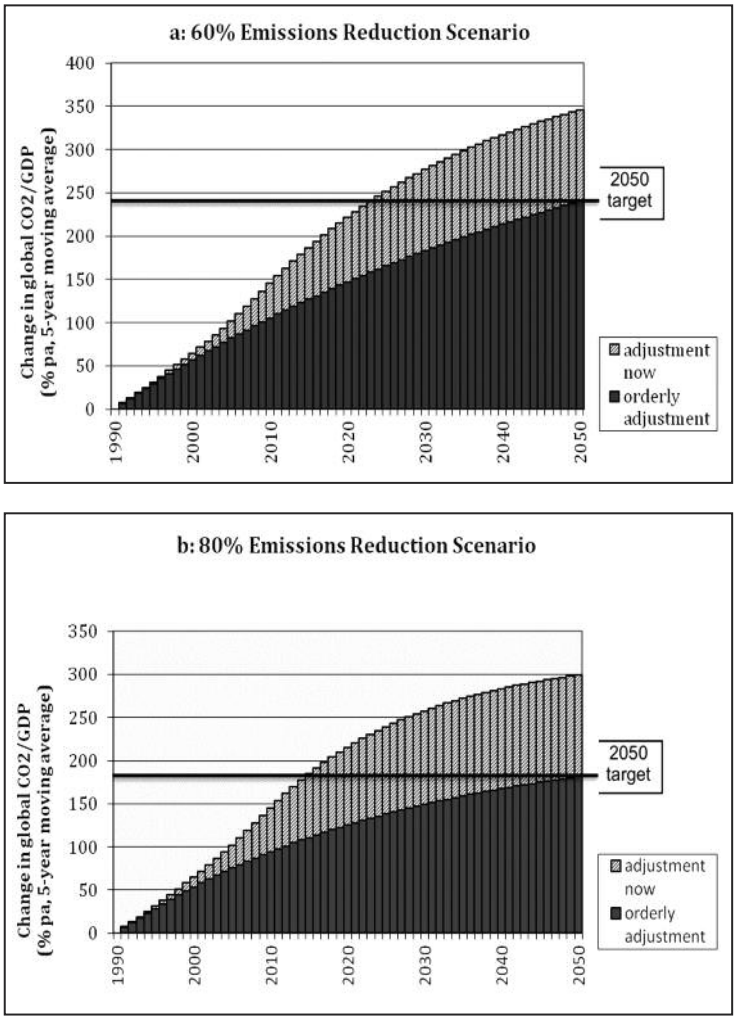
Source: Boden et al (2010)



Source: Boden et al (2010) and author's estimates

advanced by 13 years (to 2037) in the 60 % reduction scenario and by 26 years (to 2024) in the 80 % reduction scenario, the rate of reduction required would be increased to 6.5 % p. a. and15.3 % p. a. respectively.

FIG. 3A+B: CUMULATIVE GLOBAL CARBON EMISSIONS, 1990-2050



Source: Author's estimates (based on Boden et al, 2010 for "adjustment now" scenario to 2008)

These figures imply a very dramatic reversal of the trend in the carbon intensity of global production and consumption (global carbon emissions relative to global national income) if the pre-crisis rate of global economic growth (around 3 % p. a.) is to be restored. Even on the basis of the 2050 target date, and assuming that the reversal was achieved in 2009, carbon intensity would need to be reduced by 7.2 % p. a. in the 60 % reduction scenario and 8.7 % in the 80% reduction scenario (to be sustained for 42 years), compared with an average increase of 3.8 % p. a. in 2002-2008. Allowing for the foreshortening of the adjustment period in light of excess cumulative emissions would imply a reduction requirement of 9.3-17.8 % per annum.

Even on the most optimistic scenario (that only a 60 % reduction in global emissions from the 1990 level is required by 2050, making no allowance for excess cumulative emissions), this indicates a need for an immediate reduction in the rate of increase of global carbon intensity by 8.0 % (from +0.8 % p. a. to -7.2% p. a.), to be sustained for four decades. In the most pessimistic scenario (80 % reduction, taking account of the effect of excess cumulative emissions to 2008), the reduction required is 18.6 % (from +0.8 % to -17.8 % p. a).

The scale of this change may be assessed by comparison with the oil price shocks of 1973 and 1979, when energy prices increased by a factor of more than ten. Then, the adjustment achieved from peak to trough (i. e. from the five years before the 1973 oil price increase to the fives years after the 1979 increase) was 3.8 %. However, this was achieved over a period of 11 years, and was half reversed as energy prices fell dramatically over the following five years. The reduction required now, on the most optimistic scenario, is more than twice as great, must be achieved immediately, and must be sustained for 42 years.

This is a matter of particular concern because the oil price shocks of the 1970s had a dramatic negative effect on the global economy, the growth rate of global GDP per capita slowing from 2.9 % p. a. in the five years before 1973 to 0.4 % p. a. in the five years after 1979. The oil price increases also played a major role in the build-up to the 1980s debt crisis, which had a dramatic negative economic and social impact in Latin America and especially Sub-Saharan

Africa, in the latter case particularly triggering a major increase in poverty and a dramatic slowdown in the rate of improvement of health indicators.

Global Inequality in Income and the Benefits of Economic Growth

The global distribution of income is extremely unequal – more so than the distribution of income in the most unequal country (Namibia) (Woodward & Simms 2006; see Fig. 4.) The majority of the world population lives on less than USUS$ 3 per person per day at 2005 purchasing power parity, with an average income of USUS$ 1.55 per day; and more than one quarter live on less than US$ 1.50 per day, with an average income of US$1 per day.[9] By comparison, global GDP per capita on an equivalent basis (US$ 9,630) is equivalent to US$ 26.38 per day.

In 1993, the poorer 50 % of the world population (those then living on less than US$ 1.80 per person per day at 2005 PPP) received 8.5 % of the world income in purchasing power parity terms – significantly less than the richest 1 %, who received 9.5%. The poorest 20 % (below a US$ 0.90 per day poverty line) received only 2 % of total income (Milanovic 1999).[10]

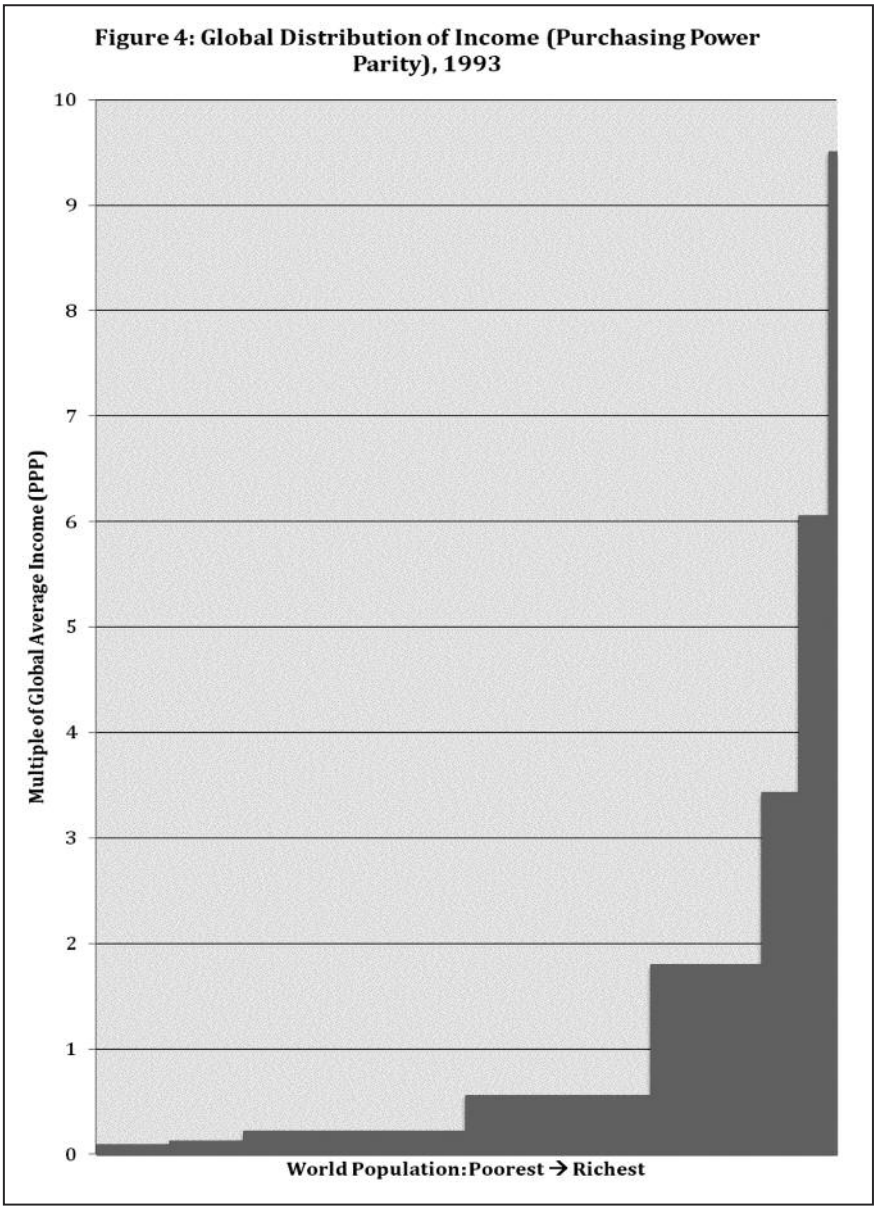
From the perspective of poverty eradication, the combination of such extreme inequality with binding carbon constraints on global economic growth is problematic in the extreme. In the absence of any change in the global distribution of income, the incomes of the poor will increase only in line with the (carbon-constrained) increase in global income; and the distribution of the additional income generated by economic growth will exhibit the same degree of inequality as initial income. Thus, if the poorer half of the world population has 8 % of world income, then they will receive only 8 % of the proceeds of global economic growth.

In practice, however, there is evidence that the distribution of global income is still more unequal than global income. Thus, it has been estimated that those below the US$ 1.08-a-day poverty line at 1993 PPP (broadly conform with the current World Bank poverty line of US$ 1.25 per day at 2005 PPP) received only 0.6 % of the proceeds of growth between 1990 and 2001 – just half of their initial share in global income. This represents more than one billion people, or one-sixth of the world population. Thus, in the absence of income redistribution at the global level, each US $1 of poverty reduction based on the US$ 1.25 per day poverty line requires US$ 166 of additional production and consumption globally, with all the carbon emissions and other environmental costs this entails (Woodward & Simms 2006).

While global estimates are not available, evidence from the United States is also indicative of a very considerable concentration of the benefits of growth at the very top of the income distribution. Thus, it has been estimated that the richest 1% of the US population accounted for 58 % of the additional income generated by US growth between 1976 and 2007 (Atkinson et al. 2009). Since the US accounted for 29 % of global economic growth in dollar terms in this period, this suggests that 2-3m people, representing 0.05 % of the world population, accounted for 16.8 % of the proceeds of global economic growth, over a period of 31 years. While the figures are not directly comparable, juxtaposing these results with those highlighted above suggests that these 2-3m people at the top of the

[9] Author's estimates using data from World Bank2012b

[10] Equivalent poverty lines are the author's estimates, using data from ibid.. It should be noted that the use of PPP exchange rates in these estimates means that they understate inequality at market exchange rates considerably, as most poor households live in low- and lower-middle-income countries, where market exchange rates diverge from purchasing power parity, typically by a factor between about two and four.



Source: Adapted from Woodward and Simms (2006), Fig. 3, based on data from Milanovic (1999)

income distribution gained something in the order of 25-30 times as much benefit from global growth as some 500 times as many people at the bottom – more than 10,000 times as much in per capita terms.

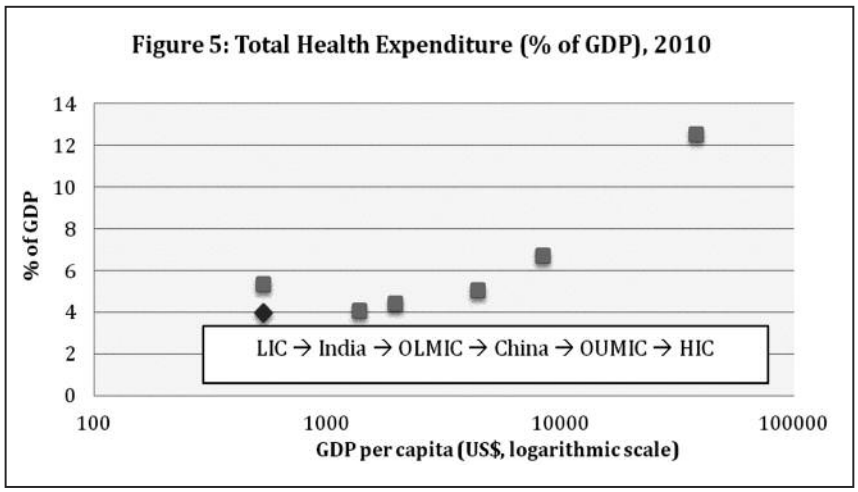
This makes global economic growth an extraordinarily inefficient means of reducing poverty. Increasing the average incomes of those below the US$ 1.25-a-day poverty line by US$ 1 through global growth (given recent patterns of distributional change) entails 25-30 times as much additional income accruing to a few million very rich households in the US alone (potentially much more globally), to increase their average incomes by more than US$ 10,000. In a context of global carbon constraints, this represents an extremely serious limitation on the potential for poverty reduction, and renders poverty eradication in any meaningful sense infeasible for the indefinite future.

This suggests that reconciling aspirations to poverty eradication (or even accelerated poverty reduction) with the dramatic reductions in global carbon emissions required to avoid catastrophic and irreversible climate change will necessarily require a major shift from global economic growth to global redistribution towards those below whatever poverty line might be considered appropriate. In the absence of a fundamental shift in economic systems and policies at the global and national levels, one means of achieving this would some form of global social security system.

Global Inequality and Health-Care Financing

It is widely recognised that expenditure on healthcare is price elastic – that is, that it increases more than proportionally with income. This may be illustrated at the macro-economic level by plotting total (public and private) health expenditure as a proportion of GDP against GDP per capita for country groupings classified by the World Bank's income criteria as high-, upper-

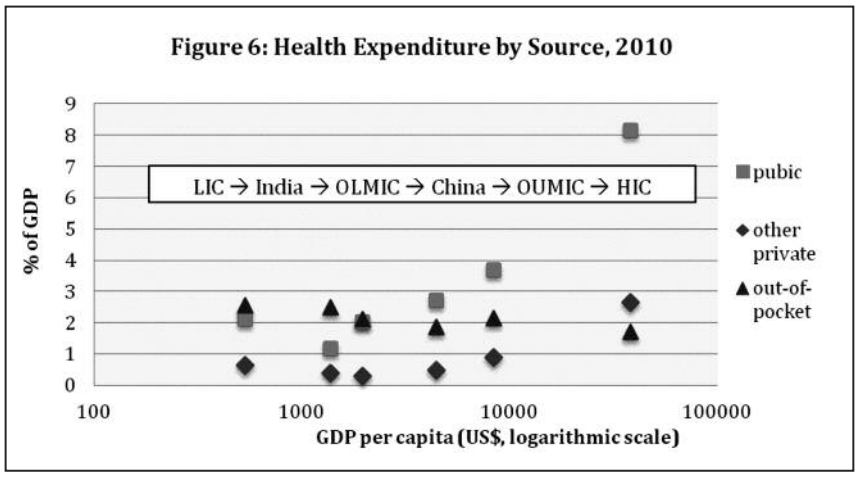
[11] We also separate out India and China from the lower- and upper-middle-income countries, to provide six observations, each with a comparable total population, ranging between 0.8 billion and 1.3 billion people.



Source: World Bank 2012a

middle-, lower-middle- and low-income countries, as shown in Fig. 5.[11]

The lower share of GDP devoted to total health spending in India than in low-income countries, despite its lower GDP per capita, is fully explained by a higher level of external support, as indicated by the blue symbol. It can thus be seen that the share of GDP accounted for by health expenditure increases from around 4 % in low-income countries (excluding external support) to more than 12 % in high-income countries.



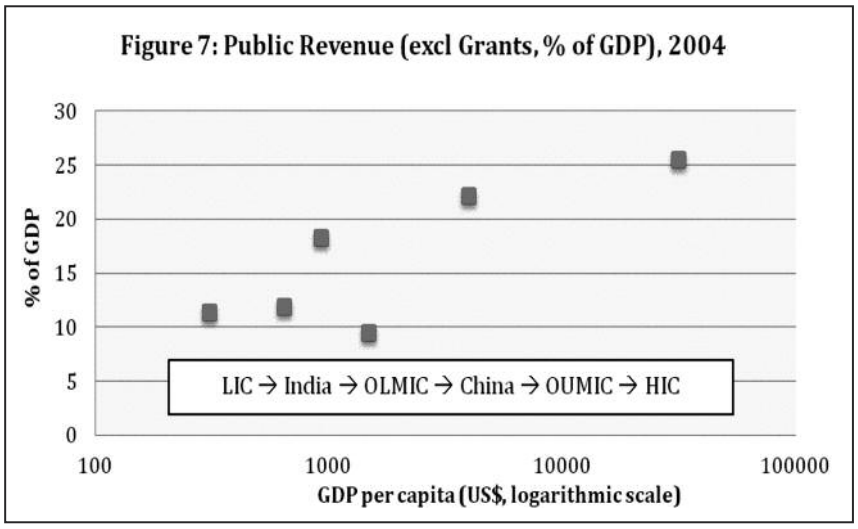
Source: World Development Indicators (ibid.).

However, as shown in Fig. 6, there is a marked difference in the behaviour of different types of health expenditure, differentiated by source, as income rises. Public expenditure on health as a proportion of GDP increases strongly and consistently as GDP per capita rises, from 1 % in India to more than 8 % in high-income countries. (It is not possible to separate out external and domestic public financing in low-income countries, but the data suggest it is likely that this accounts for the apparently lower figure for India than for low-income countries.).

This may be seen as a result of two factors: public revenues increasing more than proportionally with GDP per capita (Fig. 7); and a substantially stronger positive relationship between GDP per capita and the share of public spending allocated to health (Fig. 8). (It should be noted that the figures for government revenues may be distorted by differing levels of decentralisation, particularly in the two individual countries, China and India.) As national income rises, it appears, governments are both better able to raise revenues, and more willing and able to allocate the available fiscal resources to health, at least above the low-income level.

In marked contrast with public spending, there is a slightly declining trend in out-of-pocket expenditure as per capita income rises. Other private expenditure declines in lower-middle-income countries, then increases in upper-middle-income and high-income countries. As well as external support in low-income countries, this is likely to reflect the dualism of this category of expenditure between non-government agencies and facilities such as mission hospitals and private medical insurance. While the data do not allow these categories to be separated, it is likely that the former predominate in low-income countries and the latter in high-income countries.

Thus, in addition to the increasing share of GDP devoted to overall health expenditure shown in Fig. 5, there is a very strong shift in the composition of health expenditure as per capita income rises, the share of out-of-pocket spending declining from 48 % in low-income countries (artificially depressed by external financing for public and NGO health expenditures) and 61 % in India to less than 14 % in high-income countries. (see Fig. 9.)



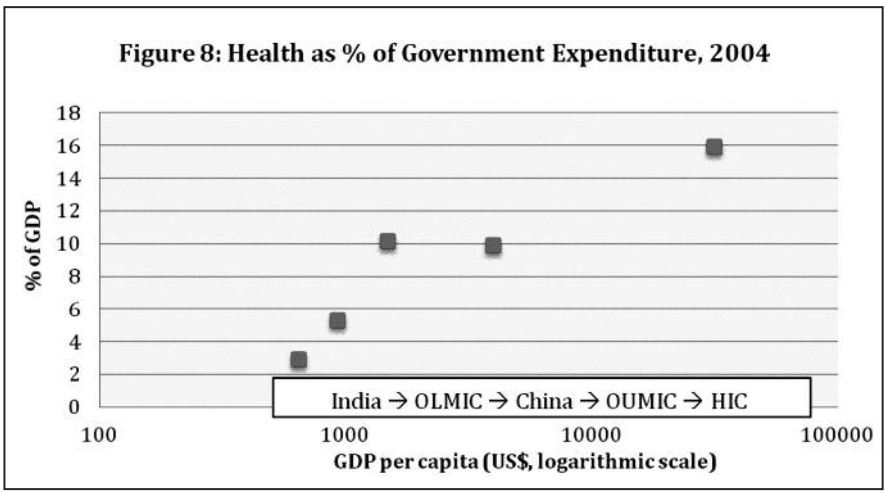
Source: World Development Indicators (ibid.). 2004 is used as the most recent year for which complete data are available.

The result is an extreme inequality in the global distribution of health expenditure – much greater than that of GDP, as shown in Fig. 10. While low- and lower-middle-income countries account for nearly half (48 %) of the world's population, they account for just 3 % of global health expenditure, considerably less even than their share of global GDP (7.4 %). By comparison, high-income countries, which represent 16 % of the world population, account for more than 82 % of world health spending.

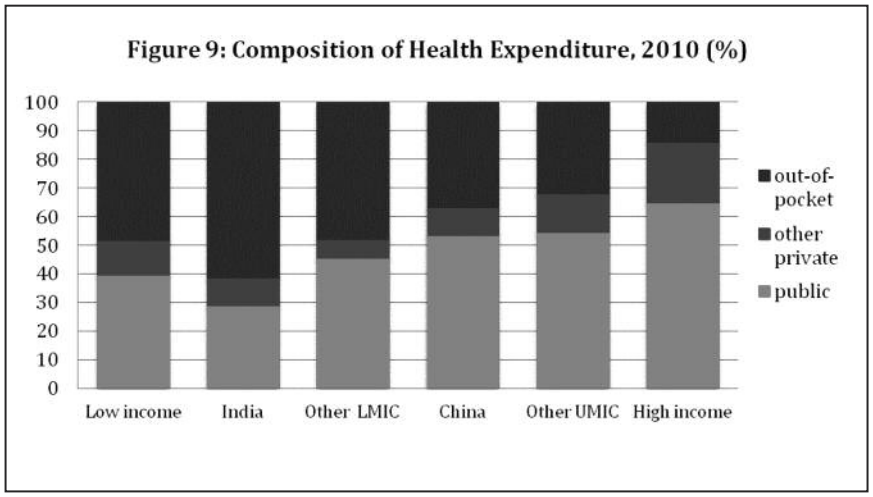
From the perspective of social protection, our primary interest is in those aspects of health expenditure which represent social (public of non-government) provision, or at a minimum some degree of risk-mitigation (social and private insurance) – that is, we should exclude out-of-pocket payments, which may be seen as a response to a failure of social protection. Beyond questions of the effectiveness of such expenditure (e. g. particularly in developing countries, expenditure by households without access to quality health services on self-medication with pharmaceuticals purchased from unqualified and unregulated retailers), such expenditure may result in impoverishment of the household concerned (Xu et al. 2003).

Because of the markedly different relationship of out-of-pocket expenditure with per capita income, excluding this from the analysis greatly increases the disparity in health spending (Fig. 10d): high-income countries, with one-third of the population of low- and lower-middle-income countries have more than 30 times the heath expenditure, excluding out-of-pocket payments.

This disparity may also be viewed in terms of per capita expenditures, as shown in Fig. 11. While low-income countries spend US$ 28 per person on health, high-income countries spend US$



Source: World Development Indicators (ibid.). 2004 is used as the year of most complete data; data for low-income countries are not available for any year.



Source: World Bank 2012a

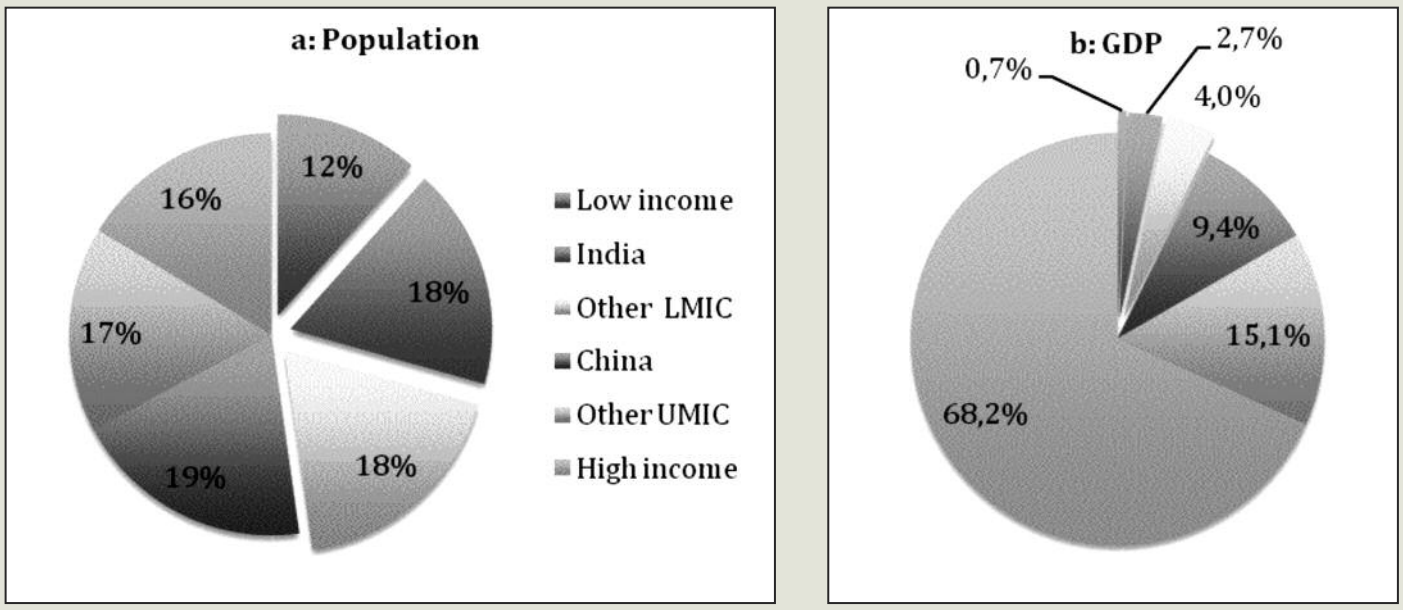
4,800 per person – 170 times as much, compared with a ratio of GDP per capita in high-income countries to that in low-income countries of 102. Moreover half of spending in low-income countries is out-of-pocket (cf 13.7 % in high-income countries), and half of the remainder is externally financed (cf 0.02 %). Excluding these components of expenditure thus more than triples the ratio to 560 (US$ 4,140 compared with US$ 7.40). It should also be emphasised that these figures take no account of inequality in the distribution of health expenditure among households within countries, so that the gap between poor people in poor countries and rich people in rich countries is undoubtedly considerably larger.

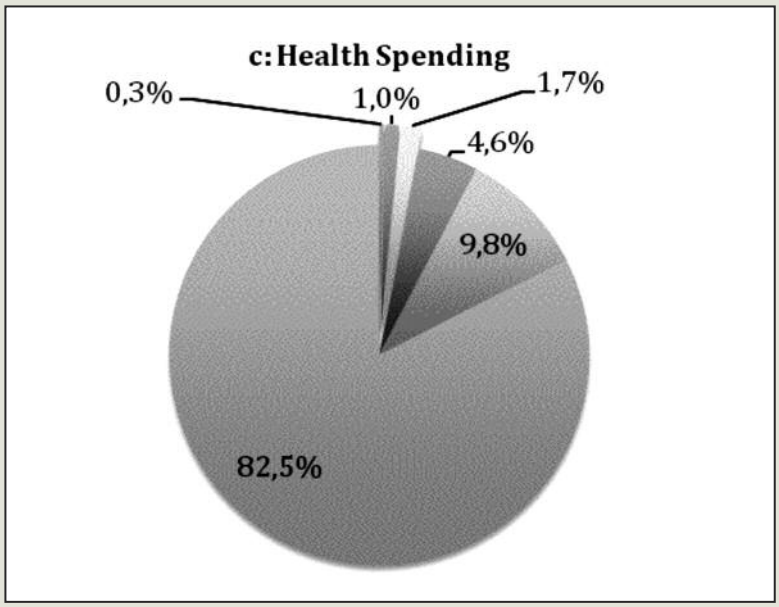
Implications for the Global Social Protection Proposal

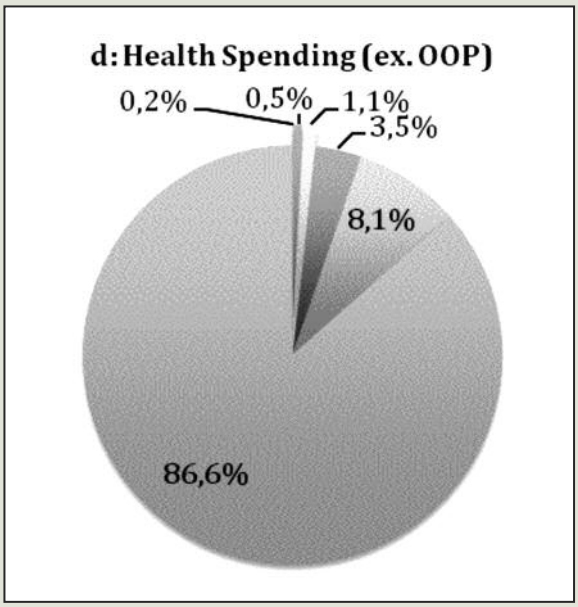
Extreme inequality in the distribution of income, whether globally or nationally, represents a major source of inefficiency in the translation of total income (and the additional income generated by economic growth) into well-being, because of the well-established economic principle of diminishing marginal utility. It is intuitively obvious that the benefit of an additional US$ 1 of income is vastly greater to (for example) a landless rural labourer in a low-income country, struggling to meet the most basic needs of his family on an income below US$ 1 a day, than it is to a billionaire.

That 25-30 times as much of the additional income generated by global growth accrues to the richest 1 % of the population in the US alone

FIG. 10: DISTRIBUTION OF WORLD POPULATION, GDP AND HEALTH SPENDING BY INCOME CATEGORY, 2010







Source: Author's estimates, using data from World Bank 2012a

than to the poorest billion people, living below the US$ 1.25-a-day poverty line, is thus seriously problematic. This problem is seriously compounded by the increasingly binding constraints in the growth of aggregate income as a result of climate change and the failure to bring global carbon emissions under control.

In the absence of such constraints it is conceivable in principle (though, in the author's view, entirely implausible in practice) that even such an extreme inequality in the distribution of the proceeds of growth could be justified by contributing to more rapid global growth. However, in a world where global growth is subject to binding constraints arising from the need to control carbon emissions, and more rapid growth has adverse environmental effects, which fall disproportionately on the poor, this argument becomes wholly untenable.

Thus the present global context (and the prospect for several decades to come) clearly implies that the primary engine of poverty reduction must be a shift in the distribution of income in the global level rather than global economic growth. Given the very limited impact of the current mechanism (official development assistance) on poverty over the last 50 years, this clearly implies a need to consider alternative mechanisms, including some form of global social protection system along the lines of those, which operate in most high-income countries.

A comprehensive system of global social protection, however desirable, would be an extremely ambitious – and, in the near future, politically unrealistic – prospect. It may therefore be desirable to start with a more limited proposal, with a view to building on this over time towards a progressively more comprehensive system.

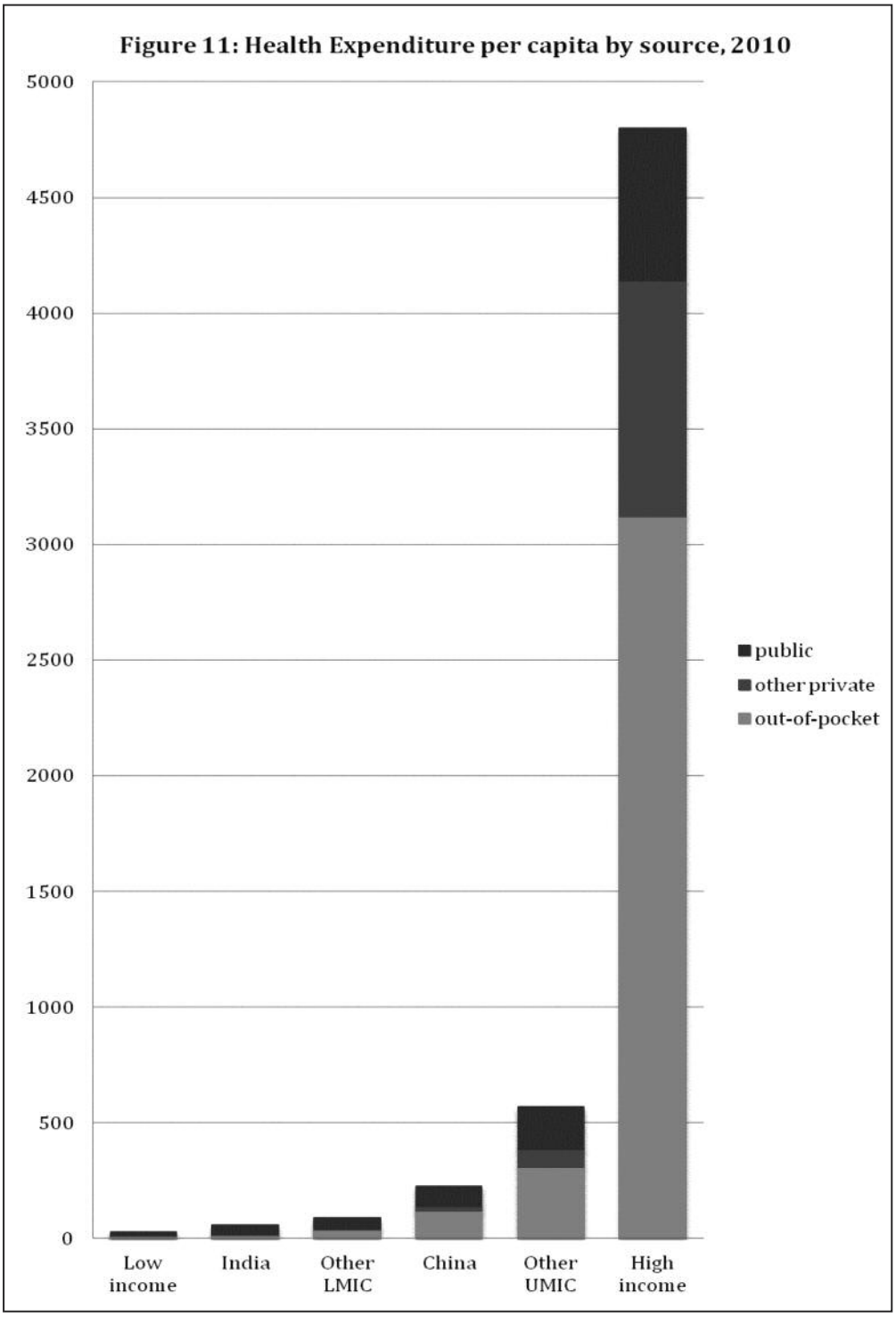
Financing for health services would be a strong candidate for such a limited proposal. Developed countries have, in recent decades, shown an increasing willingness to support (selected) health services in the developing world, at least partly reflecting an awareness of the benefits to them of strengthening the control of communicable diseases which have the potential to impact on their populations (most notably HIV/AIDS and multi-drug-resistant tuberculosis). This suggests that they might be more open to advocacy (and/or more susceptible to pressure) for a global social protection system in this area than in other sectors.

The case for a global social protection (or other global solidarity) mechanism to finance health services is further strengthened by the extreme inequality of health expenditure highlighted above, as well as more general arguments for collective financing of health systems, which apply as much at the global as at the national level.

This is partly a reflection of the principle of diminishing marginal utility: an extra US$1 of health spending for the average person in a low-income country, who currently benefits from US$ 7.40 of spending per year is clearly vastly greater than an extra US$ 1 for the average high-income country resident who already receives US$ 4,140 per year (in both cases excluding out-of-pocket payments). The potential health improvement from increased expenditure on low-cost interventions, which are not currently provided due to resource constraints – for example, vaccination programmes and oral rehydration therapy – would undoubtedly be considerable. The benefits of ensuring sufficient resources to establish and maintain effective health systems, capable of providing universal access to high-quality health services as well as such interventions would be much greater still.

However, the argument is strengthened by two further considerations. First, health expenditure is not merely extremely unequally distributed, but this distribution displays a marked inverse relationship with health needs. Social determinants of health – notably poverty, under-nutrition, living environments, working conditions, etc

Figure 11: Health Expenditure per capita by source, 2010



Source: Author's estimates, using data from World Bank 2012a

– are substantially less favourable in developing (especially low-income) than in high-income countries, as are public health programmes and health-related regulations. Climatic conditions are also generally less favourable epidemiologically in tropical than temperate latitudes. In addition, the lack of access to effective health services associated with seriously inadequate health expenditures may be expected to add to the prevalence of communicable diseases. All these factors may be expected to give rise to considerably greater needs for health services in low- than in high-income countries.

Thus, based on the above analysis, the domestic resources available for social provision and risk-mitigation in health in high-income countries are 560 times as great in high-income countries, where health risks are relatively low, as in low-income countries where they are substantially higher.

Second, in an increasingly integrated global economy, national health systems compete in global markets for essential inputs, particularly health professionals and pharmaceuticals. In the former case, the considerable disparity of resources for health systems between developed and developing (especially low-income) countries gives rise to the "brain drain" – a perverse flow of health professionals from countries where they are scarcest, and the health benefits they could provide are greatest, to those in which they are much more plentiful and less critically needed. This represents a major challenge to health systems in the developing world. While less apparent, competition in pharmaceutical markets is also important in two respects. The first is pricing: the considerable resources available for the purchase of pharmaceuticals in high-income countries (particularly those with quasi-commercial health systems) means that pharmaceutical companies can charge prices in these markets which are unaffordable in the developing world. The most conspicuous example is anti-retroviral therapy (ART) for HIV/AIDS prior to international intervention following major civil society campaigns, when a course of ART cost some US$ 10,000 per year. Following intervention, the same drugs became available – and remained profitable – at prices of US$ 300-600. The very high profits available in high-income markets provide a strong disincentive for (non-generic) pharmaceutical companies to sell at lower prices in developing countries because of the risk of leakage into developed country markets – and a powerful incentive to lobby against any measures to require them to do so.

These price effects also seriously skew the incentives for research and development for new pharmaceuticals (and other medical supplies) towards those addressing health needs in developed rather than developing countries. The vast disparities in health spending (and spending in general) globally make products for relatively minor complaints of importance to people in the developed world (e. g. hair loss, skin aging, overweight, sexual dysfunction, etc), even where similar products already exist, much more profitable than potentially life-saving medication for currently untreatable conditions which occur mainly in the developing world (e. g. so-called neglected tropical diseases). Thus, as a rule of thumb, it is considered that some 90 % of research and development in health addresses the needs of (the richest) 10 % of the world population, and 10 % the needs of (the poorest) 90 %. Again, this seriously reduces the efficiency (from a health perspective) of the considerable sums devoted to research and development in the health sector.

Both of these effects in relation to pharmaceuticals arise primarily from the dysfunctionality of the current global regime of "intellectual property rights", as applied to the health sector. Nonetheless, the problem is compounded by the global inequality of health spending. In the absence of more fundamental changes to international rules and norms concerning "intellectual property", a reduction in the disparity between health spen-

ding in high- and low-income countries could make a modest contribution to limiting the adverse effects on health.

Conclusion

In a carbon-constrained global economy, poverty can only be reduced substantially (let alone eradicated in a meaningful sense within any reasonable timeframe) through a reduction in the extreme inequality in the distribution of income at the global level. This represents a strong case for some form of social protection system, along the lines of social security systems operating in most developed countries.

While the establishment of such a system must be considered at best a long-term prospect, given the dominance of the developed countries in the global governance system, a more limited proposal could represent a more realistic entry point. The particularities of the health sector – notably the still greater inequality in the distribution of global health expenditure, the negative overall relationship between income and health needs, and completion in increasingly globalised markets for essential health systems – a proposal for a global system of health financing along the lines of a social protection system would be particularly appropriate as a first step in this direction. ■

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ARE WE VIOLATING THE HUMAN RIGHTS OF THE WORLD'S POOR?

THOMAS POGGE[12]

Abstract

A human rights violation involves unfulfilled human rights and a specific active causal relation of human agents to such non-fulfilment. This causal relation may be interactional; but it may also be institutional, as when agents collaborate in designing and imposing institutional arrangements that foreseeably and avoidably cause human rights to be unfulfilled. Readily available evidence suggests that (a) basic social and economic human rights remain unfulfilled for around half the world's population and (b) the design of supranational institutional arrangement plays a major role in explaining why the poorer half of humanity is suffering a rapid decline in its share (now below three percent) of global household income. A strong case can be made, then, that people like myself – well-to-do citizens of influential states – collaboratively violate the human rights of the global poor on a massive scale. That most of us find this conclusion obviously mistaken does not discredit it because they have not investigated the institutional causes of the non-fulfilment of human rights nor relevant institutional reform possibilities.

Introduction

Answering the title question requires explicating its meaning and then examining the empirical evidence. The first task is begun in this introductory part, which gives a rough account of the two groups whose relation is to be queried: the world's poor and the "we" addressed in the Article. The following part then proposes a specific understanding of what it means to violate human rights. I will argue that a human rights violation involves non-fulfilment of human rights as well as a specific causal relation of human agents to such non-fulfilment. Importantly, this understanding of a human rights violation includes not only interactional violations (perpetrated directly by human agents) but also institutional violations (caused by human agents through the imposition of institutional arrangements). Based on the explication of the question in the first and second parts, the following part goes on to consider some of the evidence relevant to answering the question. This evidence favours the conclusion that there exists a supranational institutional regime that foreseeably and avoidably produces massive human rights deficits. By collaboratively imposing this institutional scheme, we are indeed violating the human rights of the world's poor.

Let us define the poor narrowly as anyone who lacks access "to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care" (United Nations 1948: Art. 25). In 2005, when the average weekly income was US$ 66, half the world's people were living on less than US$ 9 a week (US$ 465 annually) and 30 percent were living on less than US$ 4 a

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week (US$ 211 annually). Even adjusting for the fact that money buys two or three times as much by way of necessities in the poor countries, these figures make clear that a majority of the world's population did not have an adequate standard of living.[13]

By "we" I mean citizens of developed countries who have sufficient mental maturity, education, and political opportunities to share responsibility for their government's foreign policy and for its role in designing and imposing supranational institutional arrangements. This definition takes for granted that typical adult citizens of each developed country share a collective responsibility for what their government does in their name (Satz 2005: 50f; Pogge 2005: 80ff).

What Does it Mean to Violate a Human Right?

Human rights violations involve the non-fulfilment of a human right and a certain causal responsibility of human agents for this non-fulilment. These two aspects of human rights violations are treated respectively in the first and third sections of this second part. The second section is a brief interlude on the normativity of human rights: their relation to morality and the law. The fourth section concludes the second part by discussing the concept of a human rights violation emerging from the preceding sections.

NON-FULFILMENT

A particular human right of some particular person is unfulfilled when this person lacks secure access to the object of that human right. This object is whatever the human right is a right to: for example, equal political participation, basic education, or freedom from assault. With regard to the human rights of the global poor, the most immediately relevant human right is the right to secure access to an adequate standard of living. But those who lack secure access to an adequate standard of living typically lack secure access to the objects of other human rights as well. Many are compelled by poverty to enter employment relations in which they are subject to serious abuse by factory supervisors or domestic employers. Many women are exposed to assault and rape because they cannot afford to divorce their husband, cannot afford a secure dwelling, or must fetch water from distant locations. Others are sold into prostitution by their own relatives or fall prey to traffickers who abduct them or promise them a living wage abroad. Most poor people are vulnerable to humiliation, dispossession, or personal domination because they lack the means to defend their legal rights.

What, then, are the duties correlative to a human right and, more specifically, correlative to the human right to a minimally adequate standard of living? A good step toward answering this question involves examining the respect-protect-fulfil triad that has become a staple of international agency thinking in this area. This triad goes back to Henry Shue's seminal book Basic Rights, which inspired Philip Alston and Asbjorn Eide popularised the respect-protect-fulfil triad in the 1980s.[14] This triad was then carefully elaborated in the famous General Comment 12, adopted in 1999 by the UN Committee on Economic, Social and Cultural Rights. Article 15 of this General Comment reads as follows:

> *"The right to adequate food, like any other human right, imposes three types or levels of obligations on States parties: the obligations to respect, to protect and to fulfill. In turn, the obli-*

[13] The data used in this paragraph were kindly supplied by Branko Milanovic, principal economist in the World Bank's Development Research Group, in a personal e-mail communication on April 25, 2010. Milanovic is the leading authority on the measurement of inequality, and his published work contains similar albeit somewhat less updated information. See generally Milanovic 2011; he calculated the 2005 median as US$ 465 per person per year and the thirtieth percentile as US$ 211.

[14] For their work and for their acknowledgement of Henry Shue's influence upon it, see, e.g. Alston 1984: 169-174. See generally Alston & Tomaševski 1984.

gation to fulfill incorporates both an obligation to facilitate and an obligation to provide. The obligation to respect existing access to adequate food requires States parties not to take any measures that result in preventing such access. The obligation to protect requires measures by the State to ensure that enterprises or individuals do not deprive individuals of their access to adequate food. The obligation to fulfill (facilitate) means the State must pro-actively engage in activities intended to strengthen people's access to and utilization of resources and means to ensure their livelihood, including food security. Finally, whenever an individual or group is unable, for reasons beyond their control, to enjoy the right to adequate food by the means at their disposal, States have the obligation to fulfill (provide) that right directly. This obligation also applies for persons who are victims of natural or other disasters" (OHCHR 1999).

These reflections largely accept two limitations widely taken for granted in the world of international relations: namely that human rights impose counterpart duties only on states and that the human rights of any person normally impose counterpart duties only upon the state or states under whose jurisdiction she falls either through physical presence or through a legal bond of citizenship or residency. I highlight these limitations because I will later challenge them along with the comfortable belief they sustain: namely, that the unfulfilled human rights of impoverished foreigners abroad impose human-rights-correlative obligations only upon their respective governments and compatriots and none upon ourselves.

HUMAN RIGHTS IN RELATION TO LAW AND MORALITY

Lest challenging existing human rights law seem arrogant, let me say that human rights are not merely part of the law but also a moral standard that all law ought to meet and a standard that is not yet met by much existing law in many countries. Law has incorporated human rights in a way that points beyond itself: to a normativity that does not depend on the law for its existence and cannot be revised or repealed by legislative or judicial fiat or by other law-making mechanisms such as treaties or international custom. This point is articulated in the legal separation from customary international law of ius cogens, a set of norms whose validity is understood to transcend the discretion of states. Ius cogens is generally taken to include at least norms prohibiting aggressive war, genocide, slavery, torture, military aggression, and piracy.[15] The point is also prominently expressed in the very first words of the Universal Declaration of Human Rights, which call for the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family" (author's emphases) (United Nations 1948: Preamble). With this formulation, echoed in frequent appeals to "internationally recognized human rights," governments present themselves as recognising cer- tain rights in law rather than as creating these rights de novo. Their use of the word "inalienable" reinforces this conclusion: an inalienable right is a right that its holders cannot lose, not through anything they do themselves (waiver or forfeiture), nor through anything others do, for instance through an alteration of the law.

Because human rights law points beyond itself in this way, the question of what duties human rights entail does not boil down to the question of which such duties competent courts applying current law would recognise. Both Shue and the authors of General Comment 12 approach the question in this spirit and the remainder of this Article follows their example.

[15] A similar and related instance of law pointing beyond itself is the legal distinction between mala in se and mala prohibita. While there is disagreement about how exactly to draw this distinction, there is near unanimous agreement that there are mala in se and, more specifically, acts that are so wrong that any legal system is morally required to prohibit them.

FROM NON-FULFILMENT TO VIOLATION

General Comment 12 distinguishes four distinct causal pathways by which one human agent's conduct may affect the fulfilment of a person's human rights. Reconstructing this distinction without the artificial limitation to states, one can say that human rights may give human agents four distinct kinds of duties: duties to respect human rights, duties to protect (secure access to the objects of) human rights, duties to provide (secure access to) the objects of human rights, and duties to facilitate human rights fulfilment. My discussion of these four kinds of duties will focus on cases where a breach of the duty counts as a human rights violation. This excludes cases of uninvolved bystanders who can protect or provide at reasonable cost. They have a duty to do so but are not human rights violators if they fail.

The most straightforward human rights violations involve breaches of duties to respect, that is, duties "not to take any measures that result in preventing" a human being from having secure access to the object of a human right. As this negative formulation indicates, these are conceived as negative duties: duties that can be honoured by remaining passive and can be breached only by taking action. Such duties should forbid any action that is reasonably avoidable and foreseeably causes some human being to be prevented from enjoying secure access to the object of a human right.

Duties to protect and duties to provide are similar in that they both are positive duties: duties that require active intervention in a situation and that cannot be discharged by remaining passive. These duties apply to agents who are neither responsible for, nor implicated in, the human rights deficits they find themselves in a position to diminish; and breaching duties of either kind does not then count as a human rights violation. They are distinguished by reference to the type of threat that triggers them and by the mode of intervention they require. Duties to protect require human agents to take preventive action when the fulfilment of human rights is endangered by social threats: by other human agents who are, perhaps inadvertently, disposed to act in ways that render such access insecure. The duty bearer must prevent either the potentially harmful actions or their potentially harmful effects. Duties to provide require neutralizing a theat's harmful effects. Duties of the two kinds are substitutional in that one becomes moot insofar as the other is discharged.

Duties to respond to natural disasters that threaten the fulfilment of human rights are generally (e.g., in General Comment 12) classified as duties to provide. This is an unfortunate practice because it obscures the fact that, as in the case of social threats, the task can be discharged in two fundamentally different ways: by preventing the harm from reaching people or by assisting people in coping with it. The common label tends to draw attention to the latter approach; and nearly all international efforts to cope with natural disasters are indeed focused on assistance ex post rather than on (often more cost-effective) prevention ex ante. A good step toward correcting this irrational bias would be to break out duties to protect human beings from natural disasters as a separate category of human-rights-correlative duties.

In explication of duties to facilitate, General Comment 12 prescribes that "the State must pro-actively engage in activities intended to strengthen people's access to and utilization of resources and means to ensure their livelihood, including food security" (OHCHR 1999). Transcending the respect-protect-fulfil triad, the authors of General Comment 12 clearly conceived of duties to facilitate as distinct from duties to provide and also as important enough to be broken out as a separate category. A possible reason is the recognition the vital importance that the design of institutional arrangements has for the fulfilment of human rights. This importance is overlooked on a purely interactional un-

derstanding of human rights fulfilment, which should then be complemented by an institutional analysis that traces such deficits to injustice in the design of social institutions. The two kinds of analysis are often complementary as when each marital rape is a moral crime committed by a husband and the persistent high prevalence of marital rape exhibits institutional injustice in legislation and the training of police and judicial officers.

Contrasting with these cases of complementarity, there are also many cases where institutional analysis reaches beyond interactional analysis and thus enables intelligent responses to human rights deficits that, on a purely interactional analysis, remain elusive. Hunger, for example, is typically systemic: arising in the context of some economic order from the effects of the conduct of many market participants who cannot foresee how their decisions, together with those of many others, will affect specific individuals or even the overall food situation. Here market participants typically cannot know what they must do to respect others' human right to an adequate standard of living. This human right can best be realised through suitable socio-economic institutions, and it was in fact appropriate institutional design that led to the realisation of this right in the countries where it is realised.

While institutional analysis with a moral purpose goes back a long way, its recent exemplar is John Rawls's great work A Theory of Justice. While focusing on social institutions and more specifically on the basic structure of a national society existing under modern conditions, this work's normative message is addressed to the citizens of such a national society, offering to explicate for them their "natural duty of justice" which, Rawls (1971: 115) believes, "requires us to support and to comply with just institutions that exist and apply to us . . . [and] to further just arrangements not yet established."[16] His argument for such a natural duty of justice is important in highlighting how the members of a society can institutionally address socio-economic deprivations and inequality even when it is very difficult or impossible to effectively address them through individual efforts toward protection or provision. But Rawls's formulation of the argument also involves a serious and highly influential flaw, namely the unthinking presupposition that citizens' duties with regard to the social institutions they are involved in designing or upholding are one and all positive duties. In an elaborate mapping exercise, Rawls explicitly characterises them in this way, likening them to duties of mutual aid and mutual respect, while contrasting them with duties not to injure and not to harm the innocent (Rawls 1971: 109). If citizens' duty to look after the justice of their shared social institutions is a positive one, then it is of lesser import — on the widely shared assumption, reiterated by Rawls, that "when the distinction is clear, negative duties have more weight than positive ones" (ibid.: 114).

Political thinkers and jurists writing after Rawls have unquestioningly accepted his view that the responsibility for the justice of social institutions is a positive responsibility, without recognizing that the adoption and incorporation of this view is a contestable decision of some consequence. So this responsibility is now everywhere cast in purely positive terms. General Comment 12 demands that "the State must pro-actively engage in activities intended to strengthen people's access to and utilization of resources and means to ensure their livelihood, including food security" (OHCHR 1999). And Shue's complex formulation is also a positive one: casting our relevant responsibility as one to design institutions that avoid the creation of strong incentives to violate human rights — rather than one not to design or uphold social institutions that create strong incentives to violate human rights. This positive duty to help improve the justice of social institutions sustains no principled differentiation

[16] See also Rawls 1971: 246, 334.

between the social institutions of one's own society and those of any other society. A Turk's obligation to promote the justice of Turkey's social institutions is on a par with her obligation to promote the justice of Paraguay's social institutions.

My concern to complement this account can be introduced with a dramatic analogy. Imagine a driver who encounters a badly hurt child by the side of the road. Being a local, the driver knows the area well and knows, in particular, how to get the boy quickly to the nearest emergency room. She can see that the boy is bleeding profusely, so that her failure to drive him there may well cost him his life. Given these facts, her duty to aid human beings in need generates a stringent obligation to drive the boy to the hospital as quickly as she safely can.

Suppose now that it was the driver's own negligent conduct that caused the boy's condition. This new information does not affect the initial conclusion that she has a weighty obligation to assist by quickly driving him to the hospital. But this conclusion is now overshadowed by an even weightier moral reason: if what she does not succeed in getting the boy's life saved, then she will have killed (rather than merely injured) him. Her negative duty not to kill thus generates another, even more stringent obligation of identical content: she must drive the boy to the hospital as fast as she safely can.

The key point of the analogy is that citizens of a society generally have two obligations to work toward making its social institutions more just. One derives from their general positive duty to promote the justice of social institutions for the sake of safeguarding the rights and needs of human beings anywhere. The other derives from their negative duty not to collaborate in designing or imposing unjust social institutions upon other human beings. In regard to a citizen's home society, the content of these two obligations is essentially the same. But they differ in stringency. Other things equal, it is worse to let an injustice persist if one is complicit in it than if one is merely an uninvolved bystander. If the injustice manifests itself in human rights deficits, then one is a human rights violator in the first case but not in the second. And this provides an additional, stronger, and non-instrumental rationale for why typical Turkish citizens should focus their political reform efforts on Turkey in preference to Paraguay.

General Comment 12 is right to acknowledge the important duties human agents have in regard to the design of social institutions by breaking out duties to facilitate as a separate category. To this must be added, however, separate category of duties not to collaborate in the design or imposition of social institutions that foreseeably and avoidably cause human rights to be unfulfilled. These duties are close to duties to facilitate in regard to the focus on social institutions and the related purpose of reducing human rights deficits through institutional reform. They are close to duties to respect in regard to their essentially negative character: it is only by breaching duties to respect or duties not to collaborate that one can become a violator of human rights.

HUMAN RIGHTS VIOLATION AS A RELATIONAL PREDICATE AND THE DUTY TO FACILITATE

As the foregoing discussion brings out, the concept of a human rights violation is a relational predicate, involving specific responsibilities by particular human agents in regard to unfulfilled human rights of persons. When many among Paraguay's indigenous population are unable to attain an adequate standard of living, then this may indicate a human rights violation on the part of Paraguay's political and economic elite insofar as they are collaborating in the imposition of unjust social institutions in Paraguay or abusing their indigenous employees. The same human rights deficit indicates merely a breach of positive duty on the part of an affluent citizen of Turkey who — though failing to do anything toward

protecting, providing, or facilitating secure access by indigenous Paraguayans to the objects of their human rights — is not involved in abusing them or in designing or imposing upon them unjust social institutions. And the same human rights deficit may not indicate any breach of duty on the part of impoverished citizens of Sierra Leone or indeed of most of Paraguay's indigenous people themselves, who are either unable or cannot reasonably be said to be morally required to undertake political action toward realizing their own and each other's human rights.

Two central points have here been made about the notion of a human rights violation. One is a call to resist the tendency to deflate the term "human rights violation" by using it in a broad sense so that it covers all cases, or all avoidable cases, of unfulfilled human rights. The other is that human rights violations come in two varieties: the interactional variety, where individual or collective human agents do things that, as they intend, foresee, or should foresee, will avoidably deprive human beings of secure access to the objects of their human rights, and the institutional variety, where human agents design and impose institutional arrangements that, as they intend, foresee, or should foresee, will avoidably deprive human beings of secure access to their human rights. That the latter variety is overlooked among those who enjoy the privilege of theorizing about justice and human rights is related to the fact that its recognition would bring into full view an ongoing crime against humanity in which these theorists and their readers are involved: the design and imposition of unjust supranational institutional arrangements that foreseeably and avoidably cause severe poverty that is by far the greatest contributor to the current global human rights deficit.

Consciously or unconsciously, normative theorists obscure this crime in two main ways. The traditional approach is to present national borders as moral watersheds. Each state is responsible for the fulfilment of human rights in its territory, and the responsibility of foreign actors is limited to (at most) a positive duty of assistance.[17] An emerging alternative contemporary approach recognises the profound effects that trans-national rules and actors have on the lives of human beings worldwide and then acknowledges a positive duty to facilitate the realisation of human rights. As with the other two positive duties, this new duty is understood as "imperfect," leaving its bearers nearly unlimited discretion over what and how much they will do.

The contemporary approach represents a step. But by assigning us merely an open-ended task of improving supranational institutional arrangements, the contemporary approach presents our responsibility as exclusively positive and thereby, like the traditional approach, hides the possibility that this supranational order is fundamentally unjust and that "progressive improvement" is therefore an unacceptable response. There was a time when people talked about the improvement of slavery — about legislative changes that might facilitate more tolerable living conditions by curbing rapes, beatings, and splitting of families, by reducing back-breaking labour, and by guaranteeing minimally adequate food, shelter, and leisure time. But as slavery came to be recognised as fundamentally unjust, the only adequate response to it was abolition. Pursuant to our negative duty not to impose unjust social institutions, we must eliminate through institutional reforms as fast as reasonably possible any reasonably avoidable human rights deficit produce by institutional arrangements we participate in upholding. In this regard, severe poverty and slavery are on a par: when social institutions avoiding these deprivations are reasonably possible, then the imposition of social institutions that perpetuate them constitutes a violation of the human rights of those who are enslaved or impoverished.

[17] Rawls (1999: 37, 106-119) exemplified this traditional view with the recognition of such a positive duty of assistance.

We are Violating the Human Rights of the World's Poor: The Empirical Evidence

The last section has shown how normative theorists sustain this injustice by allowing no space in their catalogues of duties for a negative duty not to collaborate (that is, immediately to stop collaborating) in the imposition of unjust institutional arrangements. This part will show how empirical theorists sustain the injustice by arguing that globalisation is good for the poor (first section) and that the causes of the poverty that remains today are domestic to the societies in which it persists (second section). This part concludes with some thoughts about what we ought to do in light of the actual causes of global poverty (third section).

It may be useful to precede the discussion with a brief reminder of the state of human rights fulfilment today. About half of all human beings live in severe poverty and about a quarter live in extreme or life-threatening poverty. They appear in statistics such as the following: 925 million people are chronically undernourished (FAO 2010), 884 million lack access to improved drinking water (UNICEF 2010a), 2.5 billion lack access to improved sanitation (UNICEF 2010b), and almost 2 billion lack regular access to essential medicines (WHO 2004: 3). Over 1 billion lack adequate shelter (United Nations Human Settlements Programme 2003), 1.6 billion lack electricity (UN HABITAT n.y.), 796 million adults are illiterate (UNESCO 2011: 1), and 215 million children are child labourers (ILO 2010: 5, 7). About one third of all human deaths, 18 million each year, are due to poverty-related causes (WHO 2008: 54ff).

IS GLOBALISATION GOOD FOR THE POOR?

One way of disputing the claim that we are violating the human rights of the poor is by arguing that, because the percentage of very poor people has been declining (the first Millennium Development Goal, MDG-1, is phrased in these terms), globalisation and the supranational institutional arrangements it has brought must be good for the poor. This argument employs an invalid inference. To see this, suppose in analogy someone denied that the institutional order authorizing and enforcing black slavery in the United States in 1845 violated the human rights of slaves by claiming that the proportion of slaves within the U.S. population (or even the absolute number of slaves) had been shrinking, that the nutritional situation of slaves had steadily improved, and that brutal treatment had also been in decline. Would this claim, if true, weaken, in any way, the assertion that the institution of slavery violated the human rights of slaves? If the answer is no, then the mere fact that the worst hardships of poverty have been declining throughout the globalisation period cannot refute the claim that the imposition of the current global institutional order violates the human rights of the poor. The relevant question how much of the remaining human rights deficit is avoidable through a more just design of the supranational institutional arrangements we impose (Pogge 2005: 55ff; Pogge 2007: 11ff).

Bearing this common-sense standard in mind, let us observe how various segments of the human population have fared during the globalisation period. As the table shows, the top five percent of the global income distribution has gained substantially over the globalisation period, while the poorest 80 percent have lost ground. With the losses most severe in the poorest quarter, there has been dramatic polarisation: in a mere seventeen years, the ratio between the average income in the top five percent and that in the poorest quarter has skyrocketed from 185 to 297. The table also shows that, surprisingly, the world poverty problem - so unimaginably large in human terms - is tiny in economic terms. In 2005, the shortfall of the world's poor from an adequate standard of living was about 2 percent of global household income or 1.2 percent of world income (the sum of all gross national in-

TABLE 1: DISTRIBUTION OF GLOBAL HOUSEHOLD INCOME

Segment of World Population	Share of Global Household Income 1988	Share of Global Household Income 2005	Absolute Change in Income Share	Relative Change in Income Share
Richest 5 Percent	42.87	46.36	+3.49	+8.1%
Next 5 Percent	21.80	22.18	+0.38	+1.7%
Next 15 Percent	24.83	21.80	-3.03	-12.2%
Second Quarter	6.97	6.74	-0.23	-3.3%
Third Quarter	2.37	2.14	-0.23	-9.7%
Poorest Quarter	1.16	0.78	-0.38	-32.8%

Source: Milanovic according to footnote 13

TABLE 2: MALNUTRITION WORLDWIDE

Period	Under-nourished Persons (in millions)	Under-nourished Persons as % of World Population
1969–1971	878	26
1979–1981	853	21
1990–1992	843	16
1995–1997	788	14
2000–2002	833	14
2005–2007	848	13
2008	963	14
2009	1023	15
2010	925	14

Sources: FAO 2011; FAO/WFP 2010: 50; FAO 2008; FAO 2010; Human Population Clock 2011. As this paper is going to press, an "improved methodology" of counting the undernourished has been adopted. It is now claimed that this number was much greater than previously estimated in the MDG base year of 1990 and that it has fallen steadily since then, wholly unperturbed by the doubling of world food prices after 2005. See FAO/WFP/IFAD 2012 and the gloating response of the Economist (2012) bringing to heel the FAO Report.

comes). This global poverty gap could have been filled almost twice over, just from the gain in the share of the richest ventile (one twentieth) during the 1988–2005 period. Given these facts, it would be very hard indeed to make a good case for the claim that the massive poverty persisting today was not reasonably avoidable.

With the poorest quarter losing one third of its already absurdly small share of global household income, it is not surprising that very large numbers of human beings continue to subsist in extreme poverty, well below an adequate standard of living. The most credible figures we have on this front are the numbers of undernourished people as provided by the UN Food and Agriculture Organization.

What can we conclude from these data in regard to our central empirical question of whether a feasible alternative design of supranational institutional arrangements could have led to a smaller human rights deficit? While it is certainly possible that there was no such feasible alternative, it is highly unlikely given the data. For the denial of the possibility of such an alternative would amount to the wildly implausible claim that there was no feasible alternative institutional path of globalisation that would have avoided the catastrophic losses in the income share of the poor while still achieving a reasonable rate of global economic growth.[18]

ARE THE CAUSES OF THE PERSISTENCE OF POVERTY PURELY DOMESTIC?

Empirical theorists provide a second line of defence of the status quo by arguing that the cau-

[18] For a more extensive discussion, see Pogge 2010.

ses of the persistence of poverty are domestic to the societies in which poverty persists. The observed polarisation is not one phenomenon, driven by supranational institutional arrangements, but rather two phenomena: good progress in well-organised Western countries, which maintain high levels of social justice and decent rates of economic growth, and mixed progress in many other countries, which pay little attention to social justice and whose economic growth is often held back by a range of local natural, cultural, or political impediments. Two sets of empirical findings are adduced as evidence for this picture. One is that the overall gap between affluent and developing countries is no longer growing as China and India, in particular, have been maintaining long-term rates of economic growth that are considerably above those of Europe, North America, and Japan (World Bank 2010: 378f). This is taken to show that supranational rules are not biased against poor countries and that the main driver of polarisation today is rising intra-national inequality which is under domestic control and each country's own responsibility.

In response, one might point out that, over the recent globalisation period, growth in GDP per capita has been very substantially lower in the low-income than in the high-income countries (see World Bank 2012) But the more important point is that the increase of intra-national economic inequality in nearly all countries is no longer under easy domestic control but rather driven by the increasingly important role that supranational rules play in constraining and shaping national legislation and in governing domestic markets for goods, services, labour, and investments.

The influence of supranational rules is in some cases direct and immediate and in other cases mediated through competition. As an example of a direct and immediate influence, consider an important part of the World Trade Organization (WTO) regime, namely the 1994 Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement which requires WTO members to institute national intellectual property regimes that award and enforce product patents of at least 20 year duration on new medicines and thus suppress the manufacture and sale of competing generic products. This requirement massively aggravates poverty by increasing the cost of medicines that poor people, far more vulnerable to disease, have much greater need for. Often, poor people cannot afford the medicines they would have been able to buy in the absence of TRIPS and then spend money on inferior (often counterfeit) products, or else go without medicine altogether, and suffer chronic disease or even premature death as a result, with devastating effects on their family's livelihood (Pogge 2009).

As an example of the influence of supranational rules mediated by competition, consider that the WTO Treaty, while mandating open and competitive global markets, contains no uniform labour standards that would protect workers from abusive and stressful working conditions, from absurdly low wages, or from excessive working hours. It thereby draws poor countries into a vicious "race to the bottom" where they, competing for foreign investment, must outbid one another by offering ever more exploitable workforces. Under the conditions of WTO globalisation, workers cannot resist such a deterioration of their terms of employment because, if they succeed in securing more humane working conditions for themselves, many of them will end up unemployed as jobs are moved abroad.

Massive increases in domestic inequality are to be expected, then, in developing countries. And we do indeed find this phenomenon in nearly all developing countries for which good data are available, countries as diverse as Argentina, Bangladesh, Costa Rica, the Dominican Republic, Ecuador, Hungary and Jamaica (UNU-WIDER 2008).

China is an especially interesting case, because it contains nearly a fifth of humanity and is the leading poster child of globalisation. During the 1990–2004 period, China reportedly achieved spectacular 236-percent growth in per capita gross national income.[19] But the same period also saw a stunning increase in inequality. While the income share of the top tenth rose from 25 to 35 percent, that of the poorest fifth fell from 7.3 to 4.3 percent (Data for 1990: Minoiu & Reddy 2008: 577; data for 2004: World Bank 2008: 68ff).

TABLE 3: INCOME DISPARITIES IN THE US

Segment of World Population	Share of Global Household Income 1988	Share of Global Household Income 2005	Absolute Change in Income Share	Relative Change in Income Share
Richest 5 Percent	42.87	46.36	+3.49	+8.1%
Next 5 Percent	21.80	22.18	+0.38	+1.7%
Next 15 Percent	24.83	21.80	-3.03	-12.2%
Second Quarter	6.97	6.74	-0.23	-3.3%
Third Quarter	2.37	2.14	-0.23	-9.7%
Poorest Quarter	1.16	0.78	-0.38	-32.8%

Sources: The top five rows of the table: Alvaredo et al. 2011; remaining three rows: Robyn & Prante 2011. Because the data come from different sources, columns 2-4 do not quite sum up correctly. But this should not disturb the table's point which is to display the rapid polarisation of the US income distribution documented in the rightmost column.

This means that the ratio of the average incomes of these two groups increased from 6.8 to 16.3 as average income in the top tenth rose by 370 percent while average income in the poorest fifth rose by only 98 percent. To be sure, an income gain of 98 percent over 14 years is not bad at all. But China's poor paid a high price for it in terms of marginalisation, humiliation and oppression by the emerging economic elite whose greatly expanded share of Chinese household income gives them much greater opportunities to influence political decisions, to give unfair advantages to their children, and to dominate the poor in direct personal interactions. They would have been much better off with more equal economic growth, even if this would have been somewhat less rapid.

We find a similar phenomenon in the other leading country of the 21st century, the United States. In line with the Kuznets Curve hypothesis, the US experienced gradual income equalisation from the beginning of the Great Depression until the beginning of the current globalisation period. Contrary to the Kuznets hypothesis, this period was followed, however, by a dramatic income polarisation that progressed most rapidly in the 1990s. Table 3 tells the story, and the data from the Internal Revenue Service (more fine-grained than those available for China) show, in particular, that the relative gains were heavily concentrated at the very top, where a mere 400,000 now earn as much as the poorest 150 million. The top 0.01 percent of US households (ca. 14,400 tax returns) quadrupled their share of US household income and increased their advantage in average income over the poorer half of Americans six-fold, from 375:1 to 2214:1. The top ventile (one twentieth) of the population is the only one that gained ground; each of the lower 19 ventiles saw its share of US household income decline, and these relative losses were greatest at the bottom.

This income polarisation in the US, and the consequent economic and political marginalisation

[19] Calculated from World Bank data by dividing each year's GNI (in current Yuan) by China's population that year, then using China's GDP deflator to convert into constant 2005 Yuan.

of the US poor, underscore the point that increasing intra-national inequality is a widespread phenomenon that, while certainly influenced by domestic factors and resistible by domestic political processes, is favoured and facilitated by the WTO globalisation of the last decades. US polarisation can moreover highlight a useful political point: if the poorest 90 percent of the US population had a better understanding of their own interests, they would be potential partners in a coalition aimed at democratising globalisation: aimed at reducing the near-monopolistic power of a small global elite that is now steering the evolution of the supranational institutional architecture. To win them as allies we can appeal to their interests, but also, of course, to their commitment to human rights which are the core theme of this article. Let me conclude then by highlighting some of the main features of the present supranational institutional arrangements that are especially detrimental to the realisation of human rights.

I give this account in opposition to the usual rosy story which, if it acknowledges the massive persistence of severe poverty at all, explains it by two factors: corrupt and oppressive regimes in many poor countries and the 'leaky bucket' of development assistance. Both these explanations have an element of truth. But the first fails to explain the high prevalence of corrupt and oppressive regimes, and the second fails to explain why the income share of the poor is falling, and rapidly so.

My own explanation can redeploy the metaphor: the assets of the poor are like a leaky bucket, continuously depleted by massive outflows that overwhelm the effects of development assistance, which, in any case, are puny. We take great pride in our assistance, boasting, for example, of the billions we spend annually on assistance to poor countries. Yet we ignore the vastly larger amounts that we extract from the poor without compensation. Consider the following examples.

First, affluent countries and their firms buy huge quantities of natural resources from the rulers of developing countries without regard for how such leaders came to power and how they exercise power. In many cases, this amounts to collaboration in the theft of these resources from their owners: the country's people. It also enriches their oppressors, thereby entrenching the oppression: tyrants sell us the natural resources of their victims and then use the proceeds to buy the weapons they need to keep themselves in power (Pogge 2008: 119-120, 168-173; Wenar 2008: 6, 8, 31).

Second, affluent countries and their banks lend money to such rulers and compel the country's people to repay it even after the ruler is gone. Many poor populations are still repaying debts incurred, against their will, by dictators such as Suharto in Indonesia, Mobutu in the Democratic Republic of the Congo, and Abacha in Nigeria. Again, we are participating in theft: the unilateral imposition of debt burdens on impoverished populations.

Third, affluent countries facilitate the embezzlement of funds by public officials in less developed countries by allowing their banks to accept such funds. This complicity could easily be avoided: banks are already under strict reporting requirements with regard to funds suspected of being related to terrorism or drug trafficking. Yet Western banks still eagerly accept and manage embezzled funds, with governments ensuring that their banks remain attractive for such illicit deposits. Global Financial Integrity (GFI) estimates that less developed countries have in this way lost at least US$ 342 billion annually during the 2000-2008 period (Kar & Curcio 2011; UN 2011).[20]

[20] For comparison, official development assistance during this period averaged US$87 billion annually, of which only US$9 billion was allocated to "basic social services" (UN 2011).

Fourth, affluent countries facilitate tax evasion in the less developed countries through lax accounting standards for multinational corporations. Since they are not required to do country-by-country reporting, such corporations can easily manipulate transfer prices among their subsidiaries to concentrate their profits where they are taxed the least. As a result, they may report no profit in the countries in which they extract, manufacture or sell goods or services, having their worldwide profits taxed instead in some tax haven where they only have a paper presence. GFI estimates that, during the 2002–2006 period, trade mis-pricing deprived less developed countries of US$ 98.4 billion per annum in tax revenues (Hollingshead 2010: 15).

Fifth, affluent countries account for a disproportionate share of global pollution. Their emissions are prime contributors to serious health hazards, extreme weather events, rising sea levels, and climate change, to which poor populations are especially vulnerable. A recent report by the Global Humanitarian Forum estimated that climate change is already seriously affecting 325 million people and is annually causing US$ 125 billion in economic losses, as well as 300,000 deaths, of which 99 % are in less developed countries (Global Humanitarian Forum 2009: 1, 78).

Finally, affluent countries have created a global trading regime that is supposed to release large collective gains through free and open markets. The regime is rigged; it permits rich states to continue to protect their markets through tariffs and anti-dumping duties and to gain larger world market shares through export credits and subsidies (including about US$ 265 billion annually in agriculture alone) that poor countries cannot afford to match (OECD 2009: 5). Since production is much more labour-intensive in poor than in affluent countries, such protectionist measures destroy many more jobs than they create.

WHAT OUGHT WE TO DO?

Taken together, these supranational institutional factors generate a massive headwind against the poor.[21] This headwind overwhelms the effects of public and private foreign aid, perpetuating the exclusion of the poor from effective participation in the globalised economy and their inability to benefit proportionately from global economic growth. This problem may be solvable through huge increases in development aid, but such continuous compensation is neither cost-effective nor sustainable. It is far better to develop institutional reforms that would reduce the headwind, and eventually turn it off. This would mean seeing the world poverty problem not as a specialist concern at the margins of grand politics but as an important consideration in all decisions related to institutional design.

The world's leading governments could mainstream the imperative of poverty avoidance in this way. But Western governments are unlikely to do this unless there is voter demand or at least voter approval. As of now, the opposite is the case. Even while the hardships suffered by poor people are rising, voters in the United States are putting foreign aid at the bottom of the list of expenditures to be preserved (CNN 2011: 17). Voters in Continental Europe are somewhat more supportive of foreign aid, with voters in Germany, Italy, France, and Spain holding that more of the needed budget cuts should come out of the military budget (Barber 2010). These more supportive voter attitudes are reflected in higher European outlays for official development assistance (ODA), which are 0.45 percent of gross national income versus 0.20 percent for the United States (UNSTAT 2010). Both rates are far below the Western promise of

[21] That this headwind is at most weak and uncertain has been forcefully argued by Cohen 2010: 26-38. See also author's reply: Pogge 2010: 175-191. With luck, this dispute will stimulate more and better empirical research on what the effects of various supranational institutional design decisions actually are.

the 1970s to bring ODA rates up to 0.70 percent - a promise that only five small countries (Denmark, Sweden, Norway, Luxembourg, and the Netherlands) have been honouring. It should also be noted that much foreign aid is spent for the benefit of domestic exporters or "friendly" governments; out of US$ 120 billion spent annually on ODA, only about US$ 15.5 billion is spent on "basic social services," that is, on reducing poverty or its effects (UNSTAT 2010: Tables Net ODA, million US$ and ODA to basic social services, million US$).

Citizen attitudes clearly matter. If citizens of Western states cared about the avoidance of poverty, then so would their politicians. But an individual citizen may still feel powerless to change anything and may then reject any responsibility for the massive persistence of severe poverty. When a large majority of one's fellow citizens is not ready to prioritise the world poverty problem, then there may be little that a few willing citizens can do to change their country's policies and posture in international negotiations about supranational institutional design. Should citizens in this situation be considered implicated in their country's human rights violation even if they have no reasonable option (short of emigration) to avoid contributing to, and benefiting from it?

In developed Western societies today, democratic institutions remain basically intact, and efforts to stir the conscience of one's compatriots are not futile. Moreover, citizens can avoid sharing responsibility for the human rights violations their government is committing in their name by compensating for a share of the harm for which their country is responsible. They can, for example, support effective international agencies or non-governmental organisations. Such compensation is typically less burdensome than emigration and it also reduces the relevant human rights deficit. To make room for this compensation option, our human-rights-correlative negative duty in regard to social institutions should then be amended. We have a duty not to collaborate in the design or imposition of social institutions that foreseeably cause a human-rights deficit that is reasonably avoidable through better institutions - unless we fully compensate for our fair share of the avoidable human rights deficit.

Conclusion

To show that we are indeed violating the human rights of the world's poor, I have proceeded in two main steps. The second part set forth a conception of what it means to violate a human right, arguing that "human rights violation" is a relational predicate, involving right holders as well as duty bearers, with the latter playing an active role in causing the human rights of the former to be unfulfilled. Widely neglected is one very common kind of such violations involving the design and imposition of institutional arrangements that foreseeably and avoidably cause some human beings to lack secure access to the objects of their human rights. We are actively harming people when we seize the authority to design and impose social institutions and then fail to shape these institutions so that human rights are realised under them insofar as this is reasonably possible. As argued in the third part, we violate the human rights of billions of poor people by collaborating in the imposition of a supranational institutional scheme that foreseeably produces massive and reasonably avoidable human rights deficits. We should press for more careful study of supranational institutional arrangements and their effect and for feasible reforms that make these arrangements more protective of the poor. Each of us should also do enough toward protecting poor people to be confident that one is fully compensating for one's fair share of the human rights deficit that we together cause. ■

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SOCIAL PROTECTION FLOOR FOR A FAIR AND INCLUSIVE GLOBALISATION EXECUTIVE SUMMARY

INTERNATIONAL LABOUR OFFICE (ILO)[22]

The challenge

It is hard to understate the social challenges the world faces. In 2010, global GDP was ten times larger than in 1950 in real terms – an increase of 260 per cent per capita. Yet despite the six decades of strong economic growth that followed the adoption of the universal Declaration of Human Rights, access to adequate social protection benefits and services remains a privilege, afforded to relatively few people.

Current statistics speak eloquently of widespread poverty and deprivation. About 5.1 billion people, 75 % of the world population, are not covered by adequate social security (ILO) and 1.4 billion people live on less than US $1.25 a day (World Bank). Thirty-eight per cent of the global population, 2.5 billion people, do not have access to adequate sanitation and 884 million people lack access to adequate sources of drinking water (UN-HABITAT 2010: 23f); 925 million suffer from chronic hunger (FAO 2011: 42); nearly 9 million children under the age of five die every year from largely preventable diseases (WHO 2012); 150 million people suffer financial catastrophe annually and 100 million people are pushed below the poverty line when compelled to pay for health care (WHO 2010: 5).

While globalisation has been a source of opportunities for those able to seize them, as the evidence above shows it has left many unprotected against new global challenges and transformations that are having deep repercussions at national and local levels. The persistence of such large numbers of excluded persons represents tremendous squandered human and economic potential. This is particularly important in a context of accelerated demographic ageing in countries with low coverage of pension and health systems.

Where does social protection fit into this picture? This report shows how social protection can play a pivotal role in relieving people of the fear of poverty and deprivation, delivering on the promises of the universal Declaration of Human Rights. The extension of social protection, drawing on basic social floors, is a missing piece in a fairer and inclusive globalisation.

In addition, it can help people adapt their skills to overcome the constraints that block their full participation in a changing economic and social environment, contributing to improved human capital development in both the short and longer term, and in turn stimulating greater productive activity. The report also shows how social protection has helped to stabilise aggregate de-

[22] This chapter reproduces the Executive Summary of the Report of the Social Protection Floor Advisory Group chaired by Michelle Bachelet ; the document was complemented by a series of hyperlinks and adapted to the editing format of this publication, including a bibliographical list and partly updated references.

mand in times of crisis and to increase resilience against economic shocks, contributing to accelerate recovery and more inclusive and sustainable development paths. Social protection represents, in fact, a "win-win" investment that pays off both in the short term, given its effects as macroeconomic stabiliser, and in the long term, due to the impact on human development and productivity.

Recent developments on the social protection landscape show remarkable progress in extending coverage, but this report contends that much more should – and can – be done. It also outlines how policies and programmes adopted within the social protection floor framework can have the greatest impact.

The social protection floor

The social protection floor approach has been developed by the ILO, drawing on the recent experiences of extending protection, mostly in developing countries. It was endorsed by the United Nations Chief executives Board and by the Heads of State and Government in the 2010 Millennium Development Summit as an integrated set of social policies designed to guarantee income security and access to essential social services for all, paying particular attention to vulnerable groups and protecting and empowering people across the life cycle.

It includes guarantees of:

- basic income security, in the form of various social transfers (in cash or in kind), such as pensions for the elderly and persons with disabilities, child benefits, income support benefits and/or employment guarantees and services for the unemployed and working poor;

- universal access to essential affordable social services in the areas of health, water and sanitation, education, food security, housing, and others defined according to national priorities.

The concept is part of a two-dimensional strategy for the extension of social security, comprising a basic set of social guarantees for all (horizontal dimension), and the gradual implementation of higher standards (vertical dimension), in line with the ILO's Social Security (Minimum Standards) Convention no. 102 (ILO 1952), and others, as countries develop fiscal and policy space.

The 2011 International Labour Conference undertook an extensive discussion of social protection, and in the process of defining its view of the social protection floor concurred with a unified approach to income security and access to essential goods and services set out as follows: "… social protection floors, containing basic social security guarantees that ensure that over the life cycle all in need can afford and have access to essential health care and have income security at least at a nationally defined minimum level. Social protection floor policies should aim at facilitating effective access to essential goods and services, promote productive economic activity and be implemented in close coordination with other policies enhancing employability, reducing informality and precariousness, creating decent jobs and promoting entrepreneurship" (ILO 2011a: 7f, 72).

Therefore, in addition to the elements mentioned in the CEB and Global Jobs Pact Definition, the Conference listed as core social protection floor objectives the need to promote productive economic activity and entrepreneurship, with sustainable enterprises and access to decent employment opportunities. While the above definition is multidimensional and indicative, countries have the flexibility of adopting different components in a sequential manner considering their respective needs and capabilities. Employment and entrepreneurship support policies could either complement the social protection floors or be fully integrated into their design, according to countries' institutional features.

The term “social protection floors”, in the plural, refers to national adaptations of the global approach to country-specific circumstances. Certainly, the social protection floor cannot be considered the magic solution to the world’s social problems, but a wide range of experiences from all over the world suggests that countries can move faster in reducing poverty and social exclusion if these issues are addressed in a coherent and consistent way, starting by extending horizontally access to essential social services and income security.

Why we need a social protection floor

The notion of the social protection floor is anchored in the fundamental principle of social justice, and in the specific universal right of everyone to social security and to a standard of living adequate for the health and well-being of themselves and their families. Provisions made within the framework of the floor relate to a range of rights listed in the universal Declaration of Human Rights. The core idea is that no one should live below a certain income level and everyone should at least have access to basic social services.

The social protection floor relates strongly to the Decent Work Agenda; to succeed in combating poverty, deprivation and inequality, it cannot operate in isolation. In order to realise poverty reduction effectively, its strategies must be accompanied by others, such as strengthening labour and social institutions and promoting pro-employment macroeconomic environments.

A number of countries have already incorporated the main elements and practical aspects of the floor into their social protection systems. In middle- and low-income countries, there are strong indications that access to social security programmes is closely linked to a reduction in poverty and inequality, along with other social transformations. Studies have shown that modest cash transfer programmes for older people and children have the potential to close the poverty gap significantly.

The effectiveness of social protection floor-type measures in reducing poverty, containing inequality and sustaining equitable economic growth is already well acknowledged in developed countries. In OECD countries, it is estimated that levels of poverty and inequality are approximately half of those that might be expected in the absence of such social protection provision. That said, this significant poverty reduction in such countries reflects the combination of both social protection floor measures and more comprehensive forms of social security. This signals the need for each country, having put in place measures representing a solid floor, to then take the next step of developing the vertical dimension of social protection.

Social protection floor provisions can lead to greater empowerment and autonomy for women, who are disproportionately represented in low-income groups. Women can become their own agents of change through the labour market and education opportunities likely to become available once they gain income security and access to essential services of the kind provided by the floor. Moreover, experience shows that benefits paid in the form of social transfers directly to women result in enhancement of their status and their capacity to exert increasing control over how household income is spent.

The social protection floor can contribute to addressing challenges linked to transformations such as demographic change, global health risks and food price volatility. Social safeguards provided through the floor can help to maximise the associated opportunities and minimise risks. Recent years have provided potent proof of the value of social protection interventions in a time of crisis. Throughout the economic and financial crisis many floor-type social protection measures acted as effective countercyclical stabilisers. They helped attenuate the adverse impact on la-

bour markets, contributed to maintaining social cohesion and stimulated aggregate demand. The combined effect of this effort ultimately aided and spurred economic recovery in a range of countries. More broadly, the floor's income-led approach can contribute to combating imbalances in the global economy by inducing reductions in precautionary savings and increases in the purchasing power of emerging consumer classes in developing countries, thereby strengthening the national markets.

Contrary to "received wisdom", social protection measures at a basic level, of the kind comprising the floor, can be kept within a relatively modest percentage of national income, even in severely resource-constrained countries. Several studies, notably by the ILO, UN DESA, UNICEF, WHO and ECLAC, attest to this affordability. To what extent resources should be devoted to such measures remains a country-specific choice. In other words, levels of social provision are driven much more by a country's political and policy environment than its level of economic development. The cost of a well-designed social protection floor is small compared to the tax revenues often forgone by not effectively collecting revenue from the wealthy and by not tackling inefficiencies that exist in many expenditure programmes.

Effective country-specific social protection floors, which can gradually expand, are not only affordable but can, in the long run, pay for themselves by enhancing the productiveness of the labour force, the resilience of society and the stability of the political process.

The report shows that the implementation of nationally defined social protection floors can be feasible, but not necessarily easy. Political will, fiscal space and effective institutions are preconditions for successful phasing-in of the floor. Clear strategies to minimise risks should be in place to guarantee effective delivery of benefits and services under adequate governance rules and respecting fiscal sustainability in an environment conducive to the generation of decent employment and sustainable enterprises.

Implementation

The social protection floor is neither a prescription nor a universal standard. It is an adaptable policy approach that should be country-led and responsive to national needs, priorities and resources. It facilitates a comprehensive approach to social protection, focusing on basic benefits first, having been conceived and developed on the basis of recent innovative experiences. These benefits can be introduced gradually and in a pluralistic way, according to national aspirations, to fit specific circumstances and prevailing institutional and financial capacities. The floor can help promote coherence and coordination in social protection and employment policies, so as to ensure that individuals may benefit from services and social transfers across the entire life cycle. The concept promotes a "whole government" approach that links social protection with other policy objectives.

Recent years have been marked by significant progress towards the implementation of social protection floor components in many developing countries. This process has moved faster in middle-income countries, especially through policies and programmes focusing on income security accompanied by the extension of essential services. As a result, reductions already seen in the social protection coverage gap have been further improved. In the developing world, however, a range of design and implementation issues have emerged, presenting challenges to the effective completion of a social protection floor.

Experience within and across countries offers a number of lessons. The most important are that national social protection floor policies benefit from long-term policy development, and that implementation plans should be based on national consensus. Such plans should define the ulti-

mate shape of the national social protection floor as well as priorities and key steps on the way to getting there. In addition, it is necessary to have a clear fiscal framework that establishes the approximate cost of each floor component on an ongoing basis, together with a detailed mapping of the fiscal resources that need to be generated. This is not an easy task. Indeed, successfully designing and setting priorities for elements of the floor depends on clearly understanding the objectives of benefit programmes and the effects of conditions attached to benefit payments. The definition of targeting criteria should be accompanied by reliable identification and monitoring technologies to combat fraud, minimise errors and ensure delivery to those who are entitled to the benefits and services. The choice of efficient institutional arrangements, especially delivery technologies, is also crucial. Mistakes can be costly, and may undermine public confidence and the credibility of the entire social protection floor development process. It is therefore important to learn from the experience of other countries and programmes.

Social protection floor components can be maintained on a long-term basis only if sufficient financial resources are made available, in competition with other claims on a government's spending capacity. Accordingly, it is necessary to consider in some detail the question of how to make available sufficient fiscal space for national programmes. In the past decade, the improvement in macroeconomic conditions, most notably in several middle-income countries, has enabled public institutions to begin to address social deficits and social exclusion. In many low-income countries, debt cancellation and revenues from natural resources have combined with economic growth to give governments more fiscal room for manoeuvre. While international solidarity in the form of aid can help to kick-start and consolidate the process of creating a floor in low-income countries, over the long run its implementation has to be financially sustainable at national level. Studies by the ILO, in consultation with the IMF, show that in countries such as Benin, El Salvador, Mozambique and Viet Nam, major social protection floor programmes would cost between 1 and 2 % of GDP.

Economic growth provides the easiest way to create fiscal space, which can then be claimed for social protection. But even in the absence of high growth, reallocating expenditure can generate fiscal space, provided there is political will. The fact that some countries spend much more than others on social protection even though their GDP per capita is similar bears witness to the role of political will in influencing national priorities. In some countries, fiscal reform centred on tax reorganisation has provided important new opportunities for financing social protection.

Advances in poverty analysis have been important in shaping programmes. The increased availability of household survey data, together with associated methods to identify and classify households and individuals in poverty, has improved the measurement and understanding of poverty. Multidimensional perspectives on poverty have helped promote the coordination of anti-poverty interventions, notably transfers and basic services. Specific evaluation techniques have generated information and knowledge on the impact of programmes, and of their design features and reach.

The challenge of extending the scope of existing poverty reduction programmes to strengthen pathways to work and employment is beginning to be addressed in developing countries. A stronger policy focus is needed to develop and integrate interventions, including active labour market policies and micro-enterprise development, which can open up work and employment opportunities for beneficiaries of transfer programmes. It is also important to align work incentives with poverty reduction programme objectives. In some middle-income countries with well-developed social insurance program-

mes, the interaction of social insurance and social assistance requires attention from policymakers.

The social protection floor should not be viewed as an alternative, but as a complement to social insurance institutions where these exist, and hence as a component of a comprehensive and pluralistic social protection system. In low-income countries lacking well-established social insurance institutions, the social protection floor should provide a foundation to the process of building social insurance institutions and facilitating the movement of people from social assistance into comprehensive forms of insurance. The perception of a binary division, wherein social insurance applies exclusively to those whose employment is "formal", or at least undertaken in the formal economy, while social assistance relates only to those lacking formal employment, does not correspond to the situation of many developing countries where mixed financing and institutional frameworks prevail.

Findings across countries and regions show that a variety and combination of methods have been adopted to identify intended beneficiaries. Methods for selecting people eligible to receive benefits include defining certain categories of the population or geographical areas and means testing based on income or wealth indicators. In practice, most programmes use a combination of methods, in some instances adopting procedures to enrol initially the poorest or most vulnerable, before proceeding towards upper limit thresholds that separate the eligible from the non-eligible. Combining methods is expected to improve the accuracy and efficiency of delivery systems while strengthening the effectiveness of combating extreme and chronic poverty. In addition to selection methods, the scale of a programme is important. Many experiences, particularly in less developed countries, concern pilots or small-scale programmes that cover only a limited share of those who need coverage and whose impacts cannot be measured with statistical significance at the national level. In such instances the next step must be to establish a coordinated set of social protection interventions – indeed a social protection floor.

Integrating and consolidating fragmented and underperforming social protection programmes into the social protection floor can bring important gains. Public agencies have a leading role in the development of social protection floor institutions. Government leadership helps to ensure accountability, especially regarding the rights and entitlements of people supported by the floor, and that programmes and policies fit in with development objectives. In strategies addressing multidimensional poverty, coordination between different sectors is essential, but often hard to secure. Institutional arrangements, such as for example the development of social protection sector coordinating agencies, are crucial for this. Despite significant growth of impact evaluation in the last decade, as noted below, there is still a need to deepen understanding on how to maximise the effectiveness of social policy interventions.

Monitoring, together with evaluation, is an essential management tool to provide regular information about how well a programme is working. This allows managers to act to improve programme implementation and should be viewed as a continuous process throughout the life of a programme. It should be an integral component, and must be adapted to the country and programme context. Although appropriate information technology is a key element of monitoring, it is by no means sufficient for success. Political support for the development of monitoring and evaluation capacity is vital.

Recommendations

The implementation of nationally defined social protection floors should follow some common principles. While adopted as a global concept, it is the responsibility of each country to design

and implement social floors shaped within a framework of nationally specific institutional structures, economic constraints, political dynamics and social aspirations. In other words, there are no one-size-fits-all solutions. In some countries, the social protection floor approach can serve to strengthen weaker levels of protection, fill coverage gaps and enhance coherence among social policies; in others it can serve as a tool to extend coverage in the horizontal dimension, as a first step to building fully comprehensive social protection systems.

While the design and implementation of nationally defined social protection floors should follow country-specific dynamics, we recommend that a number of principles and modalities be taken into account. These include:

- Combining the objectives of preventing poverty and protecting against social risks, thus empowering individuals to seize opportunities for decent employment and entrepreneurship.

- A gradual and progressive phasing-in process, building on already existing schemes, according to national priorities and fiscal constraints.

- Coordination and coherence between social programmes. In particular, and within a perspective treating human development on a life cycle basis, the floor should address vulnerabilities affecting people of different ages and socioeconomic conditions, and should be regarded as a framework for coordinated interventions at the household level, addressing multidimensional causes of poverty and social exclusion and aiming to unlock productive capacity.

- Combining income transfers with educational, nutritional and health objectives, to promote human development.

- Combining income replacement functions with active labour market policies as well as assistance and incentives that promote participation in the formal labour market.

- Minimising disincentives to labour market participation.

- Censuring economic affordability and long-term fiscal sustainability, which should be anchored in predictable and sustainable domestic funding sources; while noting that international solidarity in the form of cost-sharing may be needed to help to start the process in some low-income countries.

- Coherence between social, employment, environmental and macroeconomic policies as part of a long-term sustainable development strategy.

- Maintaining an effective legal and normative framework, so as to establish clear rights and responsibilities for all parties involved.

- An adequate institutional framework with sufficient budgetary resources, well-trained professionals and effective governance rules with participation of the social partners and other stakeholders.

- Censuring mechanisms to promote gender equality and support the empowerment of women.

- Effective health-financing systems to ensure access to needed health services of good quality.

To promote policy coherence and coordination among international organisations, we recommend the establishment of a mechanism for collaboration and coordination, which, while it may be developed on an ad hoc basis, should ensure the inclusion of experts from the relevant un agencies, programmes, funds, regional commissions and international financial institutions concerned with issues related to social protection.

The aim of such an inter-agency mechanism would be to ensure comprehensive, coordinated and collaborative action in responding to immediate and longer-term social protection challenges, placing a particular emphasis on the social protection floor at global, regional and national levels.

We recommend that international organisations join forces at national level to support, initially on a pilot basis, a group of self-selected countries. For these countries, we recommend that the social protection floor approach be considered part of the United Nations Development Assistance Framework (undAf) and integrated into national development plans.

With the deadline for the achievement of the Millennium Development Goals fast approaching, it is important to intensify efforts to achieve existing commitments and to start discussing a new framework for the coming decades. The social protection floor can be of help in this endeavour. By addressing multidimensional vulnerabilities in an integrated and interconnected way, it complements the MDGs perspective and provides a coherent and consistent social policy tool. We recommend that the floor approach be taken into consideration in the framework for the design of and commitments to future development approaches.

We welcome the conclusions of the 100th Session of the International Labour Conference and the discussions on a possible non-binding international recommendation on social protection floors to complement already existing social security standards, in particular ILO Convention no. 102. We recommend that the process of elaboration and adoption of such recommendation be given a clear priority in ILO activities to speed up its adoption. We encourage countries to include information on the implementation of social protection floors when reporting regularly under UN treaty obligations. We also invite the relevant treaty bodies and committees to consider preparing a general recommendation on the contribution of national social protection floors to the realisation of the social rights set out in various conventions.

We acknowledge that some low-income countries need external international support to build social protection and recommend an intensification of South–South, triangular and north–South cooperation in this area. We recommend that donors provide predictable multi-year financial support for the strengthening of nationally defined social protection floors in low-income countries within their own budgetary frameworks and respecting their ownership. We suggest that traditional donors, such as the OECD member countries, and emerging donors, agree on triangular cooperation mechanisms to enable building social protection in partner low-income countries. We recommend that such mechanisms be agreed in the high-level forums on aid effectiveness and other international forums on development cooperation.

We recommend the application where appropriate of experimental approaches to social protection, but that such programmes be subject to rigorous evaluation to assess their effectiveness and impact of social protection programmes. Technical and financial assistance and knowledge sharing should be encouraged to overcome the barriers to implementing experimental programmes in countries lacking the required financial resources. We encourage regional organisations to engage in international cooperation to promote knowledge sharing and support to low-income countries to implement social protection floors.

We welcome the explicit commitment from G20 countries[23] to extend their own social protection

[23] Argentina, Australia, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, México, Russia, Saudi Arabia, South Africa, Korea, Turkey, the United Kingdom, United States and European Union.

coverage through expanding social protection floors according to each country-specific situation and internationally agreed principles. Likewise, we welcome the G20 action in encouraging international donors to devote some Official Development Aid to strengthening social protection floors in low-income countries, while respecting the individual approaches these countries wish to take with regard to implementation. We strongly support the development and implementation of innovative financing mechanisms to raise additional funds to support the implementation of social floors. These could include a financial transaction tax, including on currency transactions; debt swap mechanisms; solidarity levies on airline tickets; and measures to facilitate remittances. Finally, we view as fundamental the G20 initiative calling for further policy coherence, coordination and collaboration in the multilateral system through the social protection floor framework. We recommend that the G20 prepare an action plan to implement its conclusions and establish periodical monitoring and reporting mechanisms regarding global progress towards the establishment of social protection floors. ■

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IMPLEMENTING THE SOLIDARITY PRINCIPLE THROUGH FINANCIAL EQUALISATION

JENS HOLST[24]

Abstract

To have any chance of becoming comprehensive and potentially universal, social protection requires societies to adjust unequal risks and differences in financial capacities between their members. Especially in welfare states, various equalisation mechanisms exist for balancing different social risks and unequally distributed purchasing power. These apply often, but by no means exclusively, to formal social security arrangements and are an integral part of social health protection schemes based on the principle of solidarity. Moreover, competitive health insurance markets require risk structure equalisation mechanisms in order to prevent or at least reduce risk selection.

Beyond social protection systems as such, financial compensation mechanisms can be applied in broader settings at national and international levels. This paper will present two well-established examples illustrating the operating mode and the potential of inter-regional and inter-state equalisation mechanisms, namely the Federal Financial Equalisation System in Germany and the European Regional Development Fund. It will further briefly discuss the capacity of financial adjustment schemes to play a role in global social protection.

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Setting up global financial support and equalisation mechanisms will certainly not be an easy task and will require both political assertiveness and persuasive concepts. As McDonald (1996: 301f) stated, rightly: “The possibilities inherent in the idea of solidarity should stimulate our thought about the constitutional and structural means by which a more democratic global society can be realized”.

Principle of Solidarity

Solidarity is a quite comprehensive term that is broadly used in very different settings and with sometimes surprisingly different meanings. Solidarity is generally defined as “a unifying opinion, feeling, purpose or interest among a group of people” (yourdictionary 2012). It alludes to positive associations connected to supportive attitudes and a mode of co-existence based on mutual help. It expresses the condition of having united or common interests, purposes or sympathies that are shared among members of a group.

But solidarity calls to respond not simply to individual misfortunes; there are societal issues that call for fairer, more equitable social structures. The concept of solidarity goes beyond engaging in charitable actions and works. In international law, solidarity refers to the principle of cooperation that identifies as the goal of joint and separate state action an outcome that benefits all states (cf. McDonald 1996: 259f). Solidarity is a fundamental principle of welfare states and so-

cial protection systems, and the overall objective of solidarity is social justice. It leads to choices that will promote and protect common goods such as health, decent life and participation.

The development of welfare states and comprehensive social protection has shown that beyond all conceptual wooliness, solidarity can be operationalised far beyond voluntary charity and occasional actions of mutual support. Social protection in health has long developed the pioneering model of converting a vague concept into social right and entitlement while safeguarding fairness and sustainability. Health financing in both national health systems and social health insurance goes beyond the principle of insurance. A broad range of insurance arrangements exist, covering life, crops, fire, assets, car accidents and many other risk classes. Insurance is based on the law of large numbers, on group sharing of unforeseeable individual risks, and on prepayment of affordable amounts for preventing high and potentially catastrophic expenditures. This applies to all types of insurance, regardless of the risk covered.

Solidarity in health insurance, however, goes beyond sharing the financial risk of potential losses among a group of insurees. The principle of solidarity does not only imply risk sharing among the healthy and the ill, but also cross-subsidisation between the wealthy and the poor. It has to be stressed that the principle of solidarity is due neither to theoretical considerations nor to wishful thinking; it is implemented in daily practice through the way resource generation and allocation are organised. All types of health-system financing that define payment according to ability to pay and entitlement according to need do, in effect, operationalise solidarity. Both tax-funded national health systems and social health insurance (SHI)[25] schemes combine income-based prepayment for health with needs-driven access to health care.

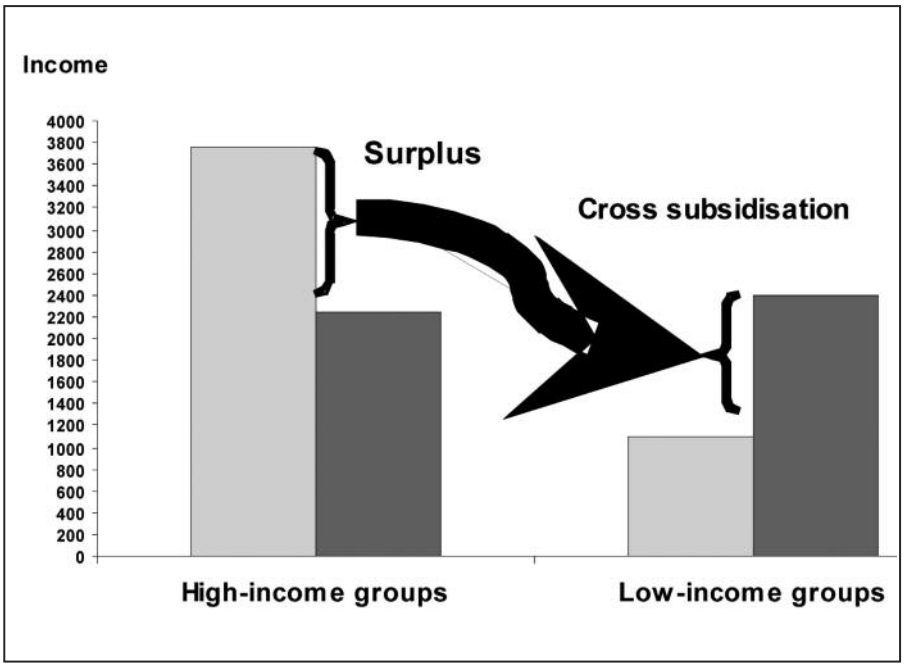
If everybody pays for health coverage according to his or her ability to pay and is entitled to the same scope of benefits whenever (s)he needs them, the solidarity principle comes into operation. The typical redistributive effects in health protection beyond the mere insurance principle – namely from the better off to the poorer members of society, from the economically active to the inactive, from younger people to the elderly and from singles and small families to larger families (if dependents are covered free of charge) – arise automatically from combining progressive resource generation with needs-driven allocation based on a unique benefit package.

To operationalise the solidarity principle effectively at society level, all members of society in need must have access to healthcare, regardless of their ability to pay. Universal healthcare systems have to ensure equal access for all to the same benefit package according to entitlements based on income-related payments and prevention of risk selection. To achieve this, tax-funded national health systems have to ensure

[25] Revising international publications on SHI and especially on SHI in developing countries reveals that many authors from World Bank, USAID, ADB and others either do not make any serious effort to define what SHI means (see e.g. Hsiao & Shaw 2007, Wagstaff 2007) or even do so erroneously. Confusion exists even among internationally recognised researchers as one might see in the abstract of a presentation held at the 2011 meeting of the International Health Economics Association. Arnab Acharya from the London School of Hygiene and Tropical Medicine and his colleagues base their systematic review on the question Do Social Health Insurance Schemes in Developing Country Settings Improve Health Outcomes and Reduce the Impoverishing Effect of Healthcare Payments for the Poorest People? A Systematic Review on a definition of SHI that is quite distant from what the concept stands for: “Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organisations at the community level provide social health insurance in developing countries. Social health insurance pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other, and is generally organized by national governments” (see also Acharya et al. 2011: fortunately this review based on wrong definitions and assumption has not yet been published in the Cochrane Database of Systematic Reviews). This type of conceptual bafflement and fogginess prevails particularly among scientists and stakeholders from other than SHI countries and reflects a mix of insufficient knowledge or even ignorance and intentional political reinterpretation.

effective and progressive tax payment and SHI systems have to achieve universal coverage. "Solidarity means that all members of society in need must have access to healthcare, regardless of their ability to pay. Solidarity is not a woolly notion about the common good. It has a specific meaning that a healthcare system is organised and managed on the basis of universal access, without risk selection, based on income related premiums and with no significant differences in the benefit package" (den Exter 2008: 698; cf. Stoltzfus Jost et al. 2006: 688). "Solidarity is neither charity nor welfare; it is an understanding among formal equals that they will refrain from actions that would significantly interfere with the realization and maintenance of common goals or interests. Solidarity requires an understanding and acceptance by every member of the community that it consciously conceives of its own interests as being inextricable from the interests of the whole" (McDonald 1996: 290).

TABLE 1: DISTRIBUTION OF GLOBAL HOUSEHOLD INCOME



Risk equalisation mechanisms for implementing solidarity

RISK (STRUCTURE) ADJUSTMENT IN HEALTH INSURANCE

Risk equalisation mechanisms are increasingly common in health-insurance markets. Risk adjustment – sometimes also called risk structure adjustment – establishes financial transfers between various insurers in order to compensate for competitive disadvantages due to differences in the risk mix of different health-insurance funds. Funds with a higher number or share of elderly, low-income and chronically ill enrolees face higher expenditures because they have more expensive customers in their risk pool. Risk structure adjustment is a common means for enhancing the fairness of health financing. In principle, risk equalisation promotes solidarity and – at least indirectly – universal coverage in multiple-player health insurance systems. Without cross-subsidising between funds with better and worse risk mixes, it will be extremely difficult to assure health protection to all citizens.

Although risk adjustment has long been present in SHI systems, the relevance of risk equalisation has dramatically increased with the implementation of market-driven concepts in social protection. Actually risk equalisation is mostly discussed in the context of introducing competitive insurance markets. Under the prevailing liberal paradigm in global health policy, competition between health insurance funds or companies has become a common denominator of health-sector reforms and is generally expected to increase efficiency and help to contain costs (e.g. Paolucci et al. 2006: 107).

Risk equalisation is typically an element in competitive health insurance systems, which are often called markets in accordance with the prevailing economic view of health care and health financing. Risk adjustment is generally considered an indispensable prerequisite for implementing competition between health-insurance funds or companies. During recent decades, practically all countries have been implementing market-driven health-sector reforms in order to achieve better performance and higher efficiency. A common approach for improving the healthcare system is to introduce measures mainly derived from micro-economic theory. Among many other aspects, this is reflected in the claim to strengthen the demand side in the health sector and to support the position of clients in the health-insurance market.

Consumer choice has become a key issue in the health sector reform debate and in health policy in general. On the one hand, the concept is in line with the Health-for-All strategy because it refers to essential demands of the primary-healthcare movement proclaimed at the Conference of Alma Ata in 1978, such as participation and empowerment. On the other hand, consumer choice is a pillar of liberal economic systems and market economies. Empowerment of both insurees and patients is usually considered a promising strategy for making healthcare systems more efficient and, lately, for containing rapidly increasing expenditure on health.

In health financing, the liberal paradigm is reflected in competition between various health-insurance funds, be they public or private. As a matter of fact, various countries with Bismarckian health insurance systems permit periodic consumer choice of the SHI provider (e.g. Belgium, Czech Republic, Germany, Israel, Netherlands, Slovakia) (van de Ven 2011: 147). Likewise, insurance companies operate in competitive markets in those countries where private health insurance is an important provider of mandatory health protection (e.g. Chile, Switzerland). Commercial health insurance companies also tend to compete with each other for their market share, but competition might vary according to the general health-sector framework e.g. in Australia, Ireland and South Africa.

The global enthusiasm for competitive arrangements in contribution-based social health protection is as evident as it is surprising. It is widely known and has been repeatedly proven that competition among health insurance providers has a series of inevitable and undesired consequences. Competitive health-insurance markets entail risk selection because health-insurance providers tend to increase revenue and reduce expenditures. The resulting market segmentation into “good risks” and “bad risks” has serious adverse effects, and impedes universal coverage unless adequate regulations and policies are in place. Risk equalisation and risk adjustment are essential for preventing the most drastic disadvantages of a competitive health insurance market, which are largely due to risk selection (cf. van de Ven 2007: 149).

The general understanding of risk adjustment in health financing refers to payments taking place between insurers to compensate for the competitive disadvantage of those insurance providers whose customers are on average older, poorer or otherwise more likely to suffer from bad health and incur higher medical expenses. Equalisation of risks takes place from insurers with low risk profiles to insurers with high risk profiles. In practical terms this means that insurers with a healthier client mix make compensation payments to those schemes that have a larger share of higher-risk beneficiaries. From a health-policy perspective this is typically done in order to encourage insurers to compete on their own merits – e.g. based on efficient contracting with providers of care and investment in quality and prevention – rather than on risk selection of their customers – i.e. insuring only healthy consumers. Moreover, without risk equalisation the other public interest policies such as open en-

FIG. 2: RISK ADJUSTMENT IN SELECTED COUNTRIES

Risk adjustment and risk sharing system 2000–2006

	Belgium	Germany	Israel	Netherlands	Switzerland
Risk adjusters in 2000	Age/gender Disability Income Employment status Mortality Family composition Social status Urbanization Preferential reimbursement (lower co-payments)	Age/gender Disability Entitlement for sick leave payments Income	Age	Age/gender Urbanization Entitlement for sickness fund membership (e.g. disability)	Age/gender Region
New risk adjusters added in 2001–2006	Diagnosis of invalidity Eligibility of social exemption Chronic illness	Registration in a certified Disease Management Programme	–	Pharmacy-based cost groups Diagnostic cost groups Being self-employed.	–
Quality of the risk adjustment system in 2006	Moderate/fair	Moderate	Low	Fair	Low
Level of ex-post cost-compensation 2000–2006	Decreased from 96% (2000) to 92.5% (2006)	Increased from 0% (2000) to 4% (2006), due to high-cost pooling	Unchanged (5%)	Decreased from 64% (2000) to 47% (2006)	Unchanged (0%)
Potential profits from risk selection in 2006[a]	In general low, but can be quite substantial for a small group of 'chronic high-cost' insured	Very high	Very high	Fair/high	Very high

Source: van de Ven et al. 2007: 164

rolment and community rating are unlikely to work, given the possibilities of de facto risk selection (e.g. based on selective marketing and neglecting the needs of undesirable consumers) (Sauter 2008, p. 5).

From a purely economic perspective, however, risk equalisation is counterproductive for applying "real" competition in health insurance markets. Nevertheless, there is general consensus that effective risk adjustment is an essential precondition for reaping the benefits of a competitive health insurance market. Without risk equalisation, the disadvantages of a competitive insurance market are very likely to outweigh the expected advantages. However, international experience suggests that in practice the implementation of even the simplest risk equalisation scheme is very complex (van de Ven et al. 2007; Armstrong et al. 2010).

Risk adjustment has the potential to reduce risk selection and prevent the most unfair excesses of competitive health-financing arrangements, but it cannot fully rule them out. Competitive health-insurance markets, whatever the level of regulation is, cannot avoid a certain risk of legal or illegal attempts by HI funds to optimise their risk mix according to the regulations in force. From the perspective of current health economics, however, health-insurance funds have financial incentives to select the predictably profitable consumers only in the case of imperfect risk adjustment. The belief is that undesired effects of health-insurance competition are due to imperfect risk adjustment and that the equalisation mechanisms have just to be brought to perfection in order to reconcile competition and solidarity (Paolucci et al. 2006: 110; van de Ven 2011: 150).

The predominant trend in health-policy debates is consciously or unconsciously casting doubt on the priority goal of social health insurance, namely to provide access to affordable health-care coverage to a certain group or, better still, the whole population. In the prevailing market-driven debate it should not be ignored that there is essentially no need for risk adjustment in non-competitive health-insurance systems. Although concepts and solutions provided by "modern" health economics might appear fashionable and even seem to hold out the promise of solving global health problems, they are associated with high risks of detrimental impacts on essential health-policy goals such as the right to health, universal coverage and solidarity.

Financial equalisation mechanisms at national level

The Federal Republic of Germany (FRG) (formerly often called West Germany) was founded in 1949 as a federal state comprising the Federation and a series of federated states known as the "Länder" (singular Land) or, more completely, Bundesländer.[26] Due to the unification of the FRG with the former German Democratic Republic (often referred to as East Germany) in 1990, the total number of partly sovereign constituent states of the extended Federal Republic of Germany is now 16. Federalism is established in Germany's Basic Law: "The constitutional order in the Länder must conform to the principles of a republican, democratic and social state governed by the rule of law, within the meaning of this Basic Law. In each Land, county and municipality the people shall be represented by a body chosen in general, direct, free, equal and secret elections" (Deutscher Bundestag 2010: 31: Art 28 (1)).

Decentralised political power and decision-making is taken as a constant in the German Constitution and defines essential elements of the political framework conditions. But to be effective and sustainable, decentralisation and federalism require adequate distribution of power, including a delegation of power towards the decentralised levels for the performance of those tasks transferred from central to regional and local governments. At the same time, corresponding financial resources have to be available at the decentralised levels. In order to fulfil their tasks under constitutional law, the Länder need both sufficient means at their disposal, and free and independent control over such resources.

The legal settings of the Federal Republic and its constituent states established by the German Basic Constitutional Law Art. 28 on "Land constitutions – Autonomy of municipalities" (Deutscher Bundestag 2010: 31) have to be considered and applied in the perspective of another noteworthy specification of the German Constitution: Art. 20 (1) specifies that the federal states have a responsibility to ensure social equity both among individuals and provinces. The basic idea behind this is to create and maintain equal living conditions for the entire population all over the country, irrespective of the region they live in. To achieve this ambitious goal, Germany's constitution guarantees the Federation and Länder appropriate levels of funding and determines the respective procedural regulations.

At the core of this constitutional duty, the Federal Republic of Germany has implemented a financial equalisation system between the Federal Government and the Länder, which aims at balancing living standards across the country, and might be combined with structural policy measures to raise living standards in

[26] Although the FRG comprised 11 Länder during the first half century of its existence, it was created in 1949 with 12 Länder: On the one hand, today's federal state of Baden-Württemberg still consisted of the three Länder Baden, Württemberg-Baden and Württemberg-Hohenzollern, which decided to merge in 1952. On the other hand, the Saarland was a French-occupied territory separated from Germany until 1956; when the inhabitants were offered independence in a plebiscite in 1955, they instead voted to become part of West Germany.

those areas (Deutscher Bundestag 2010: Art. 107 (2)).

ARTICLE 107
[Distribution of tax revenue – Financial equalisation among the Länder – Supplementary grants]

(1) Revenue from Land taxes and the Land share of revenue from income and corporation taxes shall accrue to the individual Länder to the extent that such taxes are collected by finance authorities within their respective territories (local revenue). Details regarding the delimitation as well as the manner and scope of allotment of local revenue from corporation and wage taxes shall be regulated by a federal law requiring the consent of the Bundesrat. This law may also provide for the delimitation and allotment of local revenue from other taxes. The Land share of revenue from the turnover tax shall accrue to the individual Länder on a per capita basis; a federal law requiring the consent of the Bundesrat may provide for the grant of supplementary shares not exceeding one quarter of a Land share to Länder whose per capita income from Land taxes, from income and corporation taxes and from taxes under Article 106b ranks below the average of all the Länder combined; with respect to the tax on the acquisition of real estate, the capacity to generate revenue shall be considered.

(2) Such law shall ensure a reasonable equalisation of the disparate financial capacities of the Länder, with due regard for the financial capacities and needs of municipalities (associations of municipalities). It shall specify the conditions governing the claims of Länder entitled to equalisation payments and the liabilities of Länder required to make them as well as the criteria for determining the amounts of such payments. It may also provide for grants to be made by the Federation to financially weak Länder from its own funds to assist them in meeting their general financial needs (supplementary grants) (BMJ 2010).

Source: Deutscher Bundestag 2010: 98f

The quite elaborate financial equalisation scheme ensures both vertical and horizontal redistribution of pooled national revenue: firstly, the entire tax revenue is distributed to the two levels of government (Federation and Länder) and municipalities receive a supplementary grant of revenue. Secondly, the total amount of taxes raised at state level is allocated among the 16 Länder. And thirdly, the financial equalisation of the Länder defines net flows from rich to poor regions according to the difference between a Land's per-capita revenue and the average fiscal capacity per inhabitant. For the fine-tuning of financial equalisation between wealthier and poorer Länder, a linear-progressive schedule (60 % - 95 %) is applied: the more a Land's revenue exceeds the national average, the higher the percentage of its relative surplus funds that have to be transferred to the equalisation system; and the further a Land's revenue falls below the national average, the higher the percentage of its relative deficit that will be refunded by the financial adjustment scheme. In addition to the Länder equalisation mechanism as such, uncommitted federal grants complement financial adjustment among the Länder in order to provide poor Länder with additional resources; uncommitted grants from the Federation are available as general supplementary federal funds for general purposes and supplementary federal grants for special needs (BMF 2010: 1).

All procedural regulations assuring that wealthier federal states make adjustment payments to poorer Länder as well as all details of the individual stages are established by ordinary law.

Furthermore, up to 25 % of VAT income accruing to the Länder is used for additional ex-ante financial equalisation between wealthier and poorer federal states according to linear-progressive topping-up: the lower the VAT income of a Land, the higher the relative equalisation. It is worth mentioning that financial adjustment only partially compensates the differences in revenue generation among federal states in order to safe-

TABLE 1: EQUALISATION OF THE DIFFERENCES IN FINANCIAL CAPACITY BY APPLYING THE SYSTEM OF FINANCIAL EQUALISATION AMONG THE LÄNDER AND THE GENERAL SUPPLEMENTARY FEDERAL GRANTS

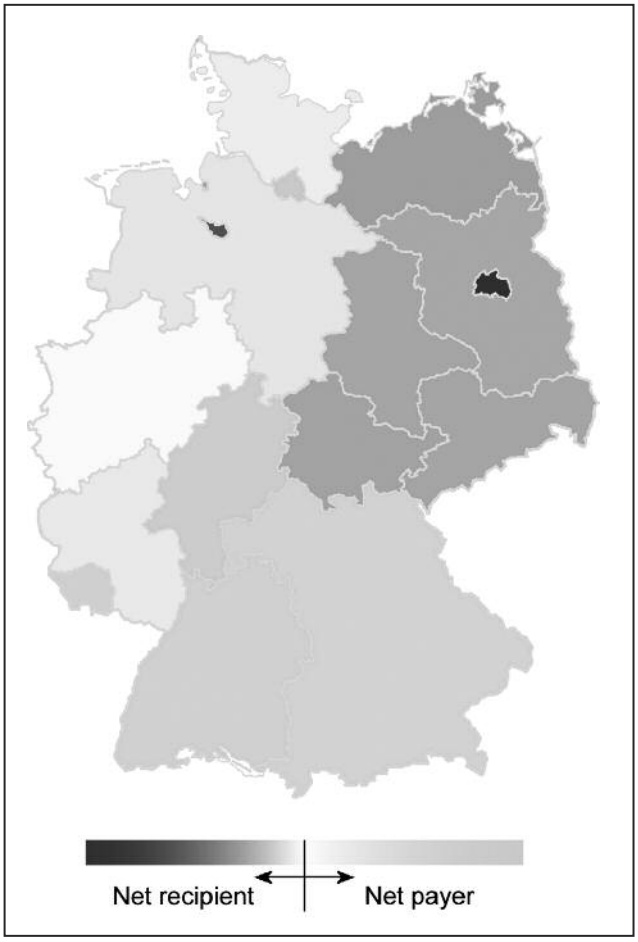
Financial capacity per inhabitant before financial equalisation among the Länder as a % of the average financial capacity per inhabitant	Financial capacity per inhabitant after financial equalisation among the Länder as a % of the average financial capacity per inhabitant	Financial capacity per inhabitant after financial equalisation among the Länder and the supplementary federal grants as a % of the average financial capacity per inhabitant
70	91	97 1/2
80	93 1/2	98
90	96	98 1/2
100	100	
110	104	
120	106 1/2	
130	109	

Source: BMF 2010: 5

guard fiscal autonomy and sovereignty of decentralised bodies. The reference point of financial equalisation among the Länder is per-capita tax revenue defined as the state tax receipts plus 64 % of the sum the of municipal tax receipts. This allows wealthier municipalities in a poor Land to reduce their net financial adjustment benefits. Moreover, financial equalisation takes into account higher per-capita resource requirements of city states and sparsely populated Länder. The overall redistribution effects of the financial equalisation system in Germany are quite considerable. In 2009, direct adjustment among the Länder according to financial equalisation amounted to € 7 billion, supplementary federal grants to € 12.8 billion and the VAT ex-ante adjustment € 6.6 billion.

In view of the current challenge of how to implement an international framework for global social protection, it has to be pointed out that all procedural regulations assuring that wealthier federal states make adjustment payments to poorer Länder as well as all details of the individual stages are equally established by ordinary law.

FIG. 3: FINANCIAL EQUALISATION IN THE FEDERAL REPUBLIC OF GERMANY



Source: Wikipedia

Financial equalisation mechanisms at international level

Of course, unequal regional income and living conditions are not restricted to national states. They are also present and often much more pronounced in supranational institutions such as free-trade agreements and economic associations. There is even some evidence that they tend to increase regional inequality and disparities within communities and countries (Perry et al. 2006: 136f) unless proactive political frameworks and supportive action are implemented.

The former European Economic Community (EEC) and current European Union (EU), as the oldest and certainly most developed full-scale trade agreement in the world, provides some compelling examples for the need to focus on inter-regional differences regarding living standards. Compensating the socio-economic and income differences in the regions was a basic political concept of the EU from the very beginning. With the intention of reducing existing disparities between development levels of the various regions and overcoming the backwardness of least-favoured regions and islands including rural areas, the EU has set up a series of structural funds and compensation mechanisms that are worth considering in more detail. Funds under the Cohesion policy are complemented by other specific funds whose objective is to contribute to the regional development within the EU. The need for financial equalisation and adjustment between regions has usually been largest when new Member States accede to the community. This was especially the case after the inclusion of three Southern European countries in 1981 (Greece) and 1986 (Portugal and Spain) and again after the waves of Eastern European enlargement in 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia and Cyprus) and in 2007 (Bulgaria and Romania). For the implementation of its policy to create more equal conditions all over the community regions and to adjust living standards, the EU provides two types of funds. In addition to structural funds aiming at improving infrastructure and investing in physical development, namely the European Regional Development Fund (ERDF) and the European Social Fund (ESF), the EU has set up so-called cohesion funds as essential tools of the EU's regional policy. Together with the Common Agricultural Policy (CAP), structural funds and cohesion funds make up the great bulk of EU funding, and the majority of total EU spending.

EUROPEAN FUND FOR REGIONAL DEVELOPMENT (EFRD)

The European Regional Development Fund (ERDF) addresses regional development, economic change, enhanced competitiveness and territorial cooperation throughout the EU. Funding priorities of this support programme include modernising economic structures, creating sustainable jobs and economic growth, facilitating research and innovation, implementing environmental protection and ensuring risk prevention. Particularly in the least-developed EU regions, the ERDF also plays an important role in infrastructure investment. For achieving their objectives EFRD funds are mainly intended for economic promotion in the following areas:

- Productive investment for creating or ensuring jobs
- Infrastructure
- Local development initiatives and support of the activity of smaller and medium-sized companies
- Promote economic and social cohesion by correcting the main regional imbalances and participating in the development and conversion of regions
- Provide assistance for cross-border, transnational and inter-regional cooperation under

Objectives 1 and 2:

Convergence Objective (formerly Objective 1): Promote the development and structural adjustment of regions whose development is lagging behind;

Regional Competitiveness and Employment Objective (formerly Objective 2): Support the economic and social conversion of areas experiencing structural difficulties Territorial Cooperation Objective (formerly Objective 3):

TABLE 2: COMMITMENT APPROPRIATIONS FROM THE STRUCTURAL FUNDS FOR 2000-06 IN MILLION € (1999 PRICES), EXCLUDING COMMUNITY INITIATIVES AND INNOVATIVE ACTIONS

Member State	Objectives					FIFG (Non-Objective 1)	Total
	1	Transitional support Objective 1	2	Transitional support Objective 2	3		
Belgium	0	625	368	65	737	34	1,829
Denmark	0	0	156	27	365	197	745
Germany	19,229	729	2,984	526	4,581	107	28,156
Greece	20,961	0	0	0	0	0	20,961
Spain	37,744	352	2,553	98	2,140	200	43,087
France	3,254	551	5,437	613	4,714	225	14,794
Ireland (2)	1,315	1,773	0	0	0	0	3,088
Italy	21,935	187	2,145	377	3,744	96	28,484
Luxemburg	0	0	34	6	38	0	78
Netherlands	0	123	676	119	1,686	31	2,635
Austria	261	0	578	102	528	4	1,473
Portugal	16,124	2,905	0	0	0	0	19,029
Finland	913	0	459	30	403	31	1,836
Sweden (3)	722	0	354	52	720	60	1,908
UK (2)	5,085	1,166	3,989	706	4,568	121	15,635
EUR 15	**127,543**	**8,411**	**19,733**	**2,721**	**24,224**	**1,106**	**183,738**

Source: CEC 2001: 14

The Convergence Objective covers regions whose GDP per capita is below 75 % of the EU average. It aims at accelerating the economic development of low-productivity and low-income regions throughout the EU. The Convergence Objective is financed by funds from the ERDF, the ESF and the Cohesion Fund. Prioritised areas are human and physical capital, innovation, knowledge society, environment and administrative efficiency. The budget allocated to this objective is current € 283.3 billion.

The Regional Competitiveness and Employment Objective is applicable to all regions of the EU territory, except those already covered by the Convergence Objective. It aims at reinforcing regional competitiveness, employment and attractiveness and focuses mainly on innovation, promotion of entrepreneurship and environmental protection. The funding of currently € 55 billion is provided from the ERDF and the ESF.

- Last but not least the territorial Cooperation Objective builds upon the Interreg initiatives[27] of previous years, which were originally planned to be fully incorporated into the main objectives of the structural funds. Financed by the ERDF with a budget of € 8.7 billion, its aim is to promote cross-border cooperation between European regions, as well as the development of common solutions for issues such as urban, rural and coastal development, shared resource management or improved transport links.

[27] Interreg initiatives are designed to stimulate cooperation between EU Member States in order to diminish the influence of national borders in favour of equal economic, social and cultural development throughout of the European Union. Interreg aims at strengthening economic and social cohesion in the European Union by promoting balanced development through cross-border, trans-national and inter-regional cooperation. One of the approaches is to place special emphasis on integrating remote regions with those that share external borders with the countries applying for EU membership.

EUROPEAN SOCIAL FUND (ESF)

The European Social Fund (ESF) is one of the EU structural funds, set up to reduce differences in prosperity and living standards across EU Member States and regions, and therefore promoting economic and social cohesion. The European Social Fund (ESF) focuses on four key areas: adaptability of work force and enterprises, access to employment and participation in labour markets, social inclusion through combating discrimination and facilitating access to the labour market for disadvantaged people, and partnership for reform in the fields of employment and inclusion.

The ESF is devoted to promoting employment in the EU. It helps Member States make Europe's workforce and companies better equipped to face new, global challenges. In short:

- Funding is spread across the Member States and regions, in particular those where economic development is less advanced.

- It is a key element of the EU's 2020 strategy for Growth and Jobs targeted at improving the lives of EU citizens by giving them better skills and better job prospects.

- Over the period 2007-2013 some €75 billion will be distributed to the EU Member States and regions to achieve its goals.

The EU Member States and regions manage ESF funds, to deal with the diverse employment challenges they face. This section gives access to Member State ESF operational programmes, their priorities, their funding and their successes.

EUROPEAN COHESION FUND (ECF)

The Cohesion Fund as a core element of EU regional policy comprises a set of financial tools set up to implement the Cohesion policy, also referred to as the Regional policy of the European

Union. They aim to reduce regional disparities in terms of income, wealth and opportunities. Europe's poorer regions receive most of the support, but all European regions are eligible for funding under the policy's various funds and programmes. The Cohesion Fund contributes to interventions in the field of the environment and trans-European transport networks. It applies to Member States with a per-capita gross national income (GNI) of less than 90 % of the EU average. As such, it covers all 12 new Member States (Bulgaria, Cyprus, the Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia and Slovenia) as well as Greece and Portugal. Spain is also still eligible for the Cohesion Fund, but on a transitional "phasing out" basis.

The European Cohesion policy pursues the objective of reducing economic as well as social shortfalls and stabilising national and regional economies. Activities financed under the ECF comprise trans-European infrastructure and environmental projects, and may also relate to transport, e.g. energy efficiency, use of renewable energy, developing rail transport, supporting inter-modality, strengthening public transport, etc..

The role of international financial equalisation schemes for GSP

LIMITED USE OF RISK ADJUSTMENT SCHEMES

Risk equalisation is typically an instrument for regulating competitive health-insurance markets and lacks relevance for non-competitive arrangements. Hence risk equalisation mechanisms are unlikely to play a role for global social protection since it is not about national health-financing schemes – either tax-borne or contribution-based – competing with each other. On the one hand, each country's risk mix is predetermined and not subject to selection. On the other hand, risk adjustment requires reliable and comparable data for ensuring a minimum of adequate compensation and of course a reference currency. The often-applied purchasing power parity, expressed in international dollars, is certainly insufficient for establishing a fair calculation basis due to the wide variability of healthcare provision costs.

A risk-adjustment approach to global social protection will require realistic and operable concepts for calculating the overall "risk" of poorer countries compared to wealthier societies. Compensation payments based on a country's health risk would first of all need reliable data on morbidity and mortality, in terms of potential years of life lost (PYLL), disability-adjusted life years (DALY) and quality-adjusted life years (QALY). Moreover, the availability, capacity and quality of healthcare facilities, health professionals, drugs and other core items of healthcare provision would have to be assessed in order to define the need. These data would have to be cross-checked with indicators of social health protection and healthcare funding in a country. All this would have to be calculated on the basis of internationally comparable reference scales, taking into account the large variability of costs and prices payable for healthcare. All in all it will be extremely difficult to establish reliable and fair mechanisms for cross-border comparisons, which are indispensable for adjusting risks between different countries.

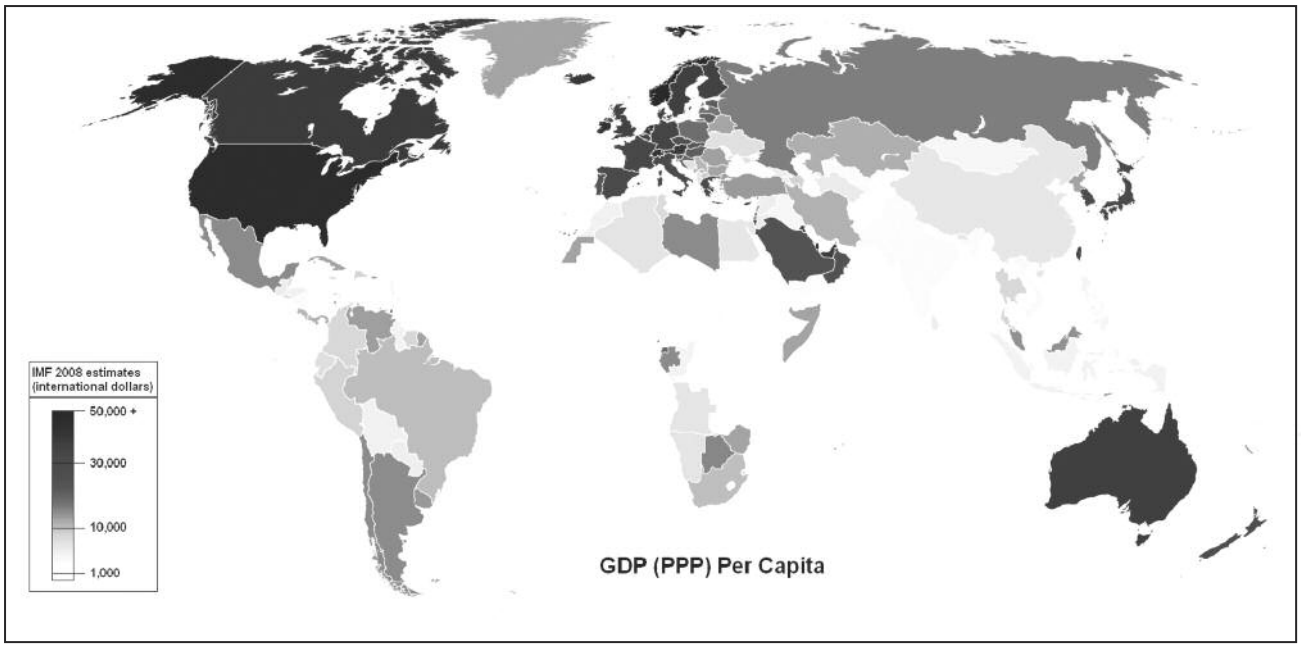
THE POTENTIAL OF NATIONAL EQUALISATION SYSTEMS FOR GLOBAL SCHEMES

National financial adjustment systems such as the Länderfinanzausgleich in Germany provide some enlightening lessons learned that can enrich the discussion about international social protection funds. They have certainly a potential for making global social protection possible, for enhancing equity with regards to global health financing and for implementing the principle of solidarity at international and global levels. Applying the principles of national equalisation me-

chanisms worldwide, however, requires a series of adaptations. Any implementation of financial adjustment among nations that vary considerably with regards to economic and social development and living standards has to take into account extremely different levels of national income, revenue and available resources.

achieved by applying linear progressive transfers where all countries pay according to the difference their per-capita GDP shows from international average. However, redistribution could be even more effective if a mechanism of more progressive adjustment is applied such as equalisation scheme between the German Länder

FIG. 4: PER-CAPITA GROSS NATIONAL INCOME IN PURCHASING-POWER PARITY



Source: Wikipedia 2012a (based on IMF 2008)

A rather practical approach would be to base adjustment payments on countries' GDP and use the average world GDP as reference scale for defining adjustment payments from wealthier to poorer nations. Countries might either be grouped in GDP brackets (as shown in Fig. 4 above) or individually categorised according to their relative position to the global mean per-capita GDP.

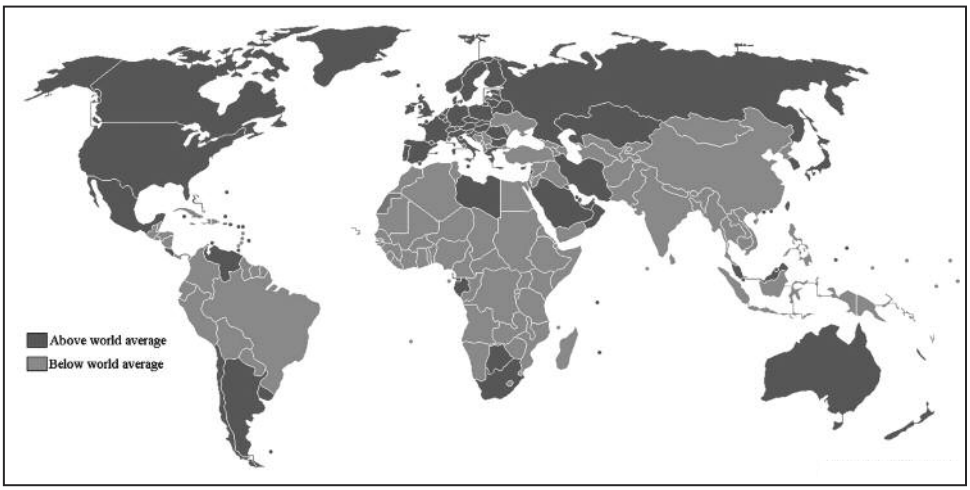
If financial compensation for global social protection is arranged this way, countries whose GDP is above the worldwide average will become net payers and those below global mean GDP will be net receivers of resources earmarked for health care and social health protection. Internation global redistribution can certainly be

(see Table 1): the richer a country or the further above average its per-capita GDP, the higher its share of the surplus to be paid to the global fund; and the lower a country's mean income or the further below average its per-capita GDP, the higher its share of the difference to be equalised. The second option will certainly be politically more challenging to implement but is much more promising to contribute to balancing the blatant worldwide inequity in health financing.

Additional challenges arise because regardless of the adjustment scheme to be set up, any kind of financial equalisation mechanism will need to be continuously updated. Even a cursory comparison of the charts above and below illustrates some relevant changes within only two years.

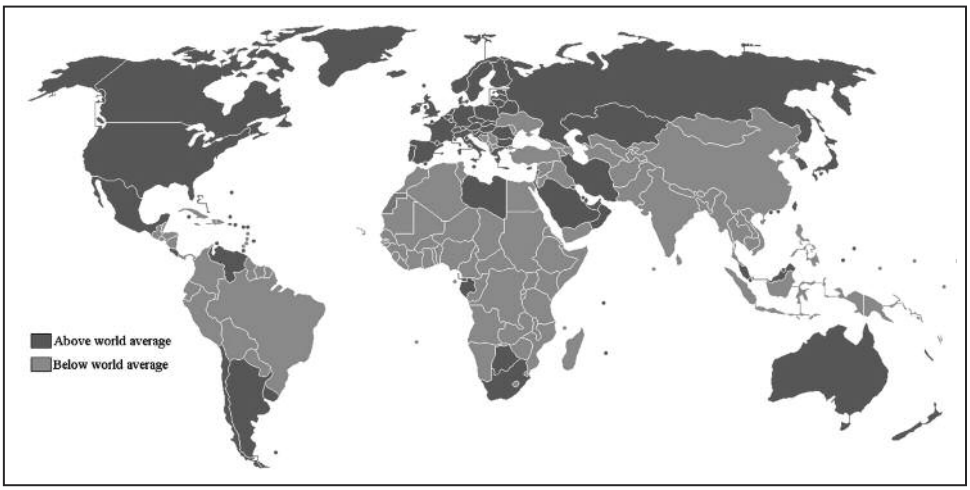
While Brazil and Turkey as well as Serbia-Montenegro and Macedonia have increased their GDP above the worldwide average and hence shifted from net recipients to net payers, South Africa has lagged behind global income development and would have converted from being a net payer to a net recipient of global social protection funds.

FIG. 5: AVERAGE GDP PPP PER CAPITA 2008



Source: Wikipedia 2012b (based on CIA Fact World Book 2008)

FIG. 6: AVERAGE GDP PPP PER CAPITA 2010



Source: Wikipedia 2012c (based on CIA Fact World Book 2010)

However, setting up global financial equalisation systems to cover healthcare costs and achieving universal coverage will face a series of political hurdles and technical challenges. On the one hand such an adjustment mechanism will have to deal with extreme variations of GDP between the countries worldwide. By way of example Liechtenstein and Luxembourg with a GNP of $145,747.58 (in 2008) and $81,278.63 (in 2010) per capita, respectively, are very different from Brazil ($11,503.01) and Indonesia ($4,348.44) and extremely remote from Zimbabwe ($349.61) and the Democratic Republic of Congo ($347.45), the two countries with the lowest national products worldwide (Nationmaster 2012).

Trans-national financial equalisation and risk compensation will have to apply all regulations, but additional framework conditions have to be met to make such an adjustment fund viable, reliable, transparent and credible. But over and above requirements within national states or between countries of comparable living standards such as member states of trade agreements, financial adjustment for social protection at global level will need further arrangements and definitions in order to be functional and operational. At global level, for the implementation of worldwide social protection based on international financial equalisation, the most important challenges will be to find a way to define adequate and fair currency and exchange rates that ensure international comparability of both national and household purchasing power and gain a high level of acceptance among all countries participating in global social protection. At the same time some general benchmarks will be indispensable for establishing the comparability of

different countries in order to define potentials and needs for providing universal health coverage; this might either happen by defining a "standard" level of healthcare provision in terms of scope, quality and accessibility, or, by determining a consistent share of GDP to be spent on social health protection by all countries.

The challenges to be overcome and the issues to be clarified at country level are certainly no less complex and difficult to accomplish. Since financial compensation for financing social protection will have to rely on public and especially on government resources, tax systems have to be effective, reliable and progressive in order to achieve global equity and equal burden sharing (cf. Gebauer: The Need to Institutionalise Solidarity for Health in this reader, pp. 14-23). This is closely linked to the ability of national governments to enforce public and fiscal policies, to implement adequate taxation and to ensure transparent use of public resources. Thus, governance, control of funds, transparency, and the reliability of governments and civil society are indispensable requirements for setting up adjustment schemes within a system of global social protection.

Last but not least, European experiences with regional development funds illustrate the need to not focus exclusively on nation states but also on sub-regions. A global social protection fund will face specific challenges to address regional differences that exist within countries because such an approach might easily come into conflict with national sovereignty and self-determination of countries.

SUPRANATIONAL DEVELOPMENT AND ADJUSTMENT FUNDS AS A MODEL FOR A GLOBAL FUND FOR SOCIAL HEALTH PROTECTION

International support funds for development and equalisation of different economic and income conditions represent an important approach of free-trade agreements for overcoming economic constraints and fostering development. The above-mentioned funds implemented in the European Union (ECF, EFRD and ESF) are good examples for this type of supranational supportive funds and show that financial adjustment is feasible, at least within economic or political blocks. And they show that the principle of solidarity can be applied at international level.

A global fund for social health protection might take up some lessons learned from existing cross-border equalisation systems. The very reason for such a fund is to organise needs-driven financial transfers for improving health coverage; resources channelled through a global social protection fund have be earmarked for both health care delivery and universal health coverage because it will certainly be insufficient to set up additional health facilities and employ more personnel if additional funds provided by international solidarity funds are not used likewise for strengthening health systems.

As for global equalisation schemes, countries have to be classified in order to define them as net payers and net receivers. Such a classification has to adequately reflect the economic development and situation of participating countries. Various strategies might be applied for defining a country's ability to pay and need to receive equalisation funding. Of course the method described above for international equalisation systems is also suitable for global funds, and payable resources can be determined according the relative position of countries with regard to average global GDP. But other, simpler financing mechanisms might also be applied as long as they safeguard the principle of solidarity and make countries pay according to their economic and financial capacities. In any case payments have to be mandatory for wealthier countries.

Naturally there are still many questions to be answered and challenges to be overcome for setting up a global compensation fund for uni-

versal health protection. One of the main problems will be to find strategies to establish an international equalisation fund in a way that allows making resource generation compulsory, reliable and sustainable. Payment of contributions has to be mandatory for all net payers, and the fulfilment of financial commitments has to be legally enforceable. On the part of recipient countries, the challenges are no less daunting. A major hurdle will be to find objective, effective and internationally accepted mechanisms for assessing the "health need" of all countries that shall or want to benefit from a global social protection fund. Moreover, all recipient countries will be required to assure that the resources they receive from such a fund are exclusively used for promoting universal health coverage. In this regard the GFTAM provides a series of interesting strategies that have meanwhile proven to be efficient in making governments accountable for the earmarked funds they receive and in enhancing transparency and governance at country level (cf. Ooms: Fiscal Space and the Importance of Long Term Reliability of International Co-financing in this reader; pp. 135-139).

POTENTIAL ROLE FOR TRADE AGREEMENTS FOR GLOBAL EQUALISATION IN SOCIAL PROTECTION

There is abundant evidence for the close relationship between good health and economic growth (Sachs 2001). Health and social protection are crucial for economic development as well as for international trade. However, free-trade agreements tend to underestimate the huge potential of social cohesion and social justice for the economic development of regions and countries. This is partly attributable to the fact that free-trade agreements are mostly designed under a simplistic macro-economic growth theory. Moreover, international regulation for promoting social protection in trade and economic relations is widely underdeveloped because they are not yet priority of the World Trade Organisation (WTO) and existent ILO conventions are often insufficient for trans-nationalised economies.

In the globalised world multinational free-trade agreements are becoming increasingly important and deploy considerable dynamics. Besides the European Union, the North-American Free Trade Association (NAFTA) and the Common Southern Market (MERCOSUR) have been established; other agreements such as the ASEAN Economic Community, the Central-American Free Trade Association (CAFTA), the Common Market for East and Southern Africa (COMESA), the East African Community (EAC) and others are emerging. Economic and trade integration generally advances under the rules of business and tends to be much faster for traditional trade items and services, and usually much slower amongst social goods and services. In 2006, WHO member states urged their governments at the 59th World Health Assembly to ensure that trade and health interests are better coordinated and more appropriately balanced (WHO 2006: 37f).

Despite the longstanding priority setting on purely economic rather than social objectives in global economy, free-trade agreements have a potential for contributing to social protection that should not be underestimated (cf. Holst 2009: 85ff). Experiences from the EU, but also from MERCOSUR and other emerging agreements, show that the latter can play an important role in internationalising and potentially globalising social protection. Even relevant differences in design, structure, financing, coverage and regulation of health systems in member states do not necessarily prevent them from implementing common block-wide social health strategies and policies (ibid.: 90f). Member states of free-trade agreements offer rather smaller inequalities with regards to their economic, social and development conditions compared to the global level. Moreover, social protection can build upon existing economic and financial arrangements set up for managing and facilitating trade and

economic exchange. And, last but not least, free-trade agreements have better possibilities than other international bodies to enforce social protection requirements and require member states to fulfil their obligations. This is certainly also true for emerging agreements, as expressed by Snyman-Ferreira & Ferreira (2010: 622): "The principle of solidarity is also recognised in the Constitutive Act of the African Union (2000). As such all member states of the Union are legally bound to act in the broader interest of the Union and should therefore refrain in the harmonisation process from promoting their own interests at the expense of other states. In fact, a stronger state like South Africa should use its power not to dominate but to guide and assist weaker participating states in the harmonisation process". ■

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MOVING FROM VERTICAL AND PROJECT FUNDING TO A SYSTEMS APPROACH, ADDRESSING DEVELOPMENT

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Abstract

The year 2015 is quickly approaching by which the MDG targets should be achieved. The scenario, however, is that many countries will miss the targets, particularly the health related ones, and there are situations where the conditions are stagnating or worsening. There are many reasons for this, but one of them and often debated without change, is the approach taken in delivering international assistance to countries in need. Solidarity that was on the background at the writing of the Millennium Declaration seems to not have materialised with the processes driven by specific projects or areas of interest.

In the debates underway on the future of global health beyond the MDGs, there are calls for framing health in a comprehensive manner, and consider addressing it in a context of overall social protection. In this perspective, it is worth reviewing some of the experiences in the current development cooperation processes and draw lessons that might be useful in informing the consultations leading to the development of a proposal for a Global Social Protection Floor.

In this context, a country perspective review is provided highlighting the complexities in dealing with multiple partners. Particular attention is devoted to the drawbacks of the project approaches, which leave the health systems unattended and little benefit to the strengthening of the country institutions. A change of attitude is called for in order to reverse the situation, and address the development of the countries instead.

There is an urgent need for moving from charity to solidarity, a spirit embodied in the concept of social protection, and hopefully generate a momentum for establishing a new paradigm. However, reality should be matched by pragmatism given the wide scope of social protection to be introduced in countries with still very weak economies; one idea to consider is the adoption of a phased approach starting with access to health care by all.

Introduction

Approaching 2015, several circles are already debating the perspectives of global health after the MDG. One of the issues at the centre of the discussions is the need for a better framing of global health, putting it in the context of the overall social protection, thus encompassing the comprehensive approach to health that takes into consideration the social determinants of

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health. It is in this line of thinking that there have been calls for the establishment of a mechanism to secure the provision of a global social protection floor (Gostin et al. 2011; ILO 2010).

This document is a contribution to the efforts to inform the debate through the lessons learned from the experience of international development assistance in the expectation that innovative approaches could be considered in order to maximise the effects of the process. As it is at the country level that the implementation has to take place, there is a strong focus on the country perspective, particularly with regard to the realisation of its development strategies and institutional capacity building.

Systems strengthening versus project approach

For long there have been multiple initiatives and calls to draw attention to the plight of billions of people who are deprived of the very basic living conditions and have only little or no access at all to health care. Many support programmes have been created and numerous organisations or institutions established with the aim of mobilising and channelling support to the countries mostly in need, parallel to the increase in bilateral government cooperation driven by the same intention.

Despite major improvements in regards to particular health problems, countries benefiting from this kind of assistance have not managed to create a good economic base that would ultimately enable them to guarantee the provision of essential social services to their people with reasonable quality and equity. One of the reasons for the very slow progress in this regard is the way the assistance is conducted, concentrated on a vertical or project approach. Funders make the release of their resources conditional to addressing a particular disease or health related problem, and using the funds to contribute to pre-defined targets and following specific indicators.

One of the consequences of this approach is the lack of investment in health systems, which notwithstanding the decades of international assistance continue to be weak with the countries still unable to respond to major challenges and remaining dependant on external aid. Among other important social aspects, the lack of access to adequate health care is one of the issues to be redressed. Therefore it is pertinent to include access to health care as a priority topic in the ongoing discussion about global social protection.

The challenge is about building consensus towards a new approach of global social protection driven by solidarity with the aim of ensuring that every country in the world will be able to have a system in place that guarantees access to health care for all. As mentioned above, there have been many examples of good will and concrete actions to help those most in need; but now it is important to draw lessons from the past by highlighting the main drawbacks, as we embark on a new approach that intends to be better and contributes to a substantial change (Juliet et al. 2009; Goldberg & Brayant 2012).

The world response to the multiple calls is impressive with billions of US$ mobilised, the considerable increase of the number of players willing to help and the emergence of new international bodies. The motivation for these developments is trying to help, particularly bearing in mind that in most instances the affected people are dying of very well-known and thoroughly studied diseases or health problems for which effective solutions exist. Moreover, these health problems are no longer an issue in the developed countries and nobody is expected any more to die early from controllable diseases or develop preventable severe complications.

Incoherent visions of funders and recipients

The term “global” is now part of the jargon, and means to express the collective world responsi-

bility for humanity, as well as the need for acting together to address the multiple challenges, some of them going beyond borders. However, in practical terms what happens on the ground is far from this aspiration, with money, power and political influence being the lead factors in setting the rules of the game. The perspectives of those who need more assistance and support are not properly reflected in the processes governing international cooperation, and this paper reflects some of the existent tension (van Olmen et al. 2012). For clarity purposes the terms funders and international assistance will be used to refer to the institutions providing resources to the countries in need of help, and the term countries referring to the countries receiving the support.

These two groups have a common objective which is to ensure that everybody has access to quality health care when needed with a minimum of barriers and without major financial strains to private households. However, the underlying political motivation leads to different approaches that are often not convergent. In general, on the one hand funders want to address specific diseases and challenges guided by predefined targets and indicators, and they want the results to be produced quickly within 6 months or one year. On the other hand, the countries are concerned about the set up of capacity needed for being able to face future challenges while they are trying at the same time to address the immediate problem for which they lack the resources; and this double task requires time.

The short-time successes the funders want to see can be achieved by adopting campaign-like approaches concentrating a considerable amount of existing resources to achieve these goals at the detriment of other activities that are equally or even more important. Countries expect the resources provided from funders to be also used for building the countries' institutions in order to gradually increase their capacity to deal with the issues on their own. Apart from the difference in perspectives, funders tend to impose conditions that force countries to accept strategies that are appealing for the funders' constituencies but not necessarily for the countries whose priority objectives might become secondary. Strict unilateral conditions entailed for releasing the development resources are the key instrument to set the tone in the process.

As a result, the countries' strategies and operational plans are not respected or altogether put on hold, and the countries are caught in a vicious cycle of planning, changing the plan and re-planning. The principle aim of countries to build institutions can not be realised; they continue with weak and non-responsive systems, and find themselves dependent on external aid at the same scale they were decades ago.

TABLE 1:

Countries' expectations	Funders' constituencies expectations
• Aid contributes to development • Country vision and strategies are fulfilled • Long-term perspective of the cooperation • Predictability of funding • Sovereignty is respected • Capacity building is addressed • Favourable and fair environment to develop-trade just as an example	• The money is used correctly and for the «intended» purpose • Want to see the results quite soon • Want to see the link between the improvement and the money provided-how to measure it in a way they understand • Concerned about the duration of their contribution-limited period • Beneficiaries selected on basis of their own criteria

Resolving this divergence of perspectives is a key step for framing a new mindset based on true solidarity and with priority on the development of the countries. So far the state of affairs was one of charity with short term interventions focused on specific diseases or problems. It is important and good to know how many lives were saved or how many pills were distributed during a certain period of time, but the ultimate goal should be to what extent a particular country has evolved in terms of its own ability to adequately respond to challenges. Addressing development requires a long-haul perspective and a sound collaborative spirit whereby all the partners involved do join forces and follow one plan that should be the country plan. This is the way to avoid the multiplicity of plans, which are often as many as the number of funding institutions or countries. In addition to their multiplicity, those plans address different things, often very specific ones and with inherent conditions (Dickinson et al. 2007).

A new paradigm of development assistance

At the end of the day, officials in ministries of health and other ministries involved in these processes, namely planning, finance, foreign affairs and cooperation, are completely absorbed by complex negotiations, drawing of plans and complying with requirements for multiple reporting. Little time, or virtually no time at all is left for them to devote their attention to the crucial tasks of organising the institutions and managing the implementation of a country strategy. It should be stressed that in practical terms priority is given to the management of the relationship with funders. The extreme limitation of financial resources is the main factor why many countries can only allocate around 40 % or less of the resources needed for implementing their operational plans. With the tight conditions imposed, there is little room for manoeuvre due to the risk that funders suspend the flow of funds if the conditions are not met. The resulting paralysis of institutions and the delay in the implementation of programmes have heavy social consequences and political implications. This should be the critical point of reference for the required change: Funders have to be moved from framing the assistance in order to satisfy their own preferences towards crafting it as a contribution to the development of a country under the guidance of its own national plan.

On the side of the countries, leadership is required for steering the whole process and clarity in providing orientation to the different players. Therefore a well articulated strategy founded on the country reality and with clear goals is essential and should be complemented by functional co-ordinating mechanisms. The process leading to these instruments should be inclusive so that all players would have the opportunity to contribute and at the end “buy in” to the plan and subsidiary documents, and eventually endorse it as the single guiding document for co-operation.

With these conditions in place, development cooperation can move from vertical funding to a more integrated approach with the perspective of building systems and developing institutional capacity. All funds should be in principle channelled through a common pool to fund the activities agreed on one plan; certainly the practical arrangements will vary according to the context, be it a designated fund at a bank, be it through the treasury. The main point is that openness allows every player to participate, so it is expected that everyone abides by what has been agreed and accepts the leadership of the country authorities (Sridhar 2011: 460f).

There will still be problems, but the partners together with the country should build as they go along. This is where expertise comes to play through the different experts coming on behalf of international assistance to team up with national counterparts and work within the local institutions thereby contributing to capacity strengthening. At the same time, the government should take bold steps to support the pro-

cess and provide orientation, acting with transparency and reinforcing the methods of good governance. These two approaches together create the right environment where every player gets a true sense of ownership in the process, and maintains the motivation and enthusiasm that are extremely important at this stage. As the country institutions consolidate and improve their staffing, the complex mechanism of coordination can be eased progressively handing over this role to the appropriate bodies.

Although there has been progress and recognition at important international conventions, funders still seem to be reluctant to perform adequate changes in order to fully address the country plan and effectively contribute to the capacity building of national institutions. This is particularly relevant when it involves a partner who is a major financial contributor, as it disrupts the normal flow of funds with negative consequences on service delivery. Due to limited alternative sources of funding, pragmatism comes to play with many countries opting for dual mechanisms - one for those who endorse the comprehensive and harmonised approach under the country plan, and the other/s for those still using a selective approach with specific conditions. Handling this kind of situations requires leadership, sense of direction and clarity, with the national authorities setting the tone. The whole management process should include the agreed mechanisms for consultation as a major foundation and a platform through which the other partners already “on board” can express their support and complement the work done by the Government, and convey the appropriate messages to exert persuasion. This is a critical stage, and also a testing moment for the government and for the level of maturity of the co-ordinating mechanism of having all the partners working for the same objective. There should be coherence within governments to ensure that the same message is used by the various departments, thus avoiding undermining each other (Sridhar 2011: 466f; Wood et al. 2011: 34ff).

Urgent need for consensus

Reporting should also be consistent with the proposed changes and reflect the implemented dynamics of working according to one strategic plan. Due to the difficulties faced by countries to provide basic services to their populations, the main premise is that all players are involved. What has to be achieved is the change of the situation so that the country will be able to deliver those services in a sustainable manner and with quality. Therefore, it is time to frame the reporting in a different way capturing the progress, not only showing programme implementation, but simultaneously and with the same importance, the progress made by the national institutions in terms of capacity building and ability to respond to the challenges. If the work of all players is guided by the same plan, the report should be a country report against the targets set in the plan: One country report for all partners with a clear indication of their contributions and as far as possible the respective attributable added value. It is urgent to reach a consensus on this approach, complemented by periodic reviews - e.g. in five-years terms - assessing the capacity of the country institutions, particularly for health, as well as the strength and responsiveness of the health systems. These processes must be well established at country level with ample involvement and ownership of local research institutions and go beyond the technical dimension to bring in parliamentarians and civil society. The arguments for the perpetuation of the “status quo” are political, and coming from the funders’ side. At the country level many parliaments are not well informed about this and virtually out of the main debates when it comes to decision making. Likewise, civil society organisations lack the elements to argue properly and raise the issues affecting the citizens, particularly the most disadvantaged.

This kind of political debate is needed to support the technical arguments for putting the country at the centre where all players have to converge

instead of the current situation where partners circulate around trying to exert influence on the country to adopt a posture that privileges their priorities and not the country's development agenda. We need to move from charity-driven short-term support to long-term engagement of true co-operation for development (Sridhar 2011). The ultimate goal is the development of the country, and this cannot be achieved by simply adding the specific objectives of different players. All together have to address and support the country development strategy. This paradigm shift requires solidarity, which is also a fundamental element for the discussion on ways of establishing a Global Social Protection Floor. For setting up a mechanism and a system of Global Social Protection (GSP) it is worth reviewing the experience faced by many countries. All strategies aiming at universal health coverage and GSP are most likely to face similar processes and challenges; hence the due lessons have to be learned from development co-operation for adequately addressing GSP.

Scope of Global Social Protection

The concept and scope of social protection is very broad and ranges from income support in order to ensure people's subsistence to old-age pensions, including quality healthcare and potentially unemployment insurance. Particularly in poor countries, the organisational structures to address the various elements of social protection are often distinct and handled by different institutions. Furthermore, most of the countries that may benefit from GSP have neither their own systems in place nor accumulated sufficient experience to handle all the components of social protection. Despite all variations in operating these schemes, almost every country provides pension funds for civil servants and similar packages benefiting employees of large state companies and corporations.

In many developing countries, apart from the privileged groups of formal employees, those working in the informal sector and the population at large do not enjoy any protection to guarantee a minimal income and other social safety measures. There are selective interventions directed at the elderly and some groups with disabilities but with very limited coverage. In addition, the adoption of a comprehensive approach that takes on board all aspects of social protection will demand mobilisation of considerable financial resources which most of the economies in these countries are not fit to shoulder. Health insurance in particular is not widely distributed in many African, Asian and some Latin American countries. Often only some groups of employees are benefiting from health coverage that shows considerable variations with regards to the services covered (ILO 2010).

Given these circumstances, and bearing in mind that the current discussions are driven by the lack of a comprehensive approach in tackling the challenges of health services delivery, it might be better to move in phases towards GSP and start with improving access to health care instead of encompassing all elements of social protection at the same time. In many countries people grapple with the distance to the nearest health centre and the related transport costs, the fees of the services, and the cost of medicines. These are concrete aspects, which could be the initial targets of a GSP scheme that can later on expand by gradually including the other elements of social protection. ■

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GLOBALISING SOLIDARITY: THE CASE FOR FINANCIAL LEVIES

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Abstract

In June 2010 a Report of the Committee of Experts to the Taskforce on International Financial Transactions and Development was released. The report focusses on the feasibility of different financial levy options to fund international development and climate change in the context of funding gaps for development, environment, health and other public goods. The report sees a global solidarity dilemma where the growth of global economies has not been matched with the needs to pay for global public goods.

The innovative mechanism favoured by the expert group is the Global Solidarity Levy, which is technically a centrally collected multi-currency transaction tax on exchanges of currencies, directly transmitted by the central settlement institutions that operate under the supervision of the Central Banks, to a Global Solidarity Fund that distributes the revenue under the governance of the stakeholders in international development. Because of the existing architecture on which this mechanism can rely, is technically and legally feasible and ready for implementation. The revenue would be additional to official development assistance and neither burden national budgets nor local economies.

Background

In June 2010 the report Globalizing Solidarity: the Case of Financial Levies of the Committee of Experts to the Taskforce on International Financial Transactions and Development (Leading Group on Innovative Financing for Development 2010) was released. On October 2009 the Committee was convened by a Taskforce of twelve countries under the auspices of the Leading Group to provide a report on the feasibility of different financial levy options to fund international development and climate change. It was comprised of experts in macroeconomics, international tax law, financial markets and development financing.

The context of the report is the funding gap for development, environment, health and other public goods. The report sees a global solidarity dilemma where the growth of global economies has not been matched with the needs to pay for global public goods. The world is facing a global solidarity dilemma where the wealth of globalised economies has not resulted in a corresponding match between development needs and traditional official development assistance, the availability of domestic sourcing, or the creation

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of corresponding funding available for global public goods. This discrepancy motivated the search for global financial sources of revenue.

This contribution offers an overview of the report, identifies four key challenges and provides four responses of the expert group to those challenges. It concludes with the substantial findings of the assessments and the report's recommendations are summarised thereafter.

New mechanisms for global solidarity

The innovative mechanism favoured and recommended by the expert group is the Global Solidarity Levy, which is technically a centrally collected multi-currency transaction tax on exchanges of currencies, directly transmitted by the central settlement institutions that operate under the supervision of the Central Banks, to a Global Solidarity Fund that distributes the revenue under the governance of the stakeholders in that development mechanism.

The expert group has come to the conclusion that this mechanism, because of the existing architecture on which it can rely, is technically and legally feasible and ready for implementation. The mechanism is innovative as it envisages raising a very substantial volume of revenue (≥ US$30-50 billion per annum) from an undertaxed segment of global finance, which is the backbone of the globalised economy. The revenue would be additional to official development assistance and neither burden national budgets nor local economies.

The expert group has considered that the States should base their international development cooperation based on any innovative form of financing on at least four considerations:

1. The economic success of globalisation in the past decade.

2. The increased use of global commons, one of which is the liberalisation of capital and trade as organised or accepted by States and which has greatly contributed to global wealth and facilitated the exceptionally high integration of the global financial architecture.

3. The increased awareness to address, as a matter of urgent need, sustainable development and the financing of global public goods at the global level since the magnitude of the challenges and the budgetary limits imply that it cannot be the responsibility of nation States acting alone.

4. As a result of the global financial crisis, followed by the global economic crisis, domestic budgets are under a severe fiscal constraint, which may jeopardise the increase of development cooperation. The sequence of these crises has demonstrated – be it in a most painful way – the interpenetration of the global financial sector with the global economy.

Given the justifications for a financial levy, the expert committee analysed five options for a levy against the background of five criteria for assessment: a Financial sector activity tax (FAT), a VAT on the financial sector (VAT – FS), a broad financial transactions tax (FTT), the nationally collected single-currency transaction tax (unilateral CTT) and the centrally collected global multi-currency transaction tax (global CTT). The criteria for assessment were: sufficiency (will the levy raise enough funds?), market impact (will harm to the economy be minimal?), feasibility (technical infrastructure available and legally possible), sustainability (stable and predictable revenues) and suitability (appropriate to finance public goods and contribute to solving the Global Solidarity Dilemma). The innovative mechanism that was favoured and recommended by the expert group is the Global Solidarity Levy that could serve as a model for all transaction taxes.

There are four central elements that justify the recommendation of the expert committee. No extra burden on national budgets and domestic economies apart from the official development pledges: The expert group recommends a shared taxing mechanism that need not be universal but that taxes the segment of economy, which is global. Moreover, the Global Solidarity Levy would tap into resources, which are beyond the reach of States acting separately.

No extra burden on traditionally highly taxed sources, such as personal labour income, household consumption tax, business profits, etc., that fuel national budgets. The Global Solidarity Levy would tax the under-taxed segment of globalised economies: the global capital markets.

By far the most globalised capital market with a very highly integrated architecture under control of the national or regional Central Banks is par excellence the currency exchange market. It is a market with a high volume of trade turnover: four to five days of currency trade correspond to a whole year of world trade in goods and services; and the entire world official development assistance on a yearly basis corresponds to ten minutes currency trade. Moreover, this currency market has a specific and vital function to be the trait d'union, the link in the global payment systems, on which all global investment, remunerations, return and cooperation, and all global trade and capital market movement necessarily rely. This foreign exchange market is thereby the nervous system of the globalised economy and the vehicle that is to guarantee the interchangeability of domestic currencies, which are, each for themselves the exclusive legal tender in a jurisdiction, and an essential part of the monetary sovereignty of States or regions. Taxing this segment of the global economy allows to tax a sector that benefits most from global economy and one that can easily take on part of the global burden-sharing.

The third justification of the recommended mechanism is the central collection of the levy. In the absence of a World Government or a World Tax Institute that collects the levies, the States can share their taxing right and in a coordinated way mandate the centralised market system of international exchange of currencies, developed by the sector under the pressure of the Central Banks that supervise its functioning. The Continuous Link Settlement Bank (CLS) in London settles the payments on a daily basis of almost the entire relevant foreign exchange capital markets in all major currencies.[30] CLS is linked to the 17 Central Banks who also supervise its activities. That also makes the recommendation mechanism innovative; it is a simple, smart and very cost effective mechanism that allows an immediate, practical implementation of a global levy.

The last element in the recommendation is the Global Solidarity Fund that distributes the proceeds under the governance of the stakeholders of this finance mechanism and that operates according to the principles of accountability, representation and transparency. It would operate as a financial facility for global public goods. The new body would not engage in the use of the funds but instead disburse financing to existing or new structures on the ground in a sustainable manner that responds to the demand for effective measurable and measured results and accountability. The governing stakeholders from South and North should represent the developed and developing countries and the private sector including the financial sector and civil society organisations.

To conclude the report provides a brief assessment of the recommendations against the agreed criteria and highlights some very significant findings:

[30] In April 2012 a turnover of over 5,000 billion US dollars; CLS has a market share of 94 % of the trade in the 17 most relevant currencies.

The recommendation is to tax the capital markets not the banks; therefore, it is a transaction tax, very different from the bank taxes proposed by IMF and discussed at G20 and EU-level. It is not a tax on assets, nor on liabilities of banks; it is not a tax on bank activities nor on its added value.

The rate of tax is extremely low (US$1 per US$20,000) and based on a very large turnover (today US$800,000 billion p.a.) with a revenue estimate of US$30-50 billion or more, as such the economic impact is minimal. It is the least distorting of all mechanisms: the Foreign exchange (currency) market turnover of four to five days at an average of over 4,000 billion $ per day corresponds to the entire annual turnover of World Trade in goods & services (+/-US$16,000 billion).

As to the legal feasibility, it is not a transfer of tax sovereignty. Although the mandate to the Central Settlement Institutes (such as the Continuous Link Settlement Bank) is based on the sharing of taxing rights, the mechanism does not imply a transfer of tax sovereignty and it is monitored by domestic central banks; the tax would be neutral and thus comply with the GATS or EU liberalisation rules.

The self-organised centralisation of settlements of the sector and the monetary sovereignty exercised through the central banks[31] can safeguard the system against tax avoidance through delocalisation, tax arbitrage and tax engineering as the assets underlying the transactions are national currencies controlled by Central Banks.

The proposed mechanism would be stable and sustainable as it would source its revenue directly from the globalised economy and would not depend on domestic budgetary policies.

[31] As long as central banks do not emigrate to off shore tax havens, tax-delocalisation of forex trade can be neutralised as not effective.

Due to its global characteristics the mechanism would be the most suitable for financing Global Public Goods precisely because it is financed out of the benefits of globalisation. It applies the principle that the beneficiaries should pay according to their ability to pay as well as the principle of fair redistribution. The ‘burden’ would fall on that part of the financial sector that is most intertwined with the global economy and benefits substantially from that segment of economy. Those who make most use of the global commons should now be tasked with absorbing their part of the burden.

The conclusion is thus that the mechanism to raise funds for development is technically feasible, legally compliant both with trade law and ready for implementation. Political will for this important exercise on global redistribution presents the next challenge. ■

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RESPONSIBILITIES AND RESOURCES: HOW TO FINANCE SOCIAL PROTECTION?

VANESSA LÓPEZ[32]

Abstract

While the current international human rights framework upholds the right to health and calls on states to promote and protect this right for their citizens, this instrument has not always been effective neither in securing this right for all people nor defining international responsibilities. Therefore, it is necessary to develop a new global social protection framework that sets forth high standards for universal health coverage and at the same time establishes the accountability and the financial burden-sharing mechanisms needed to guarantee the right to health for every person in every country, including low and middle-income countries.

The Right to Health

The first paragraph of the Universal Declaration of Human Rights asserts that the recognition of the inherent dignity as well as the equal and inalienable rights of all members of the human family are the foundation of freedom, justice and peace in the world. The declaration also establishes that everyone has the right to an adequate standard of living that ensures health and well-being, and in particular access to food, clothing, housing, medical care and necessary social services (UN 1948: Art 25). Moreover, the UN declaration states an international responsibility to help other countries in order to promote and protect the right to health for their citizens. Although humankind has a universal human rights framework, frequently it has proven to be insufficient and unable to ensure economic and social rights in practice because governments fail to fulfil their obligations and the international commitments have not been sufficiently defined. The right to health implies an integral vision based on the living conditions of individuals and their communities, environmental factors, the realisation of other human rights and of course access to health services. Without prejudice to the crucial role of the social determinants of health and the obligation of governments to ensure that all people have the conditions needed to be healthy, this discussion will focus on universal health coverage.

Although it is first and foremost a national responsibility that must also be included under national constitutions and has been realised in some cases, the data indicates that 49 low-income countries that are currently spending an average of about US$32 per capita on health (WHO 2010: XII) will need to spend US$60 to reach the health MDG and to ensure access to critical interventions, including for non-communicable diseases. This amount could be seen as insufficient if we look at countries like Thailand, which is investing US$136 (ibid.: 22) per capita

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and despite the achievements in coverage and quality of services still requires improvements. Therefore, in order to ensure the right to health to be exercised universally, the international community should create or reinforce political and legal instruments, as well as establish a global financial mechanism in order to organise and operationalise the international obligation that states have to help those countries with the will but without the fiscal capacity needed to fulfil the right to health.

A new paradigm is necessary to guarantee and safeguard this and other fundamental rights. Putting the figures together it seems that a different approach is needed: more than 2,000 million people worldwide do not have access to essential health services, 100 million people are pushed into poverty each year when compelled to pay for health care (WHO 2010: 5).

From will to responsibility

The right to health means the right to life and it is universal, for every person. Therefore, it is unacceptable that existing social and economic inequalities prevent two thirds of the world's population from exercising their right to health by benefiting from adequate quality basic health care and social protection. Furthermore health is an indispensable requirement for the development of individuals, communities and populations. It is necessary to ensure universal access to quality healthcare services and avoid any financial risk for each and every person, irrespective of the level of income and wealth of the countries in which they reside.

To do so, the way in which international assistance is conceptualised and provided should radically change. The basic inspiration of the development model in which Salud por Derecho believes resides in the need to move from a will-based framework to a paradigm based on global shared responsibility, on true global solidarity as a way to bring forward a sustainable and practical solution for overcoming the lack of access to health care for billions of people (cf. Gebauer: The Need to Institutionalise Solidarity for Health in this reader: 14-23). These core values should be at the centre of the global health governance and development agenda, which would make a difference on how social and economic rights such as the right to health are addressed.

Nevertheless, up until now, Official Development Aid (ODA) and development policy have been based on voluntary donations or investments from countries according to their willingness and political priorities. Co-responsibility is widely absent and an effective accountability system for donors and implementers is lacking. It is time to change in order to move forward towards a model of global social cohesion that clearly defines common international development standards and ensures fundamental needs and rights are satisfied for all human beings. The ethical challenge is to ensure everybody's right to live in dignity.

A GLOBAL HEALTH SOCIAL PROTECTION FRAMEWORK: SOME PRINCIPLES AND HOW IT COULD BE FINANCED?

The challenge is to bring values and ideas of global solidarity and shared responsibility into practice. With this purpose in mind, medico international and the Hélène-de-Beir Foundation convened a group of experts, academics, and members of civil society to exchange ideas and develop concepts on global social protection. The proposal presented by Salud por Derecho for discussion is called Universal Social Health Insurance[33], seeking an easy understanding and identification from the general public. The con-

[33] The expression Universal Health Insurance has received some comments in the last months within the sector. Although Salud por Derecho is using this term in order to easily communicate complex concepts such as social insurance or social protection to the general public in relation to the campaign http://saludporderecho.org/thinkingaboutyou/index.html, it is still open to discussion.

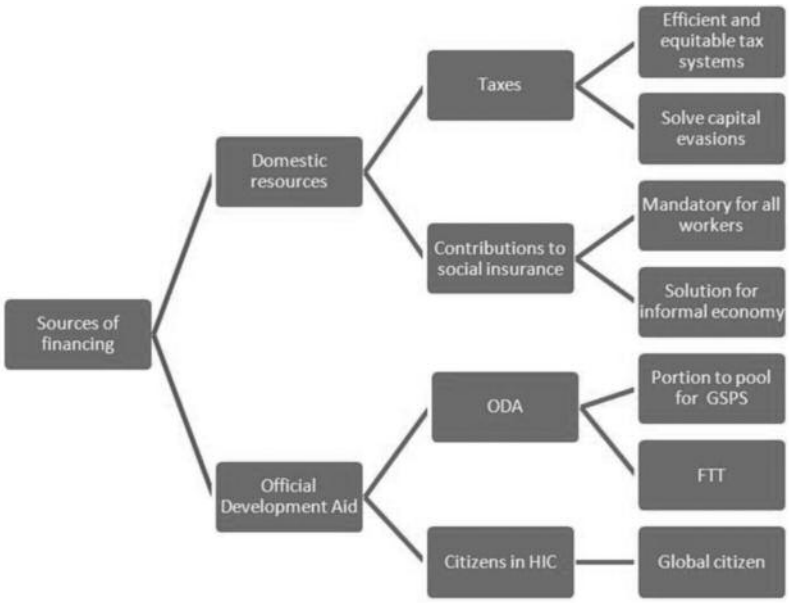
cept is inspired by the key paper by Gorik Ooms (2009) in which he discusses the idea of a World Health Insurance and of a Global Health Fund transforming the current Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) into a broader financial mechanism.

The proposal of Salud por Derecho is actually a global social protection health framework that could guarantee universal health coverage for every person in the world, pushing the principles of solidarity as applied in the European and other countries (cf. Holst: Implementing the Solidarity Principle through Financial Equalisation in this reader: pp. 86-104) beyond the national level. Under an international convention, national and international responsibilities would be defined, shaping an effective accountability system. And what is even more important, such a framework as described by the Joint Action and Learning Initiative in its manifesto asking for a Convention on Global Health, would "set high standards for universal health coverage, specifying the services and goods that should be guaranteed to every person under the right to health, including health systems that provide quality health care across the full continuum of care, that encompass public health services, and that address the determinants of health" (JALI 2012: 4).

Would all countries be able to fulfil those standards of health coverage in an acceptable period of time? The majority of middle-income countries probably could do it and even go beyond, as it would be their obligation, with political will, managing fair and progressive taxation or contribution systems, fighting against tax and contribution evasion and taking budgetary decisions that prioritise people's needs. But there is a problem with low-income countries, as the most of them do not have the fiscal capacity by themselves to attend the standards of universal coverage that should be guaranteed to every person. In the best-case scenario it takes those countries decades, and humanity has already lost too much time and too many lives.

For overcoming the hurdles that many low-income countries are facing with regard to their potential to provide universal coverage, the creation of a pooled financing mechanism is needed in order to fill the gap. This mechanism should be financed by every country within a fair burden-sharing model and with a dynamic approach. That means that the amount to contribute would be updated regularly and that medium and low-income countries would gradually take on increasing amounts of responsibility in funding the universal health coverage system as their economies grow, among other variables.

FIG. 1: HOW A GLOBAL SOCIAL HEALTH PROTECTION SCHEME COULD BE FINANCED?



Source: own elaboration

Both the financial pooling mechanism and the political framework would give such an arrange-

ment the potential to become a sustainable solution for guaranteeing universal health coverage in any country because the states would contribute to the pool according to a mandatory principle and a scheme of incentives and sanctions would be created in order to set a secure system so that the mechanism under no circumstances could be put under risk. Additionally, it would be necessary to consider a safeguarding method in the event of resource shortcomings to avoid putting millions of people's health under risk.

As the figure above shows, the two main sources of financing for the pooling financial mechanism would be domestic national budgets and Official Development Aid (ODA). Domestic resources would include taxes and social insurance contributions, traditionally mandatory for everybody working in the formal economy, and that generate resources for social protection through regular contributions shared by employers, employees and sometimes the state as the third party financer. But a major shortcoming of social insurance schemes derives from its historical and conceptual linkage to formal employment. Therefore, ensuring universal health coverage for informal workers and other members of society outside the often rather small formal sector is a major challenge that requires political will, adequate organisation, as well as innovative solutions.

Another crucial aspect of domestic resources that low-income countries would contribute is the revenue collection in each country. It is well known that the lack of fair and progressive taxation and tax evasion undermine the countries' fiscal space, development, equity and social cohesion, but in a context of "reinforced" global solidarity the debate should go beyond, thus requiring an international debate around common good practices in tax revenues at a global level. In other words, would countries that have progressive taxation systems with high taxes be willing to participate in a global solidarity and a mandatory system like the one proposed here while the rich citizens of other countries do not pay their taxes accordingly? Questions like this make evident the need for a serious international debate on taxation (cf. Waris: The Role of International Tax in the Achievement of Global Social Protection in this reader: 122-130) and other forms of mandatory contributions on behalf of a global social protection mechanism.

The second large source of financing would be official development aid, although it will not be based on the voluntary principal of traditional ODA any more, since the portion allocated to the pooling mechanism for universal social health insurance would become mandatory. Additionally, resources would also be collected from new financial mechanisms such as the financial transaction tax (FTT) (cf. Denys: Globalising Solidarity: The Case for Financial Levies in this reader: 112-116). The negligible effect such a tax would have on the international finance system and the tremendous benefits it would bring to international social development has fortunately put on the international scene the need to advance in the creation of a FTT as soon as possible.

Finally, a complex algorithm would put in relation all the variables needed in order to establish the fair share per country: how much each high income country would have to contribute as well as the percentage of finance each low and middle-income country would receive to fill their gaps in its universal health coverage system.

The challenges and doubts in striving to set up a universal social health protection framework in order to guarantee dignified standards of living for all human beings are vast. Could the risk of such "high standards for universal health coverage", which every state must guarantee to its population, and considered as a floor (ILO 2011), be seen as a ceiling? Could this threaten the progress that some countries have made or are working towards? At Salud por Derecho we

do not think so. Health is a progressive human right, and therefore rights should never be reversed once they have been achieved and a strong citizenship should be there to ensure it.

Challenges also come up when thinking about the feasibility of funding such a vision. Yet, the current system of international development is unable to sustainably address the urgent need of financing global health; therefore the implementation of a new framework is crucial. Ten years ago, the devasting consequences that the AIDS epidemic was causing in many impoverished countries, especially in Sub-Saharan Africa, urgently called for a new solution. The answer was the GFATM, whose achievements in the last ten years have been vast. In this same sense, the implementation of a global social health protection paradigm is one of the great challenges the world faces today if we want the Universal Health Coverage goal, which will likely shape the post MDG era, to be a reality for both middle and low income countries. ■

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THE ROLE OF INTERNATIONAL TAX IN THE ACHIEVEMENT OF GLOBAL SOCIAL PROTECTION

ATTIYA WARIS[34]

Abstract

Global social protection is an issue currently of great concern to many in both the developed and developing world in the wake of the continuing fiscal crisis. State governments are threatening and have gone ahead to cut spending on welfare programmes, drop development aid as well as increase taxation. In this very bleak light one sees the growing discussion on the issue of how to dig ourselves out of this hole. This paper makes a preliminary attempt to look at global social protection and taxation across state borders as a possible solution to the problem of decreasing state budgets in spending and increases in collection that are making life harder for the common person to survive.

Introduction

To eradicate poverty entirely requires much more than international solidarity. It involves forging more equitable economic relationships that will enable us to break the cycle of dependency that afflicts poor countries. We need to attack not just the symptoms but also the causes of global poverty.

Luiz Inácio Lula da Silva (Douste-Blazy 2009: X)

The purpose of this paper is to attempt to broaden the view on fiscal issues and international taxation for setting up and financing a global social protection scheme. It is however an early attempt and still requires further exploration and research in order to build the data and evidence to support the diverse potential that exists in financing expenditures that are geared towards global social protection. This would comprise issues such as efficiency of tax collection, tax justice and tax evasion at global level, which would in turn be re-distributed and shared with those that need it most. There are several challenges here, which this paper attempts to break into three separate but interconnected analysis: firstly, to conceptualise global social protection, secondly to connect resources through the existing systems of governance to the necessity or requirement of social protection; thirdly, to use the international network of states together with the need for global social protection to conceptualise ways of providing an international resource base for global social protection. Each of these issues remains unsettled but since they are all critical each step moves forward by setting out a set of assumptions before proceeding to the next stage or level.

Financing Global Social Protection

GLOBAL SOCIAL PROTECTION

Social welfare in fiscal systems can best be summarised as the provision of goods and services that improve the wellbeing of individuals and groups within a domestic society. Social

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welfare objectives include among others, direct spending for income, security, housing, health care, education, employment and training, and social services. Society perceives states that provide social welfare as providing guarantees for a improving standard of living, protecting citizens from loss of income beyond their control, especially retirement, sickness, disability or unemployment including public assistance and social protection, serving both the poor and the middle class as well as the rich (cf. Pampel & Williamson 1989; Marmor et al. 1990).

Welfare rights are seen by some to be different from the classical rights of life, liberty and property in the nature of the content. Classical rights are said to be rights to freedom of action whereas welfare rights are rights to goods. Liberty rights are seen as those that govern individual interactions, they however do not guarantee success while welfare rights are the right to have goods and services provided by others if one could not earn them themselves. In addition, liberty rights require a resource outlay that involves or includes security issues in order mainly to uphold laws. The implementation of welfare rights however is seen to involve huge capital outlay and use of public resources within a state. Finally, it is also argued that the implementation of liberty rights does not require resources in that the ability of people to avoid certain activities does not result in a function of wealth. There is no universal and non-arbitrary standard for distinguishing need from luxury and thus defining the content of welfare rights. This is dependant upon the relative wealth of a society (Kelley 2000: 259).

“You cannot have a right unless it can be claimed or demanded or insisted upon, indeed claimed effectively or enforceably. …rights thus are performative-dependent, their operative reality being their claimability; a right one could not merely be ‘imperfect’ – it would be a vacuous attribute” (Stoljar 1984: 3-4). This statement is what funds and fuels the distinction that remains and which is maintained by some social welfare scholars to keep human rights in a separate category. They argue that what society claims as a right may be contradicted by its substance or administration. Thus the issue of equality of right is used to exclude social-welfare benefits from the ‘rights’ category by some human rights scholars (see generally Sampford & Galligan 1986: 1-19).

Some scholars regard the absence of a definition of human rights as an impediment to its realisation. However, Donnelly (2003: 1) regarded it as a sign of its continually evolving content, which reflects the relationship of society within itself and with the state. This approach will be adopted in this paper as it allows one to draw into human rights the existing concepts of welfare and well-being. Human rights and human dignity can thus be perceived as the modern day interpretation of social welfare as espoused by Joseph Alois Schumpeter (1883-1950) and economic and welfare scholars. Schumpeter (1950) argued that social welfare is the ultimate purpose of any state that collects revenue on behalf of its citizens. This then allows the discussion of welfare and human rights to proceed as one idea linked to the improvement of human rights of people. This welfare/human rights then form part of the ultimate expenditure of a state and by extension the aim of the development of a state into a fiscal state.

Historically well-being and social welfare were and are policies applied by governments domestically through their domestic political process as a result of the society electing leaders who intend to apply certain policies (cf. López: Responsibilities and Resources: How to Finance Social Protection? in this reader: 117-121). Over the years this policy has been adopted by many states both with and without reference to their particular political leanings. For example the UK, which is a capitalist state, also applies social-welfare policies and provides among other services, state-borne education and health ser-

vices. Human rights on the other hand have developed internationally and are subsequently applied within the domestic state. Human rights discourse as a result provides an excellent inroad into the discussion on how to achieve global social welfare or global social protection (cf. Grover: The Right to Health and Health Financing in this reader: pp. 24-30; Pogge: Are We Violating the Human Rights of the World's Poor? In this reader: 60-76).

The Role of Taxation for Social Protection

The realisation of all rights cost some money, although some may cost more than others. Rights cannot be protected or enforced without public funding and support (Holmes & Sunstein 1999: 18-20). They can practically become more than mere declarations only if they confer power on bodies whose decisions are legally binding. A legal right exists in fiscal reality, only when and if it has budgeted costs (ibid.: 19).

As a result, although these concepts all address broadly the same content, the concept of well-being developed first in time followed by social welfare and finally human rights. With their continuing development the obstacles and solutions are also continually being addressed. The first challenge to the achievement of social welfare and a challenge that continues to face human rights is their realisation: limited resources.

The first Constitution to address the issue of resources was the French Declaration of 1789. It recognised the transfer of the responsibility for security to the state in exchange for money in its articles 13 and 14 (National Assembly of France 1987):

13. A common contribution is essential for the maintenance of the public forces and for the cost of administration. This should be equitably distributed among all the citizens in proportion to their means.

14. All the citizens have a right to decide, either personally or by their representatives, as to the necessity of the public contribution; to grant this freely; to know to what uses it is put; and to fix the proportion, the mode of assessment and of collection and the duration of the taxes.

Following from this, the French Constitution of 1793 declared: "Society owes subsistence to its unfortunate citizens either by giving them work or assuring them the means to exist if they are incapable of work" (National Assembly of France 1793). From a historical perspective, it can be argued that the French tax state was first codified here through the recognition of the link between resources and welfare or human rights in its constitution. The citizens were granted the right to control the state's resources and at the same time were granted the right to work and the constitutional authorisation to set up what were the rudimentary beginnings of modern social welfare. Despite this ground-breaking step in linking rights to resources in the French Constitution, this development did not spread to other states. Instead the world was split on the basis of class, race, gender as well as other historical factors that led to the neglect of the need to fund the improvement of the well-being of the society using its available resources, and political and civil rights took precedence over the socio-economic rights.

Rights therefore, only become more than mere declarations if they confer power on bodies whose decisions are legally binding. Thus the people who do not live in a state having effective remedies in reality have no legally enforceable rights.[35] Any and all legal rights exist in reality only when and if they have budgetary costs. If the claims to grant the right to free education for example, this will only take place in reality and

[35] E.g. the European Convention on Human Rights (Council of Europe 1950: Art 13) states that rights are reliably enforced when subscribing states treat them as domestic law.

on the ground in the country if there are adequate resources to build schools near communities that require this service.

The Role of International Taxation for Global Social Protection

Despite the push within domestic states to achieve social protection in diverse ways this has not been achieved in all states. In addition, in many countries the current fiscal crisis is further eroding the existing state-provided social protections. This entire system of domestic taxation has led to the absence of adequate discussion on international money movements and taxation sources, which are in themselves an entirely untapped global wealth chain. It is with this context in mind that the discussion moves to looking into the potential of finding support for global social protection through an international approach. The need for international co-operation was recognised as early as 1966 within the International Covenant on Civil and Political Rights stating (OHCHR 1966: Art. 2 (1)):

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

This stand was further reflected in the discussions around the right to development. Various instruments were developed allowing for international and development co-operation. These included international economic co-operation in the form of overseas development assistance or foreign aid;[36] access to markets through trade liberalisation;[37] incentives to increase investment flows and technology transfer; bilateral and multilateral assistance to implement structural adjustments and economic reforms; debt relief and assisting countries to meet financial crises.[38] However, these strategies have come under heavy criticism as being oriented predominantly towards economic growth and financial considerations, which usually indirectly results in human rights violations (United Nations 1990; cf. Gebauer: The Need to Institutionalise Solidarity for Health in this reader, pp. 14).

The right to participate in decision making has a basis in UN Human rights instruments,[39] and expert studies (see generally Ganji 1969, Ferrero 1983 and General 1985) as well as instruments in economics (United Nations General Assembly 1974) and development strategy (United Nations (1976 and 1979). Development is seen as being special or specific; thus strategies must be developed by the people themselves and adapted to meet local conditions and needs (United Nations 1990: § 155-156). This makes participation the primary mechanism for identifying appropriate goals and criteria (ibid.: § 150 and 179. In this case, the right to development becomes

[36] Foreign aid remains the most important instrument of international co-operation, because it can be used at the discretion of authorities to pursue certain policies. In addition, there is on record, a voluntary commitment by industrialised countries to provide at minimum 0.7 % of GDP as foreign aid. This proportion has however never been reached but instead has hovered around 0.32/0.33 % for over 15 years (Sengupta 2000: 571, United Nations 2003: Paragraph 61; cf. also Pogge: Are We Violating the Human Rights of the World's Poor? In this reader: 60-76).

[37] The need to spur development is not new and although the move towards the creation of the right to development is seen as a relatively new human right, the need to alleviate poverty, raise standards of living ensure full employment and allow the use of the world's resources for sustainable development are all fairly well settled parts of human rights. All these terms are found not only in human rights documents but also the preamble World Trade Organisation (United Nations 1995: 154). The mixed impact of trade and globalisation is a continuing area of discourse to date (see generally Payne 2009).

[38] Sengupta 2000: 570f

[39] The International Covenant on Civil and Political Rights (OHCHR 1966: Art. 25) (rights to elect representatives and take part in the conduct of civil affairs); and the Declaration on Social Progress and Development (OHCHR 1969: Art. 5) seeking active participation of all members of society, individually or through associations, in defining and in achieving the common goals of development and ibid.: Art 15 on effective participation in a democratic system (cf. Grover: The Right to Health and Health Financing in this reader: 24-30).

not as much a right to improve material conditions but the right to have a voice in and share control over the economic environment (Barsh 1991: 329) though within the limitation imposed by budgetary constraints and state legislative procedures (for the most recent method developed for measuring progressive realisation of human rights cf. Fukuda-Parr, Lawson-Remer and Randolph 2008).

As already stressed earlier the state's duty is to formulate development policies on the basis of 'active, free and meaningful participation' (United Nations General Assembly 1986: Art. 2 (3)). This term is linked to the concepts of 'equality of opportunity in access to basic resources' and 'fair distribution of income' (ibid. Article 8 (1)). Linking tax revenue to tax expenditure through human rights is best expressed here within the right to development and its link to its resource requirements. Participation is a tool that can be used to ensure accountability, responsibility and transparency as well as efficiency and effectiveness in the context of limited resources.

The Global Consultation on the Right to Development (United Nations 1990) went a step forward and agreed that participation must be active and involve genuine power (ibid. § 147). It set out conditions for democratic participation as including a fair distribution of economic and political power among all sectors of a national society (ibid. § 148) and genuine ownership or control of productive resources like land, financial capital and technology (ibid. § 150, which is a rejection of the welfare state; see also § 174-176). Factors to evaluate participatory processes include representation and accountability of decision-making bodies, decentralisation of decision making; public access to information; and the responsiveness of decision makers to public opinion (ibid. § 178). All these provisions are important both for the right to development as well as global social protection; and the need to link the resource allocation of tax in its collection and distribution is a direct manifestation of the peoples' region-specific needs. However, one must not loose sight of the overall bigger development picture and needs that can only be put into effect by the international co-operation of states.

Innovative Financing

The idea of universal or global social protection rests on the existence of an agreed universal requirement with a universal resource base. The multiple challenges that would need to be dealt with include the acceptance of what would fall within global protection still need greater clarity; however this paper takes the view that the human rights paradigm and socio-economic rights would be one way to conceptualise global social protection. The universal resource base can therefore rest its legitimacy upon the call for international co-operation that would allow states to come together to pool resources. The mechanisms that would be utilised however can vary. There have already been discussions about user charges as a specific consumption tax for those who need health care, about financial transaction tax or currency tax (cf. Denys: Globalising Solidarity - The Case for Financial Levies in this reader, pp. 112-116). In addition the current carbon tax provides some understanding of how this co-operation may survive or fail (cf. Woodward: Social protection as a whole in the context of increasing income inequalities in this reader, p. 48). Another simple, but often overlooked solution is to properly tax existing resources.

The World Bank distinguishes between innovative finance mechanisms that generate additional funds, make funds more efficient, and link funds to results. For this paper, the different mechanisms are grouped into two areas: raising new funds for health and new ways of linking funds to results. On raising new funds, international examples include 'solidarity' taxes on airline tickets to improve access to essential drugs and commodities for HIV, TB and Malaria; product ('Red') franchising where a portion of the

price of a branded product will go to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); and converting national debt to GFATM grants to health. Many national examples also exist, and some countries 'earmark' these additional funds for specific health goals. International examples of linking funds to results include: frontloading donor investment through the Global Alliance for Vaccines and Immunisation (GAVI) to expand new and existing vaccines; various forms of results- (or performance-) based financing; and different types of incentives to stimulate private-sector engagement, develop markets for new products, and provide subsidies to increase access to new, expensive drugs.

Non-fiscal (non-tax) Incentives

Currently within the right to health as well as general global rights there are already several forms of non-tax financing such as UNITAID, International Finance Facility for Immunisation (IFFIm), GAVI Alliance, Advance Market Commitments (AMC), the Voluntary Solidarity Contribution for UNITAID, PRODUCT^{RED} and the GFATM, Debt2Health, Carbon Market, Socially Responsible Investments (SRI). Other examples of non-tax incentives include different types of bonds. One is the diaspora bond that offers investors the opportunity to display patriotism by doing good in the country of their origin. Beyond patriotism, however, diaspora bonds allow for better risk management. Typically, the worst-case scenario involving diaspora bonds is that the issuer makes debt-service payments in local currency rather than in hard currency terms. But since diaspora investors are likely to have actual or contingent liabilities in their country of origin, they are likely to view the risk of receiving payments in local currency with much less trepidation.

The IFFIm created four years ago upon the initiative of the British Government, which uses the long term borrowing capacity of States (UK, France, Norway, Italy, Sweden, South Africa and Spain) to collect funds on the markets and finance immunisation programmes in 70 countries amongst the poorest of the world within the framework of the GAVI Alliance. Over one billion dollars have already been collected. The goal is to reach 4 billion dollars in twenty years time.

AMC offer financing for development and vaccine production mechanism for developing countries. Donors commit to guarantee the price of vaccines once developed, thus laying the foundations for the creation of a sustainable market. These commitments are essential incentives for producers to invest considerable amounts into research, staff training and production facilities.

The Debt2Health initiative, which is a partnership between creditors and grant recipient countries under which creditors forgo repayment of a portion of their claims on the condition that the beneficiary country invests an agreed-upon counterpart amount in health through Global Fund approved programmes. In its pilot phase, US$125 to US$250 million should be available through this mechanism.

(PRODUCT)^{RED}, which is a brand licensed to partner companies to raise money for the Global Fund to fight AIDS, Tuberculosis and Malaria. Each partner company creates a product with the Product Red logo and in return gives a percentage of the profit on the sale of these products to the Global Fund. Since its creation, the initiative provided the Global Fund with over US$130 million.

SRI is a strategy that seeks to maximise both financial return and social good. Socially responsible investors favour investments that promote community development and make sure companies and individuals can invest in the future.

Emissions trading (also called cap and trade), which is an approach used by countries to cap

the emissions that contribute to global warming. The overall goal of emissions trading programmes is to reduce global emissions while allowing countries that have reduced their emissions to generate additional income through the improvement of other standards in the country such as for environment protection or health care. Knowing the strong correlation between poverty and climate warming, such financial mechanism should also contribute to the achievement of the MDG.

Fiscal (Tax) Incentives

Most recently, the United Nations called for a tax on billionaires to help raise more than US$ 400 billion a year for poor countries. An annual lump sum payment by the super-rich is one of a host of measures. There are an estimated 425 billionaires in the United States of America, 315 in the Asia-Pacific region, 310 in Europe, 90 in other North and South American countries and 86 in Africa and the Middle East. Other forms of tax being proposed by diverse quarters internationally include: a financial sector activities tax; a value-added tax (VAT) on financial services; a broad financial transaction tax; a nationally collected single-currency transaction tax; centrally collected multi-currency transaction tax (Leading Group on Innovative Financing for Development 2010; cf. also Denys: Globalising Solidarity - The Case for Financial Levies in this reader: 112-116).

However, there are risks in imposing new taxes. Any new levy on goods has to be assessed to consider whether it unfairly affects the poor (i.e. is regressive). A second risk is the high level of administration that can arise from multiple 'new' initiatives: A major new, and very promising, international initiative aimed at raising funds through a voluntary levy on airplane tickets had to be closed largely because of management problems. Thirdly, there is a risk of unrealistic objectives – health financing and universal coverage involves general forms of insurance and taxation; 'innovative financing' can only bring changes in the margins, or over long periods of time. Finally, any new initiative will have unintended consequences and requires close evaluation and regular review to allow good ideas to adapt and grow (Fryatt 2012).

Last but most definitely not least comes the need to better administer the existing taxes. Traditionally peoples are resistant to paying new taxes but have to pay the existing ones. Recent discussions such as those being spearheaded by the Tax Justice Network show that billions of dollars move through the world untaxed from Africa (Froburg and Waris 2011). The challenges faced in collecting these taxes rest on the absence of adequate international cooperation in tracing and administering the existing tax system. These global wealth chains are where to find untaxed resources that would be aimed at strengthening global governance, international co-operation and solidarity and if these resources are utilised to support improved health systems would create a complete cycle of improved global welfare utilising solidarity and international co-operation (cf. Gebauer: The Need to Institutionalise Solidarity for Health, in this reader: 14-23).

Conclusion

Although there remain several challenges in implementation of financing instruments the legal framework to allow for this step to be made and crystallised is already in place. In addition there is the beginning of the will to push towards it. However, there remain several key challenges:

1. Accepting global solidarity as a concept
2. Tapping into existing global wealth chains to properly collect taxes through international co-operation
3. States agreeing to add on an additional financial instrument
4. Defining the main source or sources of these resources

5. The administration system under which the finance will be collected and re-distributed
6. How the finance will be re-distributed, the measurement system to decide who is most deserving
7. How prioritisation within global solidarity will take place for specific states, communities peoples and individuals ■

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FROM FINANCING HEALTH SERVICES TO SUPPORTING HEALTH FINANCING

JEAN-OLIVIER SCHMIDT[40]

P4H as an international instrument to support countries' transition to Universal Health Coverage

Moving from charity to solidarity in health financing is not only about additional domestic and international financing. It is also equally important to have solid know-how concerning technical and process matters in health financing. How to develop sustainable systems of health financing? How to organise the process in a way that makes it inclusive and creates solid accountable institutions?

Governments increasingly realise that out-of-pocket payments are an inefficient way to finance health services and pose a heavy burden especially on the poor and vulnerable. The worldwide magnitude of the problem is discussed in this reader in the contributions by Thomas Gebauer (pp. 14-23) and more indirectly by Gorik Ooms (pp. 31-47). Direct payments when falling sick constitute the world's biggest impoverishment risk. There is a world-wide consensus to address this huge social issue, which is reflected at international level through resolutions such as the ones at the World Health Assembly 58.33 (WHO 2006) and 64.9 (WHO 2011) urging countries to move towards Universal Health Coverage and to find fair financing mechanisms, or the Social Protection Floor Recommendation from the International Labour Conference 2012 (ILO 2012a-c).

However, how does a country move towards universal health coverage or social health protection for all? Some of the questions arising in this path are of complex and often highly ethical matter: How much does it cost to have an "essential package of health"? What should be included in such an "essential package of health" given fiscal space issues and cost-effectiveness of measures? Who should contribute how much? How to raise additional resources? What role for public finances and possible contributions from employed people in countries where there is a predominance of the informal economy? Can efficiencies in the health care delivery chain be improved? What's the best way to pay providers? How to increase accountability for handling of funds? What are structural and institutional changes required for absorbing more funding? How to strengthen links between payment mechanisms and improving quality of services? And in the end it often boils down to: "who shall live"? (cf. Fuchs 2011).

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These different questions can be clustered in three groups through a functional lense (see Kutzin 2001): If a country decides to strive towards achieving universal health coverage for its citizens – that is to enable citizens independent of their socio-economic background to access a reasonable scope of health services of adequate quality and without facing relevant out-of-pocket payments - then it needs to look at least at three different issues: how to raise sufficient funds for health? How to pool the funds in order to provide financial risk protection when accessing health services? And finally, how to use the funds in the most equitable and efficient manner?

While there is a certain logical structure in the necessary questions to be asked, the answers will differ a lot between countries as each country has a different institutional background and a different interpretation of values. The development of strategic options for health financing requires technical capacities and expertise from various sectors, such as health, social protection, economics, institutional setups, etc. while on the political level human rights, prevailing values and various often conflicting interests of different societal groups are of decisive importance for achieving universal coverage.

While for the latter a comprehensive and socially accepted policy vision needs to be developed for effective home-grown solutions, for the former part – i.e. for the effective translation of policy visions and ideas - knowledge and human as well as organisational capacities are required. In order to strengthen these capacities, a coordinated approach to technical assistance for health financing is necessary. Therefore, different development partners have come together to react to the demand for coordinated technical and policy advisory services on health financing.

P4H - the global initiative to promote Social Health Protection / Universal Health Coverage[41]

While, in the past, too often development partners have supported and advocated for the introduction of specificmodels, it has been recognised that this is an unfruitful and often confusing way to support countries. Thus, in the line with the Paris and Accra Declaration and in order to increase aid effectiveness and support country-owned health financing solutions, the international community launched the “Providing for Health Initiative” (P4H) during the G8 Summit in Heiligendamm in 2007. It consists of an innovative network of biand multilateral organisations engaged in supporting low and middle income countries on social health protection. The current core group of the P4H network comprises eight partners: the World Health Organization (WHO), the World Bank, the International Labour Organization (ILO,) the African Development Bank (AfDB), the French Ministry of Foreign and European Affairs, the German Federal Ministry for Economic Cooperation and Development (BMZ), the Swiss Development Cooperation (SDC) and the Spanish Development Cooperation Agency (AECID). P4H works with a lean management structure and draws on the global, regional and country structures of its members. To facilitate collaboration and coordination between partners at global, regional and country level, P4H partners have established a small coordination team hosted by WHO in Geneva.

Making a difference – What does P4H do?

The P4H Initiative is a response to the global challenge that every year some 100 million people are being pushed into poverty while ac-

[41] The following sections build on and borrow extensively from the website http://www.who.int/providingforhealth/en without marking explicitly direct excerpts.

cessing health services. Many more are too poor even to seek health care. It is estimated that 1.3 billion people – more than a fifth of the world's population – do not have sufficient access to health services at all. There is need to raise more awareness about this global challenge and to scale up support to partner countries in their efforts to improve social health protection.

Experience shows that the transition to universal health coverage requires extensive capacity and effort in terms of technical expertise, systems thinking, stakeholder involvement, change management and coordination of inputs and processes – a broad spectrum of issues that many countries may find themselves struggling with. Given this context, countries benefit most from P4H support if partners of the initiative (and possibly other development partners working in this area) form a local social-health-protection or universal-coverage network for joint, tailored, flexible and harmonised support to the country-led transition process. The network can deliver best international technical advice available, strengths and mandates of different organisations, inform political choices, etc. Such various support activities are usually guided by a road map or plan that is part of the national health sector strategy and reform process, such that there is a clear link to the country's broader social protection agenda.

Demand for this support is high and the P4H network is currently active in about 20 countries in Asia and Africa. As the World Health Organization has launched an Action Plan for Universal Health Coverage in 2011, the demand is rising continuously.

Some country examples of the work of P4H

In Uganda, joint consultations led to amend a draft law in such a way that the intended national health insurance becomes also available for poor population groups and the informal sector. Furthermore, they contributed to consolidate the objective of universal coverage in the national health strategy.

The strategy process In Kenya almost grinded to a virtual halt in 2011 due to different political interests but could be reactivated through joint advisory efforts of the P4H network partners. Stakeholder analyses, public debate and further assessments of strategic options for sustainable health financing shall enlighten political decision making and induce a coordinated cross-sector dialogue.

Some 15 years after the introduction of initially very successful health insurance In Mongolia, the number of citizens covered is noticeably diminishing, and the benefits package does not keep track with changing needs. Currently P4H supports a multi-sector process for developing a health protection strategy in order to overcome the existing challenges and accelerate universal coverage.

During recent years, Indonesia has made significant progress in implementing a series of laws for implementing universal health coverage. P4H initiated a local network of development organisations for coordinating technical support; particular concerns refer to the inclusion of the informal sector, the adjustment of benefits offered by the various insurance schemes, and the restructuring of the insurance-institutions landscape in order to reduce the existing fragmentation of different protection mechanisms and, thus, contribute to more universality in the system.

Moving forward: What is needed beyond this?

The P4H advisory services relate to national solutions to develop sustainable systems of health financing and social health protection. However, it is clear that in many countries domestic resources are very limited to finance an adequate essential package of health. Often, according to

the National Health Accounts public per capita spending varies between 5 and 20 US$ per capita per year. This means that in such cases where the fiscal space does not allow for more investment in the health sector, international cross-country financing is required to support effective health systems in countries. So far, international financing has focused on setting up vertical programmes for fighting specific diseases. Limited experience has been made with horizontal and comprehensive approaches for supporting health systems strengthening. One of the most notable exceptions from this rule is the case of Rwanda where resources provided through the GFATM were directly used to pay health-insurance contributions on behalf the poorest part of the population. Another example are funds from the Bill and Melinda Gates Foundation (BMGF) used to support the integration of tuberculosis services into the Rural Health Insurance in China (Wang 2012).

In future, more of this integration into national systems needs to happen in a systematic way if national health systems are to be strengthened. P4H recommendations and support could pave a way for countries to tap into the international funding mechanisms. ■

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FISCAL SPACE AND THE IMPORTANCE OF LONG TERM RELIABILITY OF INTERNATIONAL CO-FINANCING

GORIK OOMS[42]

Introduction

During the first decade of the 21st century, international assistance for health in developing countries increased substantially. This is one of the main achievements of the global fight against AIDS and wider movements to improve global health. However, the achievement is only a partial victory, for on average, developing countries have hardly increased public expenditure for efforts to improve health.

International assistance, or international co-financing of efforts to improve health in developing countries, is often delivered in such a way that it discourages governments of developing countries from increasing national efforts. Policies encouraged by the World Bank and the International Monetary Fund (IMF) contribute to the problem, but are perhaps not at the heart of the problem. One of the main problems appears to be that international co-financing is based on short-term commitments. Governments of developing countries are therefore reluctant to increase their overall expenditure, even when international assistance increases, because such increases could create expectations that they may not be able to meet in the future - health services that could no longer be provided, salaries for health workers that could no longer be paid.

The solution could be to negotiate agreements between developed and developing countries, including firm commitments on increasing national resources for health and long-term binding commitments on international co-financing. A Framework Convention on the Right to Health can provide a framework for such agreements, and a Global Fund with a broader mandate going beyond the vertical approach focussing on three diseases such as the GFTAM can become an instrument to implement such agreements.

Who pays currently for health in developing countries?

Before going any further, it is important to highlight how limited the role of international assistance on health expenditure remains in most developing countries. External resources accounted for 17.5 % of total health expenditure in low-income countries in 2007, on average, coming from 10.2 % of total health expenditure in 2000. Expressed as percentage of Gross Domestic Product (GDP), that is an increase from 0.5 % of GDP in 2000 to 0.9% in 2007. In lower middle-income countries, it was 1 % of total health expenditure, on average, in 2007 according to data published by the World Health Organization (WHO 2010).

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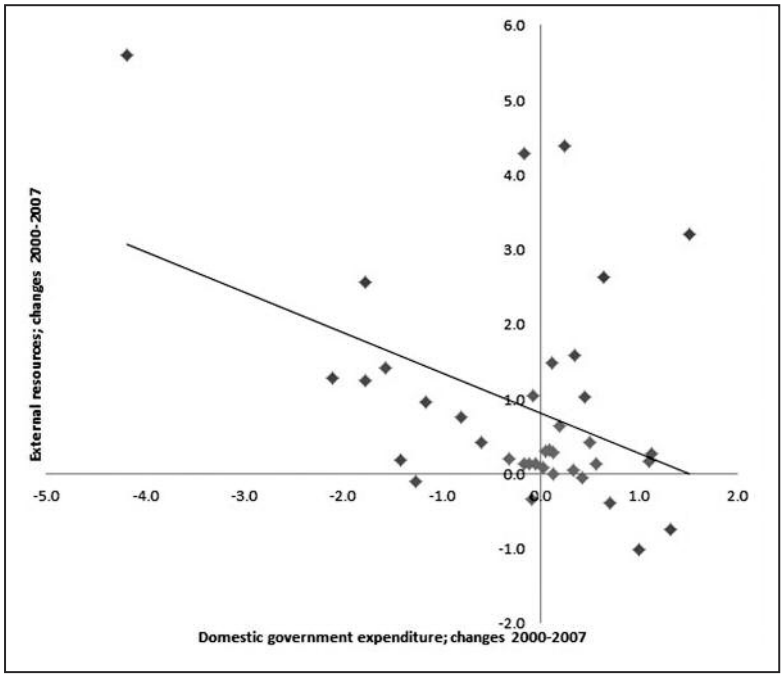
Before going any further, it is important to highlight how limited the role of international assistance on health expenditure remains in most developing countries. External resources accounted for 17.5 % of total health expenditure in low-income countries in 2007, on average, coming from 10.2 % of total health expenditure in 2000. Expressed as percentage of Gross Domestic Product (GDP), that is an increase from 0.5 % of GDP in 2000 to 0.9% in 2007. In lower middle-income countries, it was 1 % of total health expenditure, on average, in 2007 according to data published by the World Health Organization (WHO 2010).

According to the same data, domestic government expenditure on health - defined as total health expenditure, minus external resources, minus private out-of-pocket expenditure - increased from 1.7 % of GDP in 2000 to 1.8 % of GDP in 2007 in low-income countries, and from 1.8 % of GDP in 2000 to 2.0 % of GDP in 2007 in lower middle in come countries. These increases are small, and perhaps disappointing, but they nonetheless seem to contradict findings that external resources 'displace' or 'crowd out' domestic government expenditure (that for every dollar of international assistance, developing countries decrease their own efforts with half a dollar), which suggest that increased international assistance during this years should have led to decreased health spending (Faraq et al. 2009; Chunling et al. 2010).

FIG. 1. CHANGES IN EXTERNAL RESOURCES AND DOMESTIC GOVERNMENT HEALTH EXPENDITURE IN LOW INCOME COUNTRIES, 2000-2007



Source: Calculations by the author based on WHO 2010

Why do most governments of developing countries decrease resources for health when they receive more international assistance for health?

Significantly, not all governments of developing countries reacted in the same way; some did increase their national efforts. There are many explanations for this, and examining averages may cover a multitude of political choices, which may not all be negative for health: governments could have decided to spend more on education, for example, or on water and sanitation (Ooms et al. 2010). Moreover, there is a problem of 'fiscal space': a somewhat misleading expression to explain a fairly simple concept. In essence, 'fiscal space' tries to capture how much a government can spend on a given sector without running into problems in the long run - problems like not being able to sustain the expenditure level for a given sector, or having to cut back on other expenditure. The essential difference between 'fiscal space' and 'budget space' is that 'budget space' looks at how much can be spent on a sector like health, for a given year or for a multi-year budget, while 'fiscal space' looks further into the future.

This is how the World Bank experts Pablo Gottret and Georges Schieber (2006: 139f) explain 'fiscal

space' in their handbook on Health Financing Revisited: A Practitioner's Guide and how they describe countries should react to unreliable aid: "…assume that donor grants are committed to a country in an unrestricted manner until 2020 and that the country does not have absorptive capacity constraints. The restraining factor to increased social expenditures would be the recipient country's commitment to expand domestic resources up to 2020 to progressively substitute for the donor funds. If it is estimated that the domestic envelope will allow such an expansion of health expenditures, the donors funds would be accepted, and the program of increased health expenditure with grant financing, later replaced by domestic resources, would be allowed. If, however, it is unlikely that the additional margin generated in the domestic envelope will accommodate such increases in health expenditures by 2020, or there is unwillingness in the recipient country to make such a commitment to health, expenditures would not be allowed to increase as much."

It may help to elaborate this example a bit. Imagine a country with 10 million inhabitants, an average Gross Domestic Product (GDP) of US$666 per person in 2011, government revenue of 20 % of GDP, or US$ 133 per person, and a government willing to allocate 15 % of government revenue to health efforts (US$ 200 million in total, or US$ 20 per person). This country plans to spend US$ 40 per person per year on health as soon as possible, and considering its economic growth perspectives, it plans to increase government domestic health expenditure to US$ 205 million in 2012, US$ 210 million in 2013, and so on, until US$ 245 million in 2020. This country receives US$ 100 million external assistance per year for health, or US$ 10 per capita, but this aid is guaranteed until 2015 only. Figure 2 illustrates the challenges unreliability of aid creates.

This 'budget space' for health for this country is $300 million in 2011. But in 2020 it may not be willing or allowed to spend more than $250 million, so the 'fiscal space' is only $250 million. Therefore, the government may be reluctant to train and hire additional doctors and nurses, for example, or to include more medicines in the essential medicines list it provides, because that would create expectations that it cannot live up to in the future. It could 'adjust' the budget downwards, in line with fiscal space. It may also take a risk: keep the budget for health at $300

FIG. 2. GRAPHICAL ILLUSTRATION OF UNRELIABLE AID

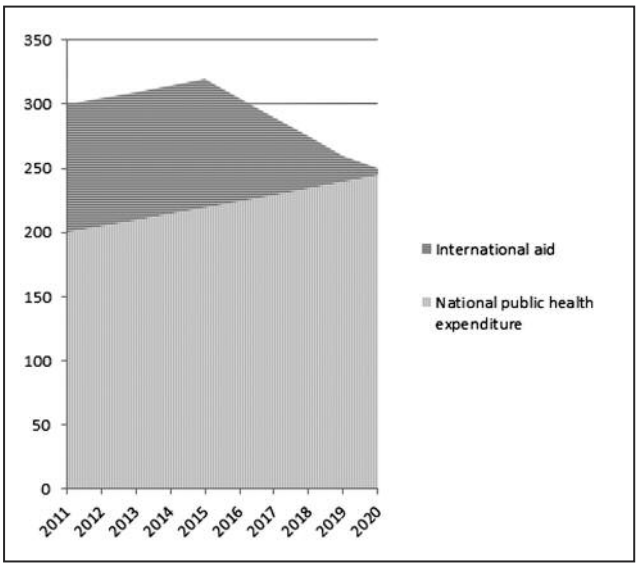
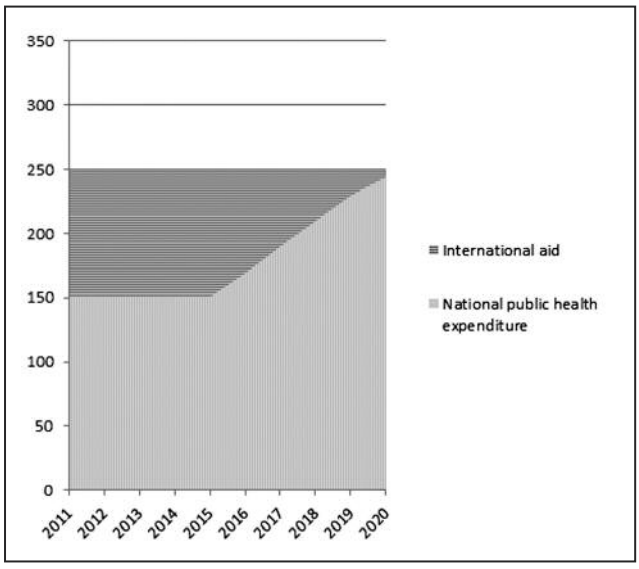


FIG. 3. GRAPHICAL ILLUSTRATION OF THE REACTION TO UNRELIABLE AID



million and hope that aid will not decrease after 2015. But then the World Bank will tell it - as the World Bank's 'Practitioner's Guide' quoted above reveals - that taking such as risk "would not be allowed".

The government of this country would have to refuse some aid ($50 million), because it cannot spend it. A more attractive solution for the government would be to direct national resources to other sectors. If, after 2015, aid for health does decrease, the government can redirect those national resources to health. Figure 3 illustrates this reaction. However, if after 2015, international assistance for health does not decrease, but again comes with short term commitments, the government of this country may well make the same choice (decreasing national resources for health), again.

Is international assistance for health always unreliable in the long run? Chris Lane and Amanda Glassman found that "aid flows to the health sector are volatile in terms of observed outcomes and uncertain in terms of making and delivering future commitments", and argue that "aid is therefore poorly suited to fund recurrent costs associated with achieving the Health Millennium Development Goals, particularly funding of Primary Health Care" (Lane & Glassman 2008: 1). However, they also found that "[p]arts of the new institutional architecture, such as the Global Fund, appear to deliver stable and predictable financing" (ibid.: 23).

Why would international assistance provided through the Global Fund to Fight AIDS, Tuberculosis and Malaria be more reliable in the long run? The first explanation could be that the Global Fund explicitly set out to provide long term reliable 'aid'- perhaps the word 'aid' is no longer appropriate here; perhaps it has become co-financing. As Michel Kazatchkine, executive director of the Global Fund, expressed it: "The Global Fund has helped to change the development paradigm by introducing a new concept of sustainability; one that is not based solely on achieving domestic self-reliance, but on sustained international support, as well" (Kazatchkine 2008). The Global Fund abandoned the old concept of sustainability (aiming for domestic self-reliance) out of necessity: some countries are simply too poor to be able to pay for AIDS treatment themselves within to foreseeable future. So the Global Fund has to try to provide sustained international support - even if that depends on the willingness of donors. The second explanation could simply be the fact that the Global Fund receives contributions from many donor countries allows them to do so. An unexpected shortfall from one donor country can be buffered by contributions from many other donor countries, and perhaps an unexpected windfall too.

Conlusion

Although the unreliability of international assistance in the long run is probably not the only reason why international assistance displaces national resources, it may not be possible to solve the problem of displacement without making international assistance more reliable. And that could require a Framework Convention on Global Health, under which all countries - donors and developing countries - make mutually binding commitments.

A mechanism like the GFTAM could help to make international assistance more reliable, and could also provide an incentive to developing countries to meet their commitments, if for example it would be agreed that the Global Fund has to reward those countries that allocate more national resources for health. (Today, countries that try harder are often 'punished'; they seem to need less assistance and therefore they receive less.) Rather than creating new global health funds for efforts not yet covered by existing partnerships, the present Global Fund should expand its mandate, if donors are willing to make greater and more reliable commitments - and to keep these commitments. ■

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ANNEXES

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Workshop programme

GLOBAL SOCIAL PROTECTION SCHEME – MOVING FROM CHARITY TO SOLIDARITY

International Seminar on Financing for Health and Social Protection

Relexa Hotel - Stuttgarter Hof Berlin - Anhalter Straße 8-9 - 10963 Berlin

PROGRAMME

Monday, 14th of May 2012

14:00 WELCOME AND INTRODUCTION
Thomas Gebauer, Director, medico International

Describing the frame
Realising the Right to Health needs Resources
Anand Grover, UN-Special Rapporteur on the Right to Health

Keynote
Globalising Social Protection
Context & Principles - The Pathway to a New Paradigm / Gorik Ooms, Institute of Tropical Medicine - Antwerp, Helene de Beir Foundation, Belgium

15:00 PANEL
Global Social Protection in the context of Human Rights, Common Goods, and Global Economy
Chaired by Attiya Warris and Thomas Gebauer

• *GSPS – a Human Rights Obligation? Shall refer to a comprehensive concept of social protection* / Dr Margot E Salomon, Centre for the Study of Human Rights, Law Department, London School of Economics

• *Social protection as a whole in the context of increasing income inequalities* / David Woodward, Economist, Independent Researcher

• *GSPS – a Global Common Good in a globalised world* / Prof. Thomas Pogge, Yale University, USA

16:30 COFFEE BREAK

17:00 DISCUSSION

18:00 WRAP UP OF THE FIRST DAY
Andreas Wulf

Tuesday, 15th of May 2012

9:30 PANEL
The End of Utopia? - Building Blocks of the New Paradigm
Chaired by Rachel Hammond and Alan Whiteside

• *Creating Political Will: The ILO "Social Protection Floor" Initiative as a Milestone on the Way to a GSPS* / Aurelio Fernández, Former Chair of the EU Social Protection Committee, Bachelet Commission for the Social Protection Floor

• *Implementing the Principle of Solidarity through financial equalisation mechanisms: Lessons to be learned from regional development funds and risk adjustment schemes for GSPS* / Jens Holst, medico international

• *Budget Funding – First lessons learned* / Francisco Songane, former Minister of Health of Moçambique

• *International Taxation* / Lieven Denys, Professor for International and European Tax Law at the University of Brussels

10:45 COFFEE BREAK

11:15 WORKING GROUP SESSION
Expectations, Challenges and Risks: Exploring GSPS

• Scope
Leading question: What shall be the scope of a Global Social Protection Scheme? (see Appendix A) / Inputs: Armando di Negri (Brazil), David McCoy (PHM-UK) / Chair: Jozef van Langendonck, Belgium

• Responsibilities and Resources
Leading question: How to finance social protection? (see Appendix B) / Inputs: Christoph Benn (GFATM), Sanjay Basu (UCSF), Vanessa Lopez (Salud pro Derecho, Spain), Attiya Waris (Tax Justice Network, Kenya), Jean-Olivier Schmidt and Marco Schäfer (GIZ-P4H) / Chair: Mariska Meurs (WEMOS, Netherlands)

• Governance – Making the GSPS a reality for all
Leading question: How to achieve transparency, participation, shared ownership and reliability governance? (see Appendix C) / Inputs: Fransisco Songane (former Minister of Health of Moçambique), Nicoletta Dentico (HIP), N.N. (EC) / Chair: Dona Barry (PiH)

13:00 LUNCH

14:30 CONTINUATION OF WORKING GROUPS

16:00 COFFEE BREAK

16:30 PLENUM
Presentation of working group results
Open discussion

18:00 WRAP UP OF DAY 2
Drafting of a Global Social Protection Scheme (GSPS) / Alan Whiteside/Rachel Hammonds

Wednesday, 16th of May 2012

9:30 PANEL DISCUSSION
Confronting politics with visions
Discussing preliminary results with politicians, trade unions, and civil society – Up to three rapporteurs presenting the results

• Dr. Inge Kaul, former Director Office of Development Studies, UNDP/New York, Adjunct Professor Hertie School of Governance

• Christiane Grefe, "Die Zeit"/ Berlin

• Manoj Kurian, Programme Executive for Health and Healing of the World Council of Churches/ Geneva

11:00 CONCLUDING SESSION
Results, next steps, creating a task force
Concluding remarks / Birgit Wendling, Federal Ministry of Economic Cooperation and Development

12:30 END


social
protection
health
countries
charity
Organisation
support
essential
Social
Health