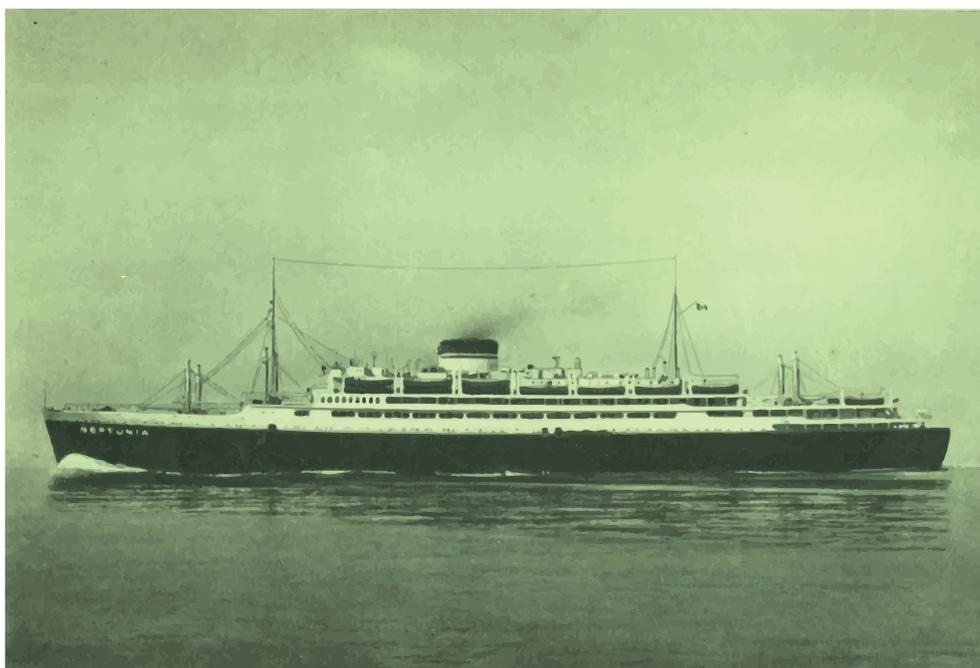


PAIX ET SÉCURITÉ INTERNATIONALES

03

2015



REVUE MAROCO-ESPAGNOLE
DE DROIT INTERNATIONAL ET RELATIONS INTERNATIONALES
(NOUVELLE SÉRIE- VERSION ÉLECTRONIQUE)



INTERNATIONAL LAW AND GLOBAL HEALTH: AN OVERVIEW

XAVIER PONS RAFOLS¹

In memory of Ned Hayes

I. INTRODUCTION - II. GLOBAL HEALTH AND THE GLOBALIZATION OF HEALTH - III. GLOBAL HEALTH AS AN OBJECT OF INTERNATIONAL REGULATIONS AND COOPERATION - IV. PRINCIPAL DIMENSIONS OF INTERNATIONAL ACTION REGARDING GLOBAL HEALTH ISSUES IN THE FIRST DECADE OF THE 21ST CENTURY - V. FINAL CONSIDERATIONS

INTERNATIONAL LAW AND GLOBAL HEALTH: AN OVERVIEW

ABSTRACT: Contemporary international society is characterized, among other elements, by its progressive humanization, which situates human beings at the centre of all international concerns. This conceptual approach, and the capacity of global health to situate itself transversally across multiple dimensions, means that health is a material domain that can become a central axis of international action and of International Law. In this paper are discussed, firstly, the international notion of health and its global character in a globalized world; secondly, are analysed certain key aspects concerning health as an object of cooperation and international regulation, particularly as it involves the United Nations and the World Health Organization (WHO). Finally, are presented some of the principal substantive dimensions of current international action in matters of global health.

KEY WORDS: Global Health; United Nations; World Health Organisation; foreign policy; epidemic outbreaks; social determinants of health.

LE DROIT INTERNATIONAL ET LA SANTÉ MONDIALE: UN APERÇU

RÉSUMÉ: La société internationale contemporaine est caractérisée, entre autres éléments, par leur humanisation progressive, qui a placé l'être humain au centre de toutes les préoccupations internationales. Cette approche conceptuelle et la même capacité de la santé mondiale à être placée transversalement dans des multiples dimensions configure la santé comme un domaine matériel qui peut devenir une pièce maîtresse de l'action internationale et du droit international. Cet article présente, en premier lieu, une approche à la notion de santé internationale et sa nature globale dans un monde globalisé; deuxièmement, sont discutés certains aspects référés à la santé comme un objet pour la coopération et la réglementation internationale, en particulier autour de l'Organisation des Nations Unies et de l'action de l'Organisation mondiale de la Santé (OMS); enfin, on fait

¹ Full Professor (Catedrático) of Public International Law. Department of International Law and Economics. University of Barcelona. This study is framed within the Research Project DER2012-36793, funded by the Spanish Ministry of Economy and Competitiveness (Ministerio de Economía y Competitividad).

une brève présentation de certaines des principales dimensions de fond de l'action internationale actuelle autour de la santé mondiale.

MOTS CLÉS : Santé mondiale ; Nations Unies ; Organisation mondiale de la Santé ; politique extérieur ; flambées épidémiques ; déterminants sociaux de la santé.

DERECHO INTERNACIONAL Y SALUD GLOBAL: UNA PANORÁMICA

RESUMEN: La sociedad internacional contemporánea se caracteriza, entre otros elementos, por su progresiva humanización, que ha situado a los seres humanos en el centro de todas las preocupaciones internacionales. Este planteamiento conceptual y la misma capacidad de la salud global para situarse transversalmente en múltiples dimensiones configuran a la salud como un ámbito material que puede convertirse en un eje central de la actuación internacional y del Derecho Internacional. En este artículo se presenta, en primer lugar, una aproximación a la noción internacional de salud y a su carácter global en un mundo globalizado; en segundo lugar, se analizan algunos aspectos clave en relación con la salud como objeto de cooperación y regulación internacional, en particular en torno a las Naciones Unidas y a la acción de la Organización Mundial de la Salud (OMS); por último, se formula una rápida presentación de algunas de las principales dimensiones sustantivas de la actual actuación internacional en materia de salud global.

PALABRAS CLAVE: Salud global; Naciones Unidas; Organización Mundial de la Salud; política exterior; brotes epidémicos; determinantes sociales de la salud.

I. INTRODUCTION

Today's complex international society is characterized, among other elements, by the universality, diversity and heterogeneous nature of its components, but it remains a society whose principal actors are the different States. They retain -in a decentralized fashion, as sovereign subjects- political power on the international stage. They are also the principal creators and subjects of international legal norms. This traditional element -inherited from the Westphalian model of States- is today blended with important new developments at the level of principles, institutions, processes and international regulations, which are themselves a result of the evolution of international society and the globalization process.

For my present purposes, I point out that the international society of the 21st century recognizes as fundamental values, among others: human rights, the achievement of peace -and, therefore, the peaceful resolution of international controversies and the prohibition of threat or use of force-, the self-determination of peoples, as well as the pursuit of common and universal objectives that satisfy human needs, foster economic and social development, and allow all human beings

to live with dignity and without the fear of violence or of a life of misery.² All these elements, which have important ethical repercussions, also present important challenges, given the profound inequalities of the contemporary world and the moral imperative that all human beings might live in a society that respects their rights and satisfies their necessities.³ This humanization of international society, which situates human beings at the centre of all international concerns, can have as its axis a single basic human right, namely, the right to the highest possible degree of health.

This conceptual approach, and the capacity of global health to situate itself transversally across multiple dimensions, means that health is a material domain that can become a central axis of international action and, for our current purposes, of International Law. In the following pages I will first discuss the international notion of health and its global character in a globalized world. Following this, I will analyse certain key aspects concerning health as an object of cooperation and international regulation, particularly as it involves the United Nations (UN) and the World Health Organization (WHO). Finally, I will briefly present some of the principal substantive dimensions of current international action in matters of global health.

II. GLOBAL HEALTH AND THE GLOBALIZATION OF HEALTH

The starting point for my approach is the notion of health itself, as it has been recognized internationally since 1946, the year that the WHO was created. In addition, we must also take into account the undeniable phenomenon of the globalization of health, which has progressively accelerated over the last few decades.

1. THE INTERNATIONAL CONCEPT OF HEALTH

Even though it is commonly known, I reiterate that the preamble to the Constitution of the WHO, adopted in 1946, establishes that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.⁴ For my present purposes, I will emphasize the reference to

²This line of discourse clearly underlies Kofi Annan’s insightful report: “In larger freedom: towards development, security and human rights for all”, Document A/59/2005.

³Similarly, article 28 of the Universal Declaration of Human Rights recognizes that: “Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized”.

⁴The Constitution of the World Health Organization, signed on 22 July 1946, and revised on numerous occasions, is available at <<http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>>.

a state of “*social*” welfare, given that my approach is based on the social sciences and, specifically, on Public International Law. This initial proposal in the WHO’s Constitution, genuinely visionary for its time, has been strengthened and extended over the years in other texts and resolutions deriving from the WHO.

There are several fundamental milestones concerning the issues I wish to emphasize. First, the Alma-Ata Declaration on Primary Health Care (adopted in 1977) asserts that “the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”.⁵ Second, the Ottawa Charter on Health Promotion (1986) states: “The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity”.⁶ On the basis of these texts we can attest that health is clearly closely connected with other economic and social sectors that have an impact on the health of individuals and on peoples as a whole. As an initial approach, therefore, we can say that the international concept of health has a holistic and transversal character, which also highlights the international dimension of the problems related to health. Thus, I employ the concept of “*global health*” intending to highlight the norms, institutions, and international processes that work with, and are related to, health.

2. THE GLOBALIZATION OF HEALTH

The second initial idea that I wish to emphasize is the constantly growing globalization of health. Certainly, as we will see further on, there are historical precedents for international cooperation in health matters. Nevertheless, in the last few decades the phenomenon of globalization -with an accelerated growth of contacts of all kinds between States and other international agents- has also given rise to a rapid globalization of health.⁷ One of the key factors in this acceleration and change that has influenced the globalization of health is the on-going change in international demographics. This is not only because there has been an increase in

⁵ See the Declaration of the International Conference on Primary Health Care, Alma-Ata, September 1978, available at <http://www.who.int/publications/almaata_declaration_en.pdf>.

⁶ See The Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, 21 November 1986, available at <<http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>>.

⁷ There is no doubt that the “Globalized Health Hazards” demand collective global action (see, in this regard, GOSTIN, L. O., *Global Health Law*, Harvard University Press, 2014, especially pp. 32-58).

life expectancy and a reduction in mortality rates, but also because of the massive population displacements facilitated by the spectacular developments in modern means of transport. Whether for tourism or business purposes, or to escape economic misery or armed conflict, hundreds of thousands of people travel daily -in good or bad conditions- from one side of the planet to the other. This clearly produces a possible vector for the transmission of disease; indeed, in many cases, the precariousness of these movements of persons turns them into an authentic health problem. Seen from the same perspective, there is another factor relating to acceleration and change: the liberalization of international trade in goods and services that globalization brings. International trade, occurring as never before in history, also constitutes a potential vector for disease transmission. This is not only because of certain agriculture and livestock products transported to feed various regions of the world, but also because the international movement of goods itself could also inadvertently carry viruses or other disease strains.

In addition -and also with consequences for the globalization of health- the enormous development in information and communication technologies generates knowledge, reaction and decision-making regarding problems of global health. Nonetheless, these new technologies can have negative effects internationally due to the alarm that may be caused by disease outbreaks or the arrival on the international stage of a new disease. There are also grey areas in modern breakthroughs in the biomedical sciences, for, together with the immense possibilities of new treatments for illnesses and the early detection and prevention of diseases, we know that these undeniable benefits are and will be unequally divided amongst the world's countries, and even within these countries. In addition, scientific experimentation also brings risks with it, and has generated serious challenges in bioethical terms and with issues relating to human dignity.

If we also add some of the problems and characteristics of the current international health situation to these factors of acceleration and change, there remains no room for doubt that health has become globalized.⁸ Indeed, in the last few decades we have witnessed the emergence of new forms of rapidly-spreading infectious diseases, such as HIV/AIDS, Severe Acute Respiratory Syndrome (SARS), the avian influenza or the H1N1, to mention but a few. To these we can add the re-

⁸ See, for a general overview, PONS RAFOLS, X., "La salud como objeto de cooperación y regulación internacional", in PONS RAFOLS, X. (ed.), *Salud pública mundial y Derecho internacional*, Marcial Pons, Madrid, 2010, pp. 23-66.

emergence of diseases that were previously thought to be under control, such as tuberculosis.⁹ Both phenomena coexist with important -albeit occasional- epidemic outbreaks of already known infectious diseases, such as the recent Ebola epidemic outbreak in West Africa, the persistent and grave issue of malaria -endemic in many developing countries- and tropical neglected diseases, such as Chagas disease. To all of this, we must add the prevalence of certain chronic, non-transmissible and non-declarable illnesses, such as cardiovascular diseases, diabetes or oncological diseases.¹⁰

All this, as I have indicated, places global health at the centre of international concerns. This central position is furthermore reinforced by the evolution of International Law and the international community. Indeed, beginning in the second half of the 20th century, international society has on the one hand become progressively more human, establishing human dignity as an essential value, with all that entails in terms of human rights and the personal welfare of individuals.¹¹ On the other hand, international society has recognized international cooperation as one of its structuring principles. International cooperation is, therefore, not only an obligation for States, but also an imperative for the collective satisfaction of needs and demands that one State -even if it is the biggest and most powerful of all- cannot adequately respond to by itself.

In this context, it should be kept in mind that there are deep health inequalities existing within the populations of individual nations, as well as between different nations. These inequities -which are avoidable in matters of health- are the inevitable result of the inequalities that exist at the heart of individual societies and between different societies. That is why I hold that global health has become a global public good that must be safeguarded on an international basis.¹² Hence the necessity for international cooperation and of an international legal framework that deals with global health problems from the holistic and transversal perspective that I indicated

⁹ In its most recent Factsheet N°104, updated October 2014, the WHO confirmed that Tuberculosis (TB) is second only to HIV/AIDS as the greatest killer worldwide by a single infectious agent, and that in 2013 9 million people fell ill with TB and 1.5 million died from the disease.

¹⁰ Which have also become a guiding principle for international action. See, in this respect, the crucial Political Declaration on the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, Resolution 66/2 of the General Assembly, 24 January 2012.

¹¹ See, for all, the position sustained by CARRILLO SALCEDO, J.A., *Soberanía de los Estados y Derechos Humanos en el Derecho Internacional contemporáneo*, ed. Tecnos, 2nd ed., Madrid, 2001.

¹² See, for example, KAUL, I., FAUST, M., "Global public goods and health: taking the agenda forward", *Bulletin of World Health Organization*, 2001, 79 (9), pp. 869-874.

above, a framework that will have progressively greater content.¹³

III. GLOBAL HEALTH AS AN OBJECT OF INTERNATIONAL REGULATIONS AND COOPERATION

The idea that global health should be the object of international regulation and cooperation is due, on the one hand, to its historical precedents and, on the other hand, to the international community's response to current health problems. In my opinion this response must involve the participation and leadership of the UN as its guiding institution and of the WHO as the international authority in all health matters.

1. HISTORICAL BACKGROUND OF INTERNATIONAL COOPERATION FOR HEALTH

The historical origins of international health cooperation must be placed, fundamentally, in the 19th century, with the convergence of a double phenomenon: on the one hand, there are the economic and social developments and the growth of medical knowledge in the 19th century that resulted in a powerful reorientation regarding the prevention of diseases; on the other hand, there has been a progressive growth in the State's role as a guarantor of health services. All this led to a certain level of international health cooperation, initially focussed on the fight against the spread across borders of infectious diseases on an international scale. That is to say, the States themselves sought to protect themselves against foreign health threats. These efforts would eventually extend to other dimensions of public health, such as the traffic of drugs, narcotics, and labour security issues.¹⁴ The first International Health Conferences were thus held in the second half of the 19th century. They were aimed at enforcing quarantine measures against cholera, yellow fever, and plague. The first international health agreements were adopted at these Conferences.

The establishment of the first international regulations in the area of infectious disease control not only sought to protect Europe against these diseases and to harmonize the quarantine requirements that distorted international trade; in addition, they aimed to create an international system of vigilance against

¹³ Some authors speak of an International Law of Health as being a set of international norms directed to safeguarding and improving people's health (see for example SEUBA HERNÁNDEZ, X., "La emergencia del Derecho Internacional de la Salud", *Revista Digital de la Facultad de Derecho de la UNED*, 1 (2009).

¹⁴ See, in general, FIDLER, D.P., "The globalization of public health: the first 100 years of international health diplomacy", *Bulletin of the World Health Organization*, 79 (2001): 842–849.

epidemics and, ultimately, international institutions that would coordinate with the participating States in all matters relating to the fight against infectious disease.¹⁵ In addition to these initial measures regarding norms and international cooperation, an institutional leap came in the 20th century with the creation of the first international Organizations with competences over health matters, such as L'Office International d'Hygiene Publique (1907) which, beginning in 1923, overlapped with the Health Organisation of the League of Nations. The two Organizations, with differing initial perspectives, maintained this overlap as well as their independent activities despite several attempts at coordination by the League of Nations.¹⁶ On the other hand, there was also -at a regional level- the creation of the Pan American Sanitary Bureau (1902), now more than a century old, which was the seed of the still existing Pan American Health Organisation (PAHO), and which is now the WHO Regional Office. This first phase of institutionalization of health cooperation in the first half of the 20th century eventually led, during the period after the Second World War and the years of the exponential growth in multilateral relations, to the creation of the World Health Organization (WHO) as the only institution established to lead international health actions and practice Global Health Diplomacy.¹⁷

2. THE INTERNATIONAL COMMUNITY'S RESPONSE TO CURRENT QUESTIONS AND PROBLEMS REGARDING GLOBAL HEALTH

In regards to the holistic, transversal character of global health, as well as its international dimension, the first noteworthy feature of the international community's response has been the creation of numerous legal instruments together with the use of existing legal regimes, as well as diverse institutions and international Organizations. Indeed, to the extent that numerous aspects of international cooperation can directly or indirectly relate to global health issues, there are several international regimes that deal, directly or indirectly, with issues relating to global health. To give only a few examples, questions related to food safety are the ambit

¹⁵ See in this respect FIDLER, D.P., *International Law and Infectious Diseases*, Clarendon Press, Oxford 1999, pp. 28-35.

¹⁶ Regarding the precedents of international health cooperation, see SEUBA HERNÁNDEZ, X., "Los orígenes de la cooperación sanitaria internacional", in X. PONS RAFOLS (ed.), *Salud pública mundial y Derecho Internacional*, *op. cit.*, pp. 67-87.

¹⁷ See, among others, KICKBUSCH, I., IVANOVA, M., "The History and Evolution of Global Health Diplomacy", in KICKBUSCH, I., LISTER, G., TOLD, M., DRAGER, N.(eds.), *Global Health Diplomacy. Concepts, Issues, Actors, Instruments, Fora and Cases*, ed. Springer, New York, 2013, pp.14-26

of the WHO and of the FAO (Food and Agriculture Organization of the United Nations), which together have co-established the *Codex Alimentarius Commission*, an institution that adopts international regulations regarding food safety standards. Questions related to the dangers and impacts on human health of chemical, nuclear or bacteriological weapons are the object of numerous international treaties and come under the jurisdiction of organizations such as the IAEA (International Atomic Energy Agency) and the OPCW (Organisation for the Prohibition of Chemical Weapons). Concerns regarding the ethical implications of developments in the life sciences fall within the scope of UNESCO (United Nations Educational, Scientific and Cultural Organization), which has already adopted several Declarations regarding these issues. Within these differing institutional frameworks, international instruments concerning multiple issues have been adopted, directly or indirectly related to global health, with some of which are mandatory and other non-legally binding.

In addition to the normative and institutional diversity of the international community's response, a recent phenomenon relating to global health has been the appearance on the international stage of new private or public-private actors, whose influence is steadily growing. Thus, to the work of philanthropic foundations and private sector corporations connected to the pharmaceutical sphere, we must add the recent blooming of public-private partnerships. These latter are new institutional mechanisms, of a private legal nature, that have competence in the domain of global health, particularly in relation to the financing of the fight against the great pandemics, such as HIV/AIDS, malaria and tuberculosis.

As I understand it, however, the United Nations remains the guiding institution on the international stage, while the WHO constitutes, without a doubt, the authority in international health matters. It must be within the framework of these international Organizations that the principal dimensions of International Law relating to global health are developed.

A) The United Nations as guiding institution of the international system

Since its creation in 1945, the United Nations has become the framework institution of contemporary international society. In particular, its constitutive Charter and other legal instruments adopted by the UN have shaped the legal framework of contemporary International Law. Its goals, of a general, universal,

timeless and interdependent nature, as well as its composition (also universal), the principles it has proclaimed and defined since its creation, and its activity over the course of the last decades, have worked together to situated the UN as the guiding institution of the international system.¹⁸ Specifically, in respect to global health, one of the principal purposes of the UN is that of confronting health problems. Thus, within the framework established in a general way in article 1.3 of the UN Charter -where it establishes the goal of achieve international cooperation in solving international problems of an economic, social, cultural and humanitarian character- article 55 of the Charter refers expressly to health problems. Nevertheless, what is most relevant, in my opinion, are the generality, timelessness and universality of the UN's aims. Their interconnection constitutes the additional element necessary for an international approach to global health issues; issues which, as I have pointed out, are of a holistic and transversal nature.

This interdependence between conceptual and operational aspects, already present in 1945, has only grown thanks to globalization. It undoubtedly influences the international approach to global health. In the '90s, in the new conditions of the post-Cold War world, the great international conferences sponsored by the UN focused international concern on human beings¹⁹ with the formulation of new concepts such as sustainable development and human security. Furthermore, these conferences highlighted clearly the presence of interdependent, indispensable and mutually-reinforcing dimensions in these matters.²⁰ These dimensions have become, inexorably, the guiding principles of the international system, as demonstrated by the Heads of State and Government who came together at the 2005 World Summit, where they recognized that “peace and security, development and human rights are the pillars of the United Nations system and the foundations for collective security

¹⁸ For a panoramic vision of the role of the United Nations in the 21st century, see PONS RAFOLS, X., “Las Naciones Unidas en el siglo XXI: funciones, retos y opciones de futuro”, *Agenda ONU*, 7 (2005), pp. 239-297.

¹⁹ This is how it is presented in the Rio Declaration on Environment and Development, adopted at the first and most important Conference in this cycle of International Conferences, the 1992 Rio de Janeiro Conference on Environment and Development. The first principle of this Declaration establishes that: “Human beings are at the centre of concerns for sustainable development” [see the report of the UN Conference on Environment and Development, Document A/CONF.151/26/Rev. 1 (Vol. I)].

²⁰ Former Secretary-General Kofi Annan, in his important 2005 Report -to which I have already alluded- “In larger freedom: towards development, security and human rights for all”, emphasized these interdependent and indispensable dimensions, which mutually reinforce each other. He states “we will not enjoy development without security, we will not enjoy security without development, and we will not enjoy either without respect for human rights” (Document A/59/2005, par. 17).

and well-being” and that “development, peace and security and human rights are interlinked and mutually reinforcing”.²¹

There is, therefore, no doubt that each of these three essential pillars of the UN system is closely linked with global health. Thus we can assert, on the one hand, that threats to human health can also be considered threats to international peace and security from a global and inclusive perspective on health.²² The Security Council itself has very recently stated that this is so, speaking forcefully on the occasion of the Ebola crisis in Western Africa: Resolution 2177 (2014), of 18 September 2014, determined that the Ebola outbreak constitutes a threat to international peace and security. At the same time, it adopted several measures and supports the Secretary General’s creation of a United Nations Mission for Ebola Emergency Response (UNMEER).²³ On the other hand, it should be understood that threats to international peace and security also constitute threats to global health. The response must focus on the consequences to human health resulting from armed conflict, the use of weapons -of whatever kind- and, in general, any threat to peace.

In a similar vein, the interactions between a low level of development and global health are undeniable. Global health ends up becoming a prior condition, a result, and an indicator of development. The unequal burden of diseases and inequalities in health have not been resolved through the Millennium Development Goals (MDGs), adopted in the year 2000 as goals to be attained by 2015. Some of these MDGs refer specifically to health-related issues, such as the goals of reducing child mortality, improving maternal health and fighting HIV/AIDS, malaria, and other diseases. There can be no doubt that the goal of promoting development has a direct influence on the decrease in health inequalities.

Lastly, regarding the third essential pillar of the UN, concerning human rights, it should be noted that from the first international text on this topic, the human right

²¹ See the World Summit Outcome of the 2005 World Summit, Resolution 60/1 of the General Assembly, 16 September 2005, par. 9.

²² As Kofi Annan indicated in his 2005 Report, emphasizing this ecumenical perspective on security and threats against peace in the 21st century, these threats “include not just international war and conflict but civil violence, organized crime, terrorism and weapons of mass destruction. They also include poverty, deadly infectious disease and environmental degradation since these can have equally catastrophic consequences. All of these threats can cause death or lessen life chances on a large scale. All of them can undermine States as the basic unit of the international system” (Document A/59/2005, par. 78).

²³ In addition to the resolution just cited, the Reports of the Secretary General contained in Documents A/69/389-S/2014/679 and A/69/404 are of particular importance.

to health has been internationally recognized. The Constitution of the WHO itself states in its preamble that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”. A similar assertion is found in the Universal Declaration of Human Rights (1948), article 25.1, from an integrative perspective: “Everyone has the right 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 and necessary social services”. Finally, article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) clearly establishes that “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”.

From this angle we can understand the human right to health as a right that forms part of the core of inderogable human rights. Even if it is not an absolute right in the sense of an entitlement to health, it is a right having priority that is an essential condition for the enjoyment of other rights. It is also a right that is simultaneously individual and collective, and which incorporates the universal right of access to health services, prevention, assistance, treatment, rehabilitation, palliative care, aid and access to medicines, i.e., everything that we can subsume under the notion of universal health coverage. Based on what was demanded by the ICESCR, the Committee on Economic, Social and Cultural Rights (CESCR) adopted, in the year 2000, its General Comment No. 14 (2000) on “The right to the highest attainable standard of health”.²⁴ This document stressed that the human right to health foreseen in the International Covenant is a right linked to other rights, has an “inclusive” character -in the sense that it highlights the holistic and transversal character of global health²⁵- and which includes, as fundamental elements, the availability, accessibility, acceptability and quality of health services.

²⁴ General Comment No. 14 (2000), *The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, Document E/C.12/2000/4.

²⁵ The Committee interprets the right to health “as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health” (par. 11 of the General Comment No. 14).

B) The World Health Organization (WHO) as the international authority in health issues

The creation of the WHO in 1946²⁶ in the context of the creation of diverse international Organizations that would later be linked to the UN as specialized Organisms, involved a significant qualitative leap with respect to prior international institutions and objectives in the area of health, which were fundamentally focused on the fight against the international propagation of infectious diseases. Indeed, beyond these approaches, and while maintaining the same perspective on the concept of health given in the preamble to its Constitution, the WHO declares: “The objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health” (article 1). This is, obviously, a generic, universal, and timeless goal that should be linked to the human right to health and to the holistic and transversal concept of health itself. It has an undeniable power due to its clarity and forcefulness.

Responding to this generic goal, the WHO’s functions are of a broad and preferentially technical character, taking responsibility for all matters and related issues regarding health and hygiene on a global scale.²⁷ Among other functions, it acts as a directing and coordinating authority. It helps governments provide health services and public health resources, such as technical or emergency help. It carries out tasks related to epidemiology (studies, statistics, and actions to suppress diseases), promotes the improvement of hygiene standards (nutrition, housing, sanitation, economic and labour conditions, etc.) and promotes accords and regulations concerning international health. Finally, it provides preventive and operative technical assistance in the area of health, especially immediate alerts and preventive action in the face of epidemic outbreaks.²⁸

The WHO carries out these functions through an institutional architecture that

²⁶ The WHO Constitution went into effect on 7 April 1948. Previously, between 1946 and 1948, an Interim Commission, with the participation of 18 countries, took over the work of L’Office International d’Hygiene Publique, the Health Organisation of the League of Nations, and the Health Division of the UN Relief and Rehabilitation Administration (see, in this regard, McCARTHY, M., “A Brief History of the World Health Organization”, *The Lancet*, Vol. 360, Issue 9360, 2002, pp. 1111-1112).

²⁷ Regarding the general role of the WHO, see SAURA ESTAPÀ, J., “La Organización Mundial de la Salud y la cooperación internacional frente a las grandes pandemias: el nuevo Reglamento Sanitario Internacional”, in PONS RAFOLS, X. (ed.), *Salud pública mundial y Derecho internacional, op. cit.*, pp. 165-192.

²⁸ See, in this regard, RUGER, J.P., YACH, D., “The Global Role of the World Health Organization”, *Global Health Governance*, vol. 2, num. 2 (2008/2009).

is fundamentally realized in the World Health Assembly and the Executive Board, which are its two principal inter-governmental organs. The Director-General, currently Dr. Margaret Chan, from China, together with the necessary personnel, provides assistance to these institutions from the headquarters of the WHO in Geneva, and from the Regional Offices scattered throughout the world. As I have indicated previously, the WHO is characterized by a considerable degree of decentralization in its activities, thanks to the establishment of Regional Offices; the WHO Regional Office for the Americas is also the headquarters of the independent Pan American Health Organization.

It should be emphasized that the WHO also has normative competences, which, in accordance with articles 19-23 of its Constitution, enable it to adopt conventions or agreements, regulations and recommendations.²⁹ The adoption of conventions and international agreements requires the approval of two thirds of the World Health Assembly and, obviously, their entry into force requires the formal consent of its Member States. In any case, the original feature of the WHO is that an 18 month window is established for ratification of these agreements by the Member States. If one of these States does not ratify the agreement, it must formally communicate its reasons to the Assembly; this constitutes a facilitating mechanism with dissuasive elements. Nevertheless, these broad possibilities for the development of international conventions about a wide range of matters relating to health have not, up to now, been taken advantage of sufficiently. Over the years the adoption of various conventions has been proposed -for example, about infectious diseases or about biomedical research- but within the framework of the WHO only one convention has been adopted: the WHO Framework Convention on Tobacco Control, approved in 2003, in force since 2005 and, currently, with 179 States taking part.³⁰

The possibility of adopting legally binding regulations is also provided for in the WHO's Constitution, though it is restricted to certain matters specified in that document, and which are limited to sanitary and quarantine requirements, along with other procedures developed to prevent the international spread of diseases: Fixing

²⁹ See in this respect GOSTIN, L.O., SRIDHAR, D., "Global Health and the Law", *The New England Journal of Medicine*, 370, 18 May 2014, pp. 1732-1740; and SOLOMON, S.A., "Instruments of Global Health Governance at the World Health Organization", in KICKBUSCH, I., LISTER, G., TOLD, M., DRAGER, N. (eds.), *Global Health Diplomacy. Concepts, Issues...*, *op. cit.*, pp. 187-198.

³⁰ Available at <http://www.who.int/fctc/text_download/en/>.

the nomenclature of diseases and causes of death; Advocating for standards with respect to the safety of biological, pharmaceutical and other products moving in international commerce; and Advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.

In spite of this constitutional foresight, the WHO has adopted only two sets of regulations: the International Statistical Classification of Diseases and Related Health Problems (ICD) in 1948 (revised on several occasions)³¹; and the International Health Regulations (IHR), a first version of which was adopted in 1951, and then thoroughly amended in 2005. I will refer to these later in this paper. One remarkable peculiarity of the WHO's regulations -which clearly favours their universality and effectiveness- is that, after due notice has been given of their adoption, they come automatically into force and are obligatory for all Member States except for such Members as may notify the Director-General of rejection or reservation within the period stated in the notice (like a kind of "opting out" or "contracting out" clause).

Finally, the WHO has competences over the adoption of recommendations about all kinds of issues related to health, a competence which the World Health Assembly and the Executive Board employ extensively. Some of these recommendations are especially important and have a certain normative component, even if they are not binding. These include, for instance, the Pandemic Influenza Preparedness (PIP) Framework and the Global Code of Practice on the International Recruitment of Health Personnel. The lack of a mandatory character has strengthened, without a doubt, their general adoption, particularly in regards to health policy and the description, etiology and treatment of diseases. In general, these recommendations have turned out to be sufficiently effective, since the States have ended up recognizing the central authority of the WHO in health matters. As a result, they normally adjust their activities to comply with these recommendations.

IV. PRINCIPAL DIMENSIONS OF INTERNATIONAL ACTION REGARDING GLOBAL HEALTH ISSUES IN THE FIRST DECADE OF THE 21ST CENTURY

It is now time to tackle, again in a panoramic manner, the principal dimensions of international action in the area of global health in the first decades of the 20th century. I will briefly discuss five issues: health in the foreign policy of the States; international cooperation against epidemic outbreaks and public health emergencies

³¹ Available at: <<http://www.who.int/classifications/icd/en/>>.

of international concern; the social determinants of health and international action to promote development; global health, innovation and intellectual property; and, finally, international innovative financial mechanisms in the area of global health.

1. THE INFLUENCE OF HEALTH ISSUES ON THE POLICIES AND AGENDAS OF THE FOREIGN POLICY OF THE STATES

The starting point of the approach to health in all policies, including the foreign policy of the States is, naturally, the holistic and transversal character of global health. This obvious integration has become stronger and more intense in recent decades. For illustrative purposes, I will highlight certain elements that clearly express it in highly relevant international forums. Thus, for example, the WHO itself has proposed an evolution in its institutional goals; the notion maintained of “*Health for All*”³² has evolved to incorporate the idea of “*Health in All Policies*”, with the aim of integrating health into all public policies. Overall, the WHO seeks to confront health inequalities using a multifaceted approach.³³ This is actually a political concept that originated in certain Member States of the European Union -basically Finland- and which is also reflected in the current article 168 of the Treaty on the Functioning of the European Union (TFEU), which states that “A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”, thus integrating health in all Community policies -both at a conceptual and operative level- even though concrete competencies linked to public health in the EU are only at the level of support, coordination or supplementary competences.

Along these lines, an important initiative has recently been put into motion to incorporate global health in the foreign policy agenda, an initiative that began with the Oslo Ministerial Declaration of 2007 about “Global health - a pressing foreign policy issue of our time”.³⁴ In recent years, to the extent that the UN General

³² A central axis of the WHO’s policies since 1978 has been influenced by the adoption of the Alma-Ata Declaration and the “*Health for All by the Year 2000*” strategy.

³³ The definition suggested in the Declaration of Helsinki, and adopted at the 8th Global Conference on Health Promotion (Helsinki, 10-14 June 2013), states that “Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being”. The Declaration is available at <http://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf?ua=1>.

³⁴ The Oslo Ministerial Declaration reproduced in Document A/63/591.

Assembly has adopted this initiative, the Secretary General has published several reports and the General Assembly has adopted numerous resolutions regarding the topic of global health and foreign policy. These documents have highlighted, on the one hand, the existence of important foreign policy matters that influence global health, such as: security, arms control, armed conflicts and their aftermath, the economic and financial global crisis, natural disasters and emergency responses, climate change, food insecurity, the promotion of health as a human right, and migrations. Additionally, there are important issues of global health that should be confronted via the foreign policy of the States, such as: the place of health in national and global security, achieving the Millennium Development Goals related to health, securing access to and affordability of medicines, controlling new infectious diseases, particularly through the exchange of biological material with the potential pathogen, improving access to vaccines, medications and other benefits, promoting international support to strengthen healthcare systems, addressing the challenges faced by global governance in matters of global health, and, finally, integrating health into all policies and confronting non-transmissible diseases.³⁵

From this perspective, the UN General Assembly's Resolution 68/98 of 11 December 2013, on "Global health and foreign policy", reiterated the call to increase the attention paid to health issues "as an important cross-cutting policy issue on the international agenda, as it is a precondition for and an outcome and indicator of all three dimensions of sustainable development"; it also called for "enhanced partnerships by Member States and other relevant stakeholders, from the public and private sectors, including civil society and academia, to improve health for all, in particular by supporting the development of sustainable and comprehensive health systems, ensuring universal access to quality health services, fostering innovation to develop to meet current and future health needs and promoting health throughout the life course".³⁶

³⁵ See, among others sources, the extensive and complete Report by the General Secretary entitled "*Global health and foreign policy: strategic opportunities and challenges*" (Document A/64/365, from 23/09/2009).

³⁶ In this same resolution, the Secretary General was asked to produce "a report on partnerships for global health that assesses and addresses global health governance and the interlinkages between health and all determinants, including social, economic and environmental determinants, and presents recommendations for action to be taken by relevant stakeholders to achieve improved global health governance, taking into account, in particular, human rights, good governance, mutual respect, equity, sustainability, solidarity, shared responsibilities of international community and a people-centred approach".

2. INTERNATIONAL COOPERATION AGAINST EPIDEMIC OUTBREAKS AND PUBLIC HEALTH EMERGENCIES OF INTERNATIONAL CONCERN

The fight against infectious or contagious disease has been, as I have already indicated, a constant in international health cooperation. Recent decades, however, have seen the emergence of new, rapidly spreading infectious diseases, which in turn has required a qualitative leap in the demands for international cooperation. In these matters, the WHO acts as governing authority, employing the International Health Regulations (IHR), which I have already referred to as well, as the instrument for international cooperation. The first version of these regulations was adopted in 1951, and they were amended in 1969 and 1981. Despite these revisions, over time the IHR became an obsolete and ineffective norm, unable to impede the global spread of diseases, since it provided only for notification and action regarding certain specific diseases: until 1981 these included cholera, plague, yellow fever, typhus, smallpox and recurring fever; since then, only cholera, plague and yellow fever have been included. Furthermore, the IHR did not include adequate instruments for guaranteeing correct compliance with WHO decisions by its Member States. This situation, and especially the appearance of new illnesses like HIV/AIDS, avian influenza and SARS -which I have also mentioned already- created pressure in the 90's for a revision of the IHR. This revision was finally achieved in 2005, and the newly revised IHR came into force on 15 June 2007.³⁷

The purpose and scope of the revised IHR, as stated in its article 2, is “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”. Besides highlighting its similarities with previous goals and a clear prevalence of interests related to international commerce, the essential novelty of the new IHR resides in the fact that the obligation of notification is no longer limited to certain diseases, but extends to any “events that may constitute a public health emergency of international concern” (PHEIC). That is to say, it extends to any risk for the public health of other States through the global spread of a disease, where the latter is defined, in its broadest sense, as “an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans” (article 1). The IHR includes a mechanism for officially declaring the existence of a public

³⁷ Available at <<http://www.who.int/ihr/publications/9789241596664/en/>>.

health emergency of international concern, beginning with the notification of the affected State. The official state of emergency is to be determined by the Director-General of the WHO with the counsel of an emergency committee, and may imply the adoption of temporary or permanent recommendations.

In this way, the IHR establishes as primary obligations of the States: notifying of events that occur in their territory that may constitute a public health emergency of an international concern; having the capability to detect, evaluate, and notify of these events; having the necessary capabilities to rapidly and efficaciously respond to public health risks and emergencies of international concern. Due to the difficulties experienced by some States, the IHR provided for a period of five years after coming into force before it would demand these capabilities of all States. The WHO was also directed to provide assistance to Member States that need help with putting all of these capacities into place. There is clearly a commitment shared by all the Member States for the purpose of facilitating technical cooperation and logistical support in order to strengthen these capacities.

During the epidemic outbreak of Ebola in Western Africa in 2014, the emergency mechanism of the IHR was activated, though probably too late, if we consider the extent and magnitude of the outbreak. This outbreak initially occurred in December of 2013 and spread to Guinea, Liberia and Sierra Leone -with projected spread to other countries- over the course of eight months. It was not until the 8th of August 2014 that the Emergency Committee was convened by the Director-General, who declared that the conditions for a Public Health Emergency of International Concern (PHEIC) had been met. On this basis, the WHO coordinated the international adoption of means for confronting the epidemic and, as I have already noted, the United Nations as a whole also put into effect their emergency response mechanisms, including the creation of a United Nations Mission for Ebola Emergency Response (UNMEER).

3. SOCIAL DETERMINANTS OF HEALTH AND INTERNATIONAL ACTION TO PROMOTE DEVELOPMENT

Social determinants are all the dimensions, fundamentally economic and social, that affect the health of persons and peoples. In general terms, they are the circumstances in which people are born, grow, live, work and grow old, including the health system. It should be recognized that these circumstances depend, at a global,

national and local level, on the distribution of wealth and the policies adopted at each level. From this broad perspective, which is clearly subsumed by the international concept of health that I indicated at the beginning of this paper, there is no doubt that these social determinants of health are what best explains the largest part of health inequalities, i.e. of unjust and avoidable differences within and between the States in regards to their health situation. What is relevant for my argument is that in recent years an authentic new paradigm of international action has arisen, and there has been a shift from an approach that is more strictly medical (an emphasis on epidemiological factors and on public and community health) to one that is much more global, with an explicit acknowledgment of the multiplicity of international factors of a socioeconomic character that impact global health.

In the face of the growing concern provoked by these health inequalities, which are persistent and constantly growing, the WHO established in 2005 a Commission on Social Determinants of Health, which would offer advice on the ways to alleviate health inequality. The final report of the Commission, published on August 2008, is titled “Closing the gap in a generation. Health equity through action on the social determinants of health”.³⁸ In the Report, on the basis of the three principal axes suggested by the Commission’s analysis, three general recommendations were put forth: first, to improve daily living conditions with more healthy and just environments; secondly, to tackle the inequitable distribution of power, money, and resources; and finally, to measure and understand problems and assess the impact of actions. While the first recommendation suggests proactive action and the third one an analysis, the second recommendation clearly calls into question the profound inequalities of today’s world. This may be the reason why the World Health Assembly -after taking note of the Report, thanking the Commission for its labours and drawing the Member States’ attention to its content- limited its operative response to the future celebration of a worldwide meeting that the Member States would attend in order to “to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health”.³⁹

This meeting was the World Conference on Social Determinants on Health, held in Rio de Janeiro on 19-21 October 2011. One result of this Conference was the adoption of the Rio Political Declaration on Social Determinants of Health which,

³⁸ The Report is available at: <http://www.who.int/social_determinants/thecommission/finalreport/en/>.

³⁹ Resolution WHA62.14 of the World Health Assembly, 22 May 2009.

among other aspects, recognized that “health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an ‘all for equity’ and ‘health for all’ global action”. The Declaration speaks of the existence of five spheres of activity held to be critical for dealing with the problem of health inequalities. These are: (i) to adopt better governance for health and development; (ii) to promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability.

It also declares that governance for addressing social determinants necessarily implies transparent and inclusive decision-making processes. These are relevant considerations, but they are not far from being mere international rhetoric, since in the Declaration there is no questioning of the unequal distribution of wealth among the States and in their interior. But the fundamental problem is that despite affirming the necessity of and determination to act on the social determinants of health, no effective financial commitments were incorporated into the Declaration.⁴⁰

Linked to all of this, it should also be noted that the results achieved respect to the MDGs related to health and the MDGs in general -which I have already referred to- are very unequal, and vary according to the countries and regions in question, leaving important deficiencies to address. This situation, with the looming approach of the 2015 deadline set by the Millennium Declaration of the year 2000, brings with it the perspective of the current debates about the Post-2015 Development Agenda, which, in regards to health, seem to be oriented -at least from the point of view of the WHO- towards attaining universal health coverage.⁴¹

4. GLOBAL HEALTH, INNOVATION AND INTELLECTUAL PROPERTY

Another relevant factor in recent international action in relation to global health issues is closely linked with innovation and intellectual property: pharmaceutical patents, on the one hand and, on the other, access to essential medicines. Regarding the first issue, it should be noted that legal protection via patents on innovations

⁴⁰ See the Rio Political Declaration on Social Determinants of Health, Rio de Janeiro, 21 October 2011, available at: <http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1>.

⁴¹ See, along these lines, *Health in the Post-2015 Development Agenda*, Report of the Global Thematic Consultation on Health, 2013, available at <<http://www.worldwewant2015.org/file/311537/download/338636>>.

of all kinds -with a highly unequal distribution in the different States- was one of the axes that gave focus to the negotiations at the Uruguay Round of the General Agreement on Tariffs and Trade (GATT), which culminated in 1995 with the creation of the World Trade Organization (WTO). One of the Agreements adopted in that Round -and administrated by the WTO- is the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement).

This Agreement, recognizing that in developed countries there already exist guarantees and legal protections that are not present in developing countries, and also recognizing the growth of industrial and technological piracy, imposed upon all Member States of the WTO the obligation to protect via patent “any inventions, whether products or processes, in all fields of technology, provided that they are new, involve an inventive step and are capable of industrial application” (article 27 of the TRIPS Agreement).⁴² The rights implied by the patent can be enjoyed without prejudice resulting from the location where the product was invented, the field of technology in question, or whether the products are imported or produced in the country in question. Furthermore, these rights apply to all kinds of products and procedures, including -and this is what is of interest here- products and procedures for the treatment of diseases, fundamentally pharmaceutical products.

The TRIPS Agreement allows for certain flexibility, such as the concession of compulsory licenses.⁴³ However, the truth is that, in connection with the protection of public health, the legal protection of pharmaceutical patents has been reinforced in all States. This, together with its possible effects on the price of and access to medications, promptly caused a sharp controversy between developed countries (which have the headquarters of the principal multinational pharmaceutical companies) and developing countries (the most affected, as I have mentioned, by infectious epidemic outbreaks, by neglected tropical diseases and by a growing prevalence of non-declarable diseases), and also the legal actions of

⁴² See, for a general overview and among the Spanish internationalist legal doctrine, M. MARTÍNEZ BARRABÉS, *La patente biotecnológica y la OMC*, ed. Marcial Pons, Madrid, 2014.

⁴³ They consist in the authorization by a government or a legal institution permitting a third party to use an invention even while it is protected by a right to intellectual property, and even without the approval of the rights holder. As a result, this right is transformed from exploitation of the product into royalties fees. Regarding these aspects see, for Spanish doctrine -and highlighting the connection between global health and the legal protection of pharmaceutical patents- SEUBA HERNÁNDEZ, X., *La protección de la salud ante la regulación internacional de los productos farmacéuticos*, ed. Marcial Pons, Madrid, 2010, as well as FERNÁNDEZ PONS, X., “Las patentes farmacéuticas en el régimen del Acuerdo sobre los Aspectos de los Derechos de Propiedad Intelectual relacionados con el Comercio”, in PONS RAFOLS, X. (ed.), *Salud pública mundial y Derecho internacional*, *op. cit.*, pp. 243-287.

the pharmaceutical companies in domestic courts. A relevant milestone of this controversial situation was the “Ministerial Declaration on the TRIPS Agreement and Public Health”, adopted at the meeting of the Ministerial Conference of the WTO celebrated at Doha on 14 November 2001.⁴⁴

The Declaration, along with other later developments at the WTO, seeks to strengthen both compulsory licensing and the mechanism of parallel imports, with the aim of achieving that fragile and unstable balance between the protection of intellectual property and public health. In this vein, in May 2008 the World Health Assembly approved a “Global strategy and plan of action on public health, innovation and intellectual property” to give support to those countries that wish to make use of the dispositions of the TRIPS Agreement in the most flexible manner possible. This plan of action seeks to harmonize the potential market of pharmaceutical products with the health needs of peoples living in poverty, while at the same time preserving the incentives for the research and development of new medications.⁴⁵

From another point of view, one of the noteworthy initiatives of the WHO in regard to access to medicines has been the promotion of the concept of essential medicines and its associated policies. The WHO defines essential medicines as those that are considered basic, indispensable and necessary for satisfying the high-priority health needs of the population. Since 1975 the WHO has promoted a policy whereby the States are responsible for the selection and supplying of essential medications at a reasonable cost, and in 1977 the Organization developed the first “WHO Model List of Essential Medicines”. The WHO also promotes the rational use of drugs and, as part of its mission, fosters the development of national pharmaceutical policies. In spite of all this, the reality of the situation is that of a deep lack of equity in the access to medicines, which without a doubt constitutes an additional dimension of health-related inequities and, therefore, an attack on the human right to health, which includes access to medicines as a fundamental part.⁴⁶

⁴⁴ Available at <http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm>.

⁴⁵ See regarding all this VELÁSQUEZ, G., “El derecho a la salud y a los medicamentos: crónica de una negociación sin rumbo claro”, in PONS RAFOLS, X. (ed.), *Salud pública mundial y Derecho internacional*, *op. cit.*, pp. 289-309.

⁴⁶ See for example SEUBA, X., “A human rights approach to the WHO Model List of Essential Medicines”, *Bulletin of World Health Organization*, May 2006, 84 (5), pp. 405-407.

5. INTERNATIONAL INNOVATIVE FINANCIAL MECHANISMS IN THE FIELD OF GLOBAL HEALTH

The last dimension that I would like to stress -and which closely relates to those discussed above- is that which regards international financing for development, particularly the necessary international funding to confront global health problems, even if it is only to the same extent that underdevelopment is the greatest social determinant of health from the international perspective. From this perspective, recent trends in international financing for development revolve around The International Conference on Financing for Development, held in Monterrey in 2002, which produced the so-called “Monterrey Consensus”.⁴⁷ The Consensus is oriented along three axes: the priority of mobilizing internal resources as the basis for development, the necessity of diversifying the sources of development funding, and finally, the necessity of coordination and greater cooperation among international Organizations. In the current climate of global financial and economic crises, this approach has experienced a strong drop in its effectiveness, with important restrictions and setbacks. This has prompted a necessary search for additional, innovative sources of income, because the funds provided by donors are not longer predictable nor sufficient. Novel ways to bring in financial resources have therefore been suggested; for example, there is the Tobin tax, the carbon tax and the air transport levy, to name a few.

In general, the fundamental features of these innovative income sources are, on the one hand, a greater predictability and sustainability of resources in the long term, and, on the other hand, a market focus that implies the introduction of market incentives for research and for the production of certain drugs, vaccines and other pharmaceutical treatments. In this way, these innovative sources have acquired a particular relevance in the domain of global health and have entailed its articulation via the establishment of diverse trust funds specialized in particular topic areas. Indeed, one of the principal landmarks in the domain of global health funding is the prominent presence of certain hybrid networks that bring together agents from the public and private spheres; these are referred to as public-private

⁴⁷ See the Monterrey International Conference Report, Document A/CONF.198/11, also available at <<http://www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf>>. In regards to this new international consensus around the strategy for cooperation with development, see, among others, the reflections of ABELLÁN HONRUBIA, V., “Mundialización de la economía y estrategia internacional de cooperación al desarrollo”, *Cursos Euromediterráneos Bancaja de Derecho Internacional*, Vol. 6 (2002), especially pp. 419 ff.

partnerships.⁴⁸ These are hybrid international networks whose purpose is providing funding in the area of health. To a large extent, they are shaping up to be structures that provide a genuine alternative to classic international actions that are financed through international Organizations which, in practice, end up being weakened by this process.

Participants in these public-private partnerships include international Organizations and States together with private agents, including NGOs and the private corporate sector, which includes private agents both with and without an interest in profit. The variable and changing character of these partnerships leads to their legal nature and structure being different in each case. The results depend on willingness and the relation that exists between the different agents that comprise the partnership, together with the financial contributions that they make⁴⁹ Thus, there are partnerships with a greater public participation and control in their organs of government, and partnerships where there is greater participation and control by the private sector, whether the private partners have a for-profit status or else have a non-profit status. As a result, the decision-making process can be conditioned at its origin due to the greater influence of certain partners. In some cases, further, there is a minimal participation of the States or the communities benefited by the actions of the public-private partnership. In the case of partnerships in the area of health, some may not even involve the presence of the WHO in the corresponding governing body.

Along this same line, one of the most delicate aspects of the functioning of these public-private partnerships concerns the risks and ethical contradictions that may arise in those partnerships that have a strong presence of the private sector -that is to say, the pharmaceutical industry- and which predominantly dedicate themselves to correcting market deficiencies. This they do by introducing commercial incentives for the research and development of new products or treatments, such as vaccines. The conflict of interests that can arise grows even more serious due to the fact that certain organizations in the private sector do not so much seek to promote worthy causes, but instead simply seek financial advantage over the long term. Others wish to obtain tax breaks, while yet others seek to improve their company's public image.

⁴⁸ See NISHTAR, S., "Public-private 'partnership' in health - a global call of action", *Health Research Policy and Systems*, 2004, 2:5, p. 1.

⁴⁹ See BUSE, K., WALT, F., "Global public-private partnerships: part II- what are the health issues of global governance", *Bulletin of the World Health Organization*, Vol. 78.5 (2000) pp. 700.

I believe, however, that the risks should be balanced with the advantages brought by these mechanisms.⁵⁰

Thus UNITAID, for example, is a fund for the acquisition of medicines whose fundamental purpose is to reduce the cost of treatment of certain diseases such as HIV/AIDS, malaria, and tuberculosis, by way of influencing the market (both supply and demand). With the contributions of donors -principally States, but also other private and non-governmental sectors- capital is amassed in order to achieve an increased negotiation power, and in turn to obtain significant reductions in the price of certain medicines. These medications are then bought jointly and sent to the countries that need them. By guaranteeing sustainable and predictable income through the acquisition of particular medicines, UNITAID also serves the purpose of creating incentives to correct market defects, inducing manufacturers -pharmaceutical companies- to invest in research activities and the development of medicines that otherwise, due to their unprofitability, the pharmaceutical companies would not produce.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was established in 2002 thanks to the impulse given by the United Nations; it might appear to be an international Organization, but legally speaking it is a non-profit foundation that exists under the jurisdiction of Swiss law. Its objectives are “to attract, manage and disburse resources that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals established by the United Nations”.⁵¹ Representatives from developing States, donor or develop States, together with representatives of civil society and private sectors participate in the Global Fund Board. In addition, representatives of the WHO, the joint program of the UN on HIV/AIDS (UNAIDS), and the fund’s trustee -the World Bank- participate but lack voting rights.

⁵⁰ See, for a general perspective, PONS RAFOLS, X., “Mecanismos financieros internacionales de lucha contra las grandes pandemias: especial referencia al Fondo Mundial contra el Sida, la Tuberculosis y la Malaria”, in PONS RAFOLS, X. (ed.), *Salud pública mundial y Derecho internacional*, *op. cit.*, pp. 339-374.

⁵¹ Article 2 of The Global Fund to Fight AIDS, Tuberculosis and Malaria By-laws, as amended on 21 November 2011, available on <http://www.theglobalfund.org/documents/core/bylaws/Core_GlobalFund_Bylaws_en>.

V. FINAL CONSIDERATIONS

As a summary of what has been discussed in these pages, I believe the first issue to highlight is the undoubtedly holistic, transversal, and international nature of the notion of global health, which leads to its characterization as a global public good that must be internationally protected. On the basis of this premise, the necessities and the reach of cooperation and the legal regulation of global health have been discussed, in particular, the international governance of global health in a world like our own, characterized by constant interaction between all the participating actors. In any case, what is also evident are the difficulties for and the imperious necessity of better international cooperation in the governance of global health, in order to attend to the social determinants of health, i.e. all the socioeconomic factors that affect the health of persons and peoples.

This perspective brings up the issue of the multiplication of international institutions and of various actors involved in the governance of global health, whether they are States, international Organizations, NGOs, the private sector or other mixed mechanisms, including public-private partnerships. Within this complex web of institutions, the WHO undeniably stands out as the guiding axis, due to its specialized and technical character; it should be properly recognized and its character as an international authority in health matters should be strengthened. In particular, it should be strengthened in relation to public health events of international concern, in relation to the social determinants of health, in relation to access to essential medicines and in relation to the financing of the fight against the great pandemics. In general terms, multilateral international cooperation focuses on the United Nations, which is founded, in turn, on three essential pillars which are also closely related to global health: peace and security, development, and human rights. These three pillars -the basis for “collective security and well-being”- are very much pertinent in this context, inasmuch as the major problems of global health entail serious threats against the security of the entire world, are important obstacles to development, and affect essential human rights such as that of the right to health.

The third concluding idea that I would like to emphasize has to do with the repeated verification of the profound health inequities that characterize the modern world, both between countries and within their borders. The conceptual connection between the social determinants of health and certain fundamental principles and

normative contents of contemporary International Law may be an incentive to the international community to address these issues and, therefore, to advance towards an improvement in the health of individuals and nations. Nevertheless, profound contradictions exist between States, as a function of their level of socio-economic development and their sovereign interests. Among other aspects, these contradictions are expressed via the presence of competing interests relating to the protection of intellectual property or relating to the financing of development and innovative mechanisms for the financing of international action in matters of global health.

Finally, I believe -without any doubt whatsoever- that greater international attention should be paid -together with better international financing- to global health and to all the other economic-social sectors that are connected with health. All persons and all peoples must be enabled to attain the highest possible level of health, i.e. the state of complete physical, mental and social well-being that the Constitution of the WHO referred to nearly seven decades ago.

Barcelona, December 2014

PAIX ET SÉCURITÉ INTERNATIONALES

03

2015

REVUE MAROCO-ESPAGNOLE DE DROIT INTERNATIONAL ET RELATIONS INTERNATIONALES
NOUVELLE SÉRIE - VERSION ÉLECTRONIQUE

SOMMAIRE / Janvier -Décembre 2015 / N° 3

ÉTUDES

Andrea DE GUTTRY

Developing Effective Partnerships in Peacekeeping Operations between the UN and Regional Organizations. A Recent Report of the UN Secretary General on the transition in Mali and in the Central African Republic

Xabier PONS RAFOLS

International Law and Global Health: An Overview

Boutaina ISMAILI IDRISSE

Moroccan-Brazilian Bilateral Cooperation: Achievements and Prospects

Inmaculada MARRERO ROCHA

Foreign Fighters and Jihadists: Challenges for International and European Security

Pierre Afouda ADIMI

Nouvelle offensive diplomatique du Maroc en Afrique subsaharienne : quel regard?

Alonso IGLESIAS VELASCO

La souhaitable inclusion des opérations de paix dans la Charte des Nations Unies

Jacqueline HELLMAN – Raquel REGUEIRO

Targeted Killings of Suspected Terrorist in the Light of the Right of Self-Defence

NOTES

Carlos ECHEVERRÍA JESÚS

Risk and Threats in the Western Sahel. Radicalization and Terrorism in the Sub-Region

Sarra SEFRIQUI

L'extension du plateau continental au delà de 200 milles : Un point de vue juridique

Ana SÁNCHEZ COBALEDA

The Chemical, Biological, Radiological and Nuclear (CBRN) Risk Mitigation Centres of Excellence of the European Union: The Case of Morocco

DOCUMENTATION

Reunión de Alto Nivel España – Marruecos, Madrid, 5 de julio de 2015

Juan Domingo TORREJÓN RODRÍGUEZ

La XI Reunión de Alto Nivel hispano-marroquí. Análisis y reflexiones sobre su contexto y sobre las materias discutidas en el ámbito del diálogo político

Siham ZEBDA

XI Reunión de Alto Nivel hispano-marroquí, Madrid, julio de 2015: reflexiones sobre la cooperación en economía, seguridad y cultura