Global health governance as shared health governance

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Introduction

Global health is experiencing a record influx of public and private actors with unprecedented levels of funding directed to global health activities. Despite the popular attention, in scholarly debates, the multiple academic disciplines that inform global health governance, have yet to provide an adequate theory that moves beyond national and self-interest of sovereign states and international human rights law. Moreover, a theoretically grounded normative approach to global health governance has failed to emerge from the interdisciplinary intersection of medical ethics, international relations, international human rights law, health policy and law and public health law. This paper aims to provide the beginnings of a theory of global health governance that, unlike international relations and international law, uniquely situates the problem of global health governance as one of a failure, in terms of the roles and responsibilities of both domestic and global actors, to fully agree on, commit to and implement policies to effectuate the public moral norm of equity in health. This approach takes health and disease control out of the realm of: national or security interests of powerful countries like the United States; the self-interests of wealthy non-governmental organizations and foundations and; international legal instruments. Rather this approach grounds global health governance in principles of global health justice. These values identify overarching goals, principles and duties and obligations of national and state actors. This approach develops an ethical paradigm that emphasizes a particular type of norm – a public moral norm – to form the basis of self and societal regulation to achieve equity in health. By emphasizing these factors, this approach offers findings distinct from those provided by existing theories of international relations and international law, and the paper concludes with prescriptions for future reform of the global health governance architecture.

Alternative Governance Frameworks

Global health governance is a relatively newly emerging field. Construed broadly, it encompasses work in multiple disciplines including economics, political science and sociology; environmental and gender studies; history; international relations and international law; and medicine and public health. More “narrowly,” the field is comprised of three dominant frameworks that have emerged primarily for global
health cooperation: national and security interests; domestic and global economic
development; and international human rights.² Horizontal participation and vertical
representation are cross-cutting dimensions to these frameworks.³ Just a few years ago,
for example, the World Health Organization (WHO) Commission on Macroeconomics
and Health advocated international cooperation on health due primarily to the national
and global economic impact of such investments; demonstrating the powerful influence
of economic approaches to global health governance.⁴

Decades earlier, powerful sovereign states, primarily in Europe, saw investments
in controlling the spread of cholera and yellow fever as essential foreign policy to
thwart off external threats to the health of their populations. A 2007 issue of the
Bulletin of the World Health Organization highlighted the unprecedented focus on
health as a foreign policy issue and the rise in nations’ pursuit of health as a foreign
policy concern linked to security, power, economic prosperity and influence and a move
beyond health as a humanitarian issue.⁵ This framework has enveloped the argument
for framing health threats as security challenges, especially in the area of biological
terrorism, HIV/AIDS and pandemic influenza where world superpowers have driven the
global security agenda by concerns about threats to their nations’ interests. Moreover,
many international legal instruments such as international treaties (agreements among
states), customary international law (unwritten rules established over time through
practice), and general principles of law (domestic law principles adopted in
international law) have been established under a framework of international cooperation
for protecting state interests. For example, the purpose of the newly revised
International Health Regulations (IHR) 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 restrict to public health risks, and which avoid unnecessary
interference with international traffic and trade.⁶ The new IHR are closely connected
to international trade law and based on the premise that fully functioning global
markets (that are not hindered by health threats) are essential for the free flow of
international economic activity. The focus on addressing health measures that might
restrict global trade in goods and services brings together both the economic and
national interest motivations for international health cooperation.
The third framework, human rights, has increasingly been invoked as the only viable framework for evaluating global health atrocities such as the HIV/AIDS pandemic in Sub-Saharan Africa, the break-out of SARS in China, and the public health impact of the South Asian Tsunami disaster. Human rights have as such filled a “moral gap” in the international discourse in global health left void primarily by economic and geo-political governance frameworks for international health issues. In 2002, for example, international human rights law, as embodied in the South African constitution, was brought to bear on a case in which the Treatment Action Campaign of South Africa brought suit against the South African government alleging that limitations on the availability in public hospitals of Nevirapine violated HIV-positive pregnant women and their children’s right to health as stipulated under the South African constitution. The trial court in this case ruled in favor of the Treatment Action Campaign stating that restricting Nevirapine in public hospitals “is not reasonable and is an unjustifiable barrier to the progressive realization of the right to health care.” A year later, the Constitutional Court of South Africa (South Africa’s highest court) upheld the lower court’s decision.

Despite its recent resurgence in particular contexts (with respect especially to HIV/AIDS) and numerous successes, the human rights movement – as embodied in the 1948 adoption of the Universal Declaration of Human Rights (UDHR), and the subsequent adoptions of the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and taken forward thereafter in legal academia especially by Ronald Dworkin, Lawrence Tribe, Louis Henkin and later by Abram and Antonia Chayes, Harold Koh, and others -- has also been viewed with considerable skepticism and doubts. And concern about compliance with international human rights law has now become an issue as has the topic of the effectiveness of legal human rights instruments in influencing the behavior of state and non-state actors more broadly.

One would be hard pressed to find a more controversial or nebulous human right than the “right to health” – a right that stems primarily, although not exclusively, from Article 12 of the ICESCR and requires governments to recognize “the right of everyone to the highest attainable standard of physical and mental health.” As noted above, the
“right to health” has been brought to bear in domestic case law, but it has also been invoked much more widely in a rhetorical sense – especially by non-governmental organizations and activists in efforts especially to raise awareness and mobilize support for addressing disease and morbidity world-wide. And thanks to the work of the late Jonathan Mann and colleagues\textsuperscript{19}, the field of health and human rights is now widely accepted as a domain that brings together academicians and practitioners to incorporate a human rights perspective to specific diseases and to health more broadly.\textsuperscript{20} Yet despite the significant progress made in promoting a human rights approach to health and the field of health and human rights more generally, the human rights strategy has been only moderately effective, for example in efforts to control and mitigate the HIV/AIDS epidemic.\textsuperscript{21} International human rights law scholars doing work in public health and health policy have typically focused on government’s binding legal obligations to promote and protect both public health and human rights\textsuperscript{22} and on drawing on human rights to address public health issues, especially the HIV/AIDS pandemic.\textsuperscript{23} Yet scholars in this field have, in the words of Larry Gostin, “developed a sophisticated understanding of civil and political rights but have failed systematically to examine the meaning and enforcement of social and economic rights.”\textsuperscript{24} And while General Comment No. 14, issued by the UN Committee on Economic, Social, and Cultural Rights (CESCR), provides the most reliable report on the “right to health,” it too, by necessity and purpose, lacks a systematic theoretical approach to global health governance.

Values and Norms in Global Health Governance

The theoretical approach taken here states that values and norms, particularly their level of generality, and the social agreement or lack thereof around them, have an independent role in understanding global health governance. This approach does not attempt to arrive at a single unified framework for explaining global health governance, and it recognizes the complementary roles of political science, economic and legal perspectives. Nonetheless, it argues that unarticulated values and norms have a critical role to play in global health governance; this role has been inadequately studied and has lacked a theoretical framework.\textsuperscript{25}
Within this theoretical framework, this paper argues that policy goals, which require individuals to make financing commitments (e.g., tax contributions) in the form of redistributing resources for implementation (e.g., health systems development), should be analyzed within a normative framework that evaluates actors ethical commitments to making such sacrifices and effectuating policies and programs that are beyond their self-interest. The distribution of public moral norms, their degree of internalization, and the social consensus, or lack thereof, which applies to them must be objects of study in the effort to better understand global health governance.

Surprisingly, few systematic efforts have been made to deal with the underlying normative frameworks of global health injustices. Some views from the field of global justice more broadly provide background, however. One view, the Hobbesian tradition, states that collective security and national-interest are the primary aim of justice. From this perspective, global health inequalities provide no moral motive for remedy. This view is consistent with the overarching framework of national and security interests in global health governance noted above. A second view stems from John Rawls’s theory and coincides with Thomas Nagel’s account; both apply a relational perspective and ground the obligation of justice in the sovereign nation state; global health inequalities have no moral standing; justice, an associative obligation, is owed only our sovereign citizens. Both Hobbes and Rawls would require global sovereignty or world government to justify duties and responsibilities of global actors to address global health inequalities.

A final view, cosmopolitanism, argues principles of justice apply to all individuals wherever they are in the cosmos; and varies from strong demands for fair terms of cooperation on a global scale to at a minimum adherence to the no harm principle, that international institutions and agreements be prohibited from causing harm, particularly extreme poverty, to others. Rectifying such harm justifies international action. Despite this broader background, however, ethicists have provided very little on the philosophical foundations of global health, its distribution and global health justice.

I’ve argued elsewhere that global health disparities are morally problematic and that efforts to reduce them are morally justified. The moral concern in global health
inequalities is individuals’ reduced capability for physical and mental functioning or even for being alive. Deprivations in the capability to function rob individuals of the freedom to be what they want to be. This underlying principle of justice applies to all humans regardless of where they live and regardless of any given person’s or people’s specific relationship to them. It takes individuals as the central moral unit of justice. This approach does not seek to find ways in which global and national actors deal with global justice by virtue of their effect on self-interest, national interest, adherence to a global social contract, collective security, requirement of cosmopolitan duty or humanitarian assistance; all insufficient foundations of global health justice. Rather, it endorses the more robust concept of human flourishing and the desire to live in a world where all people have the capability to be healthy.

This perspective differs from other schools of thought. The contractarian or utilitarian views see contracts to achieve mutual advantage—or states of affairs that maximise societal welfare (the aggregation of individual welfare)—as solutions to problems of global justice. The approach espoused here differs from general cosmopolitan theory by rejecting the attenuation of attachments of duties and obligations to the nation-state, fellow citizens and local communities. From this perspective, the primary, though not sole, duties fall on nation-states. Global health inequalities are morally troubling because our intuition and ethical claim of equal respect for all humans tells us that being born into a country or society in which one has a good chance of being in the worse-off health group is morally arbitrary and requires rectification. Moral arbitrariness should not be the basis for determining one’s health; or survival. This approach differs from positivist theories of international relations (e.g. realism, neo-realism and neo-liberalism or neo-classical economics) and adopts an optimistic or idealistic view of a future world order in which the ideals of domestic and international cooperation to reduce health disparities prevail.

**Rational Actor Model of Global Health Governance**

The current global health architecture does not represent this ideal. A major problem with the current system, I argue, is that it can be characterized as operating under the assumptions of a rational actor model of international cooperation. The current global health environment is comprised of a collection of individual actors who...
are rational decision makers. This assortment includes individuals (e.g. a minister of health), groups (e.g. non-governmental organizations like Medicins Sans Frontieres, Oxfam, Self-Employed Women’s Association and foundations such as the Gates, Ford and Rockefeller Foundations), institutions (e.g. the World Bank, UNICEF, WHO, UNAIDS), public-private partnerships (e.g. IAVI and GAVI), and nation-states (and the public institutions within them such as the legislative body, the executive, the bureaucracy, ministries or departments of state, sub-national bodies and local authorities). This architecture can be adequately described by the rational actor model, because each actor has its own set of goals and objectives and these actors each take account of their own goals and take actions based on analysis of the costs and benefits associated with various options available to them. Moreover, even within many multilateral institutions, the most powerful actors within the institution (especially multilaterals without a democratic governance structure), dominate and effectively control policy and resource allocation decisions in terms of their goals and objectives. And even many NGOs, which have a distinctly populist fervor, represent themselves and their own interests, not their so-called constituencies, in national-level mechanisms such as the Country Coordinating Mechanism established by the Global Fund.

The current landscape in global health represents a record number of global health actors and financial commitments, both public and private, and is no longer the domain of the UN system and the World Bank. In 2000 alone, over 17 new public-private partnerships were launched. In addition to the WHO, World Bank, and the European Union, some of the largest players are relatively new and include the Gates Foundation, the United States President’s Emergency Plan for AIDS relief (PEPFAR) and USAID, The Global Fund to Fight AIDS, Tuberculosis, and Malaria (financed by donations from governments, philanthropists, corporations, etc.), and corporate actors (e.g. pharmaceutical companies.) The Global Fund, for example, now provides roughly 20% of all global funding of HIV/AIDS programs and 65% of funding for TB and malaria. The Global Fund is the quintessential contemporary global health initiative, focused on selective aid for narrow programs of disease control in particular countries and a trajectory of monitoring and evaluation of process and intermediate indicators at the expense of developing broader health systems. Health systems, while not as high
profile as specific diseases like AIDS, are an essential building block for sustainable health long term.

A recent study of international cooperation in health identified several key factors that characterize donor support for recipient countries. These factors include a rather narrowly defined set of criteria for success (e.g. performance results based on organization criteria rather than health outcomes), overlapping mandates, competition and duplication of health activities, shifting power structures, and poor coordination. As a result, most technical assistance, grants and loans actors provide to developing countries comply with donors’, rather than countries’, organizational priorities, policies and values. This phenomenon is known as donor-driven development. And because these efforts are evaluated by organizational criteria (e.g., number of loans dispersed, amount of funding provided), they are not subject to critical scrutiny in terms of their ultimate impact on health and disease control. In 2006, for instance, the World Bank estimated that half of aid for health in sub-Saharan Africa fails to reach intended recipients (clinics and hospitals.) Another study of children’s vaccines and immunization programs found that countries were delayed in the uptake and financing of new vaccines due to confusing priorities and policies at the global and country level. This confusion and paralysis was created by overlapping interests of numerous organizations such as the WHO, partners of the Task Force on Child Survival, GAVI, the Children’s Vaccine Program of the Melinda and Bill Gates Foundation.

Conflicts among actors create competition and duplication of health activities that stress developing country governments to manage each donor’s project in terms of organizational accounting and reporting requirements. These goals often conflict with what might be best for a recipient country at any given time. The World Bank and wealthy industrialized countries have been the focus of criticism for competitive behavior with other international institutions and countries and with different groups within developing country governments. The World Bank and the Japanese government, for example, have been critiqued for undermining the long term sustainability of Ministry of Health efforts, for example, in tuberculosis control in Nepal where the Japanese governments’ donation of the TB drug rifampicin distorted the sourcing, prescribing practices and long term sustainability of the Nepalese governments’
tuberculosis control program. In Tanzania and in Kenya donors undermined the
governments’ essential drug distribution system in one case and its production of
pharmaceuticals for treatment of sexually transmitted diseases in the other by creating
their own in facilities and systems parallel to the Ministry of Health. Most donor
funding is disease and program-specific, determined by donor preferences and
priorities, not health needs, and fails to address weak institutional capacity in country.

As a result of competition, duplication and poor coordination among actors, the
burden and mayhem at the country level is evident in numerous recipient countries. In
2003, the OECD commissioned a study of the effects of donor practices in 11 recipient
countries. In that study, five of the highest burdens for recipient countries included:
difficulties with donor procedures, donor-driven priorities and systems, uncoordinated
donor practices, excessive demands on time, and delays in disbursements. In another
study of donor practices in Mozambique, Tanzania, Uganda, and Zambia, all countries
that had successfully received Global Fund resources, researchers found in all four
countries difficulties at the country level in incorporation of additional global fund
resources above and beyond existing funding and partnerships and concluded these
countries were bombarded and overwhelmed by the need to juggle activities among
multiple donors. In Uganda alone, 20 different global health initiatives were in play.

Common Goals and Common Commitments

While the rational actor model is predominant in global health governance, a few
examples of successful collective action stand out as model partnerships for global
health cooperation. Successful coordination among agencies can be found, for example,
in the Onchocerciasis Control Program, the Task Force on Child Survival, and the
Global Polio Eradication Initiative. All of these examples of global health cooperation
exhibit four general characteristics: partnerships defined by a shared common goal;
clear objectives and agreed upon respective roles and responsibilities; delineation of
complementary expertise and accountability in the means to achieve goals; and donors’
willfulness to step back and allow other agencies to take the lead in goal achievement.

A necessary ingredient to successful collective action on global health is shared
common goals. In order to achieve consensus, global health governance must move
beyond the rational actor model to a normative model of social agreement theory, in
which actors achieve consensus on shared values to achieve stability and social unity. I draw on John Rawls’ notion of an “overlapping consensus” to clarify this dynamic. The overlapping consensus framework emphasizes the need to determine shared values -- even values that are shared for different reasons -- and emphasizes the necessity to achieve social agreement for collective decision making. Social agreement theory can help us understand how public values are effectively internalized by citizens and their representatives and connected through stable coalitions.

John Rawls draws a sharp distinction between political bargaining models, which I associate with a rational actor model, and conceptual models rooted in political philosophy and legal doctrine. He suggests that political process models based on political bargaining are akin to a *modus vivendi* -- a “social consensus founded on self- or group interests, or on the outcome of political bargaining: social unity is only apparent…” 46 A *modus vivendi* is thus a consensus on “accepting certain authorities, or on complying with certain institutional arrangements, founded on a convergence of self- or group interests” 47 For example acceptance of an international agreement among the G-8 nations as a result of trading favors would be unstable because the bargain would be “contingent on circumstances remaining such as not to upset the fortunate convergence of interests”. 48 Thus, if the power relations shift or if the position of certain countries changed, and powerful countries were no longer in a position to strike the bargain and hold their countries to it, the international agreement would no longer be followed. Agreements based on *modus vivendi* are also less stable than agreements based on a true overlapping consensus because the former depend more on “happenstance and a balance of relative forces”. 49 An international consensus on paper, such as the Millennium Development Goals, for instance, does not necessarily signify a true consensus and guarantee achievement of those goals. For example, successful implementation of polio and smallpox eradication requires each country to continue to immunize their children, even if that country has been free of the disease for sometime. It is especially important for neighboring countries to collaborate in eradication programs to reduce the chance of transmission across borders. Each country has to agree to and commit to achieving this underlying goal.
There are additional reasons for a distinction between social agreements based on an overlapping consensus and those that result from political bargaining. First, as Rawls notes, the object of an overlapping consensus is itself a moral conception, such that it is valued in itself. Second, the overlapping consensus is affirmed on moral grounds and includes “conceptions of society and of citizens as persons, as well as principles of justice, and an account of the political virtues through which those principles are embodied in human character and expressed in public life”. In other words, it represents a consensus among elites, and in this case, citizens as well, on the public good, which may rise above the intersection among group- or self-interests. Third, the overlapping consensus is more stable because it is not simply a balance of power, but is instead a reasonable consensus. A modus vivendi, by contrast, reflects a temporary agreement among different and opposing peoples and parties. Thus, the overlapping consensus framework increases stability because those who affirm a decision “will not withdraw their support of it should the relative strength of their view in society increase and eventually become dominant”. Fourth, a social agreement framework attempts to draw out “certain fundamental ideas viewed as latent in the public political culture of a democratic society”. As such, it attempts to tap into individuals’ true values, even if individuals and their representatives have difficulty articulating those values in a completely theorized way. Fifth, this type of framework contrasts legitimate political authority with political power. For example, it differentiates “an account of the legitimacy of political authority” from “an account of how those who hold political power can satisfy themselves, and not citizens generally…” Stability is not promoted, by “bringing others who reject a conception to share it, or to act in accordance with it, by workable sanctions…”. Instead, it is promoted by a reasonable consensus on a political conception that is politically legitimate. Political legitimacy, in turn, involves a “public basis of justification and appeals to public reason, and hence to free and equal citizens viewed as reasonable and rational”.

From this social agreement perspective, legitimate political authority is not just a matter of political philosophy; it has pragmatic advantages in forging consensus and coalitions in global health cooperation. In this way, a social agreement framework
helps illuminate the rational actor model because it throws light on how political actors can undermine the conditions for reasoned agreement on common interests. It calls for research to examine whether the conditions of international diplomacy help produce an informed, reasoning, and deliberative decision making and implementation process.

At the national level, a social agreement model of policy-decision making emphasizes public deliberation, responsible leadership, and mass communication and relies on popular sovereignty and political leadership to enhance deliberative public debate and public reasoning in order to agree on the common good. In many developing countries common ground for reaching agreement on the ethical principles that govern health and health care has yet to be achieved, yet it must be realized to establish accord on policy and implementation to achieve equity in health.

**Governance to Achieve Equity in Health**

Reducing global health disparities requires social organisation and collective action of four key functions: redistribution of resources; related legislation and policy; public regulation and oversight; and creation of public goods. Redistribution of resources is conducted between groups within and between societies. Policy measures are required to make transfers and include progressive taxation, equitable and efficient risk pooling, redistributive expenditure patterns, subsidies and cash transfers. In many countries, especially those in the developing world, the distribution of resources within society is inequitable. In such areas of social organisation and collective activity, ethical commitments are required.

Ethical commitments are required because without such norms, it is not possible to socially organize and redistribute resources; the efforts to do so must be *voluntary* and not coerced, and they must be based on moral grounds. This is because individuals must sacrifice some of their resources and autonomy to be regulated and redistribute those resources to others. Once individuals internalise these ethical commitments, they freely enter into them and create obligations for individuals to obey them. Individuals also need to internalise public moral norms that motivate their social action towards other regarding or altruistic behaviour. Individuals who are willing to give up some of their autonomy and resources through collective action can take steps towards achieving this goal.
Internalizing a public moral norm of equity in health at the collective and individual levels is important because the regulation of self and society requires not just self- and national interest or even legal instruments, but individuals and groups armed with internalized public moral norms -- as part of their own internal value systems -- to inform choices individuals make for themselves, their institutions and their society to take positive measures to ensure that all individuals have the opportunity to be healthy. Such internalization in turn leads to domestic and global policies to ensure the long term sustainability of an ethical demand for equity in health.

A paradigmatic change from rational actor to normative commitments in global health governance also changes the framework for evaluating the health activities of global and domestic actors. Domestic (national and sub-national governments) and global (the World Health Organization, the World Bank, the Gates Foundation and bi-lateral aid and assistance) actors in a global health governance architecture must be evaluated in terms of their effectiveness in contributing to and advancing the overarching goal of equity in health. Thus, even though wealthy foundations and powerful developed countries have a legal right to spend their money in accordance with their own objectives, they have an ethical obligation to do so in a manner that will improve the prospects of achieving equity in health in conjunction with the constellation of other actors in the domestic and global arena. This is a one goal, multiple actors, approach to global health governance, in contrast to a multiple goals and multiple actors approach that characterizes the current disjointed, ad hoc, redundant and ineffective system.

Shared Health Governance

How do multiple actors in a global health governance system work together to achieve a common goal. Although the overarching framework espoused here delineates duties and responsibilities for both national and international actors, the primary duty falls to nation-states who have the most direct and prior obligations. Individual nation-states must assume primary responsibility for health policy within their own borders and must generate the majority (and eventually all) resources for health, with a goal toward reducing entirely aid from multilateral, bilateral, or NGO sources. The extent of extra-national or international obligations is thus defined in the context of the scope and
limits of national obligations. Secondly, it is important to highlight the need for a variety of institutions; the framework presented here and elsewhere\textsuperscript{56, 57} is one I call shared health governance, whereby state and international governments and institutions along with non-governmental organisations, communities, businesses, foundations, families and individuals are responsible for shared governance in correcting global health injustice. Global and national institutions and actors’ roles relate to the functions and their comparative roles in dealing with deprivations in health functioning and health agency.\textsuperscript{58}

Global actors and institutions, whether they act bilaterally (especially direct overseas development assistance, trade agreements) or multilaterally (through eg, the United Nations system, World Bank or International Monetary Fund), are obligated to remedy global inequalities that exist in affluence, power, and social, economic and political opportunities. Global actors and institutions, while serving a secondary rather than primary role in achieving just health outcomes, nonetheless represent the will of the international community not only to function collectively on national interest but to rectify global market failures, create public goods and address concerns of fairness and equity on a global scale. Global actors and institutions should have a supportive and facilitative role such that countries can develop, flourish and promote health. The focus should be on a broad approach that deals with all determinants of health and poverty, not a narrow, technical approach. In terms of the macrosocial environment, global actors and institutions should pursue the following: facilitate growth in developing countries; promote global financial stability; finance global public goods; develop country participation in global fora; provide debt relief and development assistance; offer fair trade and open markets to developed countries; provide technical assistance and know-how to developing countries; and finance global public goods.

Global health institutions have a more narrow set of obligations and duties around four sets of work: generate and disseminate knowledge and information; empower individuals and groups in national and global fora; provide technical assistance, financial aid and global advocacy for equitable and efficient health systems; and coordinate institutions to exclude redundancies.\textsuperscript{59} In terms of generating and disseminating knowledge and information, global health institutions can help create
new technologies; transfer, adapt and apply existing knowledge; manage knowledge and information; create and set standards and international instruments; and help countries develop information and research capacity. In terms of empowering individuals and groups, global health institutions can aid in reforming state and local institutions; encourage political will for public action; help governments improve public administration; provide greater voice in national and international fora; and assist states in ensuring greater citizen participation in decision making. Finally, in terms of health system development, global health institutions can provide technical assistance in the following key domains: equitable and efficient health financing; training of medical and public health professionals; management of tertiary, secondary and primary care facilities; regulatory agencies; and standardised diagnostic categories. Global health organisations can also provide financial aid and mobilise resources for health systems development and specific disease areas, and offer global advocacy.60

Individual nation-states have primary and prior obligations to reduce health inequalities. Firstly, state actors and institutions assume primary responsibility for creating conditions to fulfil individuals’ capability to be healthy; states are in the most direct position to reduce the shortfall between potential and actual health.61 This includes efforts to deal with the social, economic and political determinants of health. Secondly, states assume the primary responsibility for creating an institutional framework for equitable and affordable healthcare and public health; this includes allowing equal access to quality health-related goods and services, and to proximal and controllable determinants, including nutritiously safe food and potable drinking water, basic sanitation, adequate living conditions, healthcare, public health surveillance and health literacy. Regulation and stewardship of the health system is a critical state action.

Conclusion

Global health actors must work together and in a supportive and facilitative role vis-a-vis state actors and institutions to correct global health injustices. State governments, institutions and actors, along with non-governmental organizations, local communities, businesses, foundations, families and individuals must assume a prior and direct role and responsibility, through a framework of shared health governance, at the
level of the nation-state. A moral framework should be applied to all global health policies. Reducing gaps in preventable mortality and morbidity is an essential common goal of the global health community in the 21st century.

5 Drager N, and Fidler DP. Foreign policy, trade and health: at the cutting edge of global health diplomacy. Bull World Health Organ. 2007 Mar;85(3):162
6 Article 2 of International Health Regulations
8 Quoted in Nevirapine Case, at 751.
9 Minister of Health v. Treatment Action Committee, Constitutional Court of South Africa, 2002 (10) BCLR 1033 as cited in Nevirapine Case
32 Ruger JP. Ethics and governance of global health inequalities. *Journal of Epidemiology and Community Health* 2006; 60(11): 998-1003
41 Fryatt B Foreign aid and TB control policy in Nepal. Lancet, 1995, 346, 328

57 Ruger JP. Ethics and governance of global health inequalities. *Journal of Epidemiology and Community Health* 2006; 60(11): 998-1003