Bellagio JALI meeting report

In February 2012, JALI held a global strategy session at the Bellagio Center, with the generous support and participation of the Rockefeller Foundation. From the meeting emerged a Manifesto on Health Justice, launching a Global Campaign on the Framework Convention on Global Health (FCGH) and outlining the FCGH’s key elements. The Manifesto is now on JALI’s website (http://wwwjalihealth.org) and available for sign-on.

Participants also began to develop principles on JALI’s four key question, involving what universal health coverage should entail, national and global responsibilities for health – and securing the right to health – and a global governance structure to effectuate these responsibilities. This still draft, working set of principles will be posted on JALI’s website, and we will solicit feedback to continue to build on and improve these principles.

The meeting also saw rich discussion, from the nature of the right to health to the research and actions that JALI must take to further develop and build social and political support behind an FCGH. Some of the highlights of those discussions are provided below. By and large the points reflect an overall consensus of Bellagio participants, though that is not necessarily the case for all points included below, some of which may represent the views of a smaller number of participants, or ideas proposed that would require further discussion.

We have organized these important points – which include recommendations for actions that will advance JALI and an FCGH – from the meeting into several categories:

- Building social movement support for an FCGH
- A political strategy for an FCGH
- Strategic questions about JALI and the process towards an FCGH
- Research needs
- The process towards an FCGH
- Issues pertaining to the right to health
- Global governance for health
- The post-Millennium Development Goals development agenda process
- Health financing
- FCGH scope
- Global and national health facts
- Universal health coverage

First, however, we relate a short vignette that one of the participants shared with the group, of a recent visit to a referral hospital in Tanzania, and its labor ward. There were four women to a bed, the hospital lacked essential medicines and gloves, and women were delivering on the floor. There was also a dead woman on the floor, lifeless for hours. She had died the day before, having bled out. She was still connected to an IV line. Did the fact that she was HIV+ play any role in this neglect? Or was this simply a function of a health system lacking in every way – lack of health workers, lack of medicines, lack of space, lack of respect, lack of accountability? Neglected too was a baby, wrapped up, by
the windowsill. It was her baby, alive and as ignored as her mother. Meanwhile, her family was outside. They still hadn’t been informed of what had unfolded in the labor ward the previous day.

We learned too of a school in South Africa where there was one toilet for 700 students – though that single toilet was often broken, because it is made out of corrugated iron, which is often stolen) toilet for 700 students. Another school in South Africa has four toilets for 1,500 students.

Bellagio participants are all cognizant of such tragic – and inexcusable – realities that persist, and are committed to an FCGH that will end such offenses against dignity, that will be relevant to the people who could, today, be that pregnant woman who receives inadequate care in life and is ignored in death, to her family, to all those who suffer from health injustices, from the widespread violations of the right to health.

Social movements

1. An FCGH will only be achieved on the back of a groundswell of public support. There are no shortcuts around this. The public needs to be informed, well-educated on the right to health, much as the Treatment Action Campaign’s strength was founded on educating people about their own health with treatment literacy education. Then people were able to effectively claim their rights.

2. We are not creating a new movement for the FCGH so much as exciting and mobilizing existing movements and institutions towards this goal.

3. There is huge potential for a large social movement around the FCGH and right to health. Everyone has an interest in their health. Consider the success of other movements, such as around the Ban Mines Convention and the Rome Statute establishing the International Criminal Court (ICC), even though many supporters were not worried about themselves being harmed by landmines or by crimes under the ICC jurisdiction. It will be important, though, to define the problem in a way that does not alienate based on people’s instinctive political affiliation. Consider how politicized the U.S. health reform debate became, with many people working against their own interests.

4. People must be able to connect the FCGH and the right to health to their daily needs and lives. And people should understand the present injustices (e.g., the woman dying in childbirth in Tanzania).

5. We should be cognizant of the fact that it is easier to stop an injustice than to work for distribute justice and positive rights (and similarly can be easier to get government to protect rights than to fulfill them, including the right to health. The global fight against child labor started with one person in India, and two years later materialized in the first ILO convention against child labor. A powerful set of questions in mobilizing the public (can we adopt or adapt them?) were: Are
you against it? Are you doing anything about it? Could you do more? This last question is pushing people out of their comfort zone.

6. We need a discussion on the people, the networks, the movements that we would like to be behind an FCGH.

7. FCGH must address and engage not only NGOs but also communities (to determine whether someone is part of a community, ask, does the issue advocating for affect them personally?). AIDS unified affected communities. What will unify people around an FCGH?

8. How can we get the middle class on board with a movement for an FCGH – rather than viewing it as something for the poor, to join in solidarity for an FCGH?

9. An important social movement to engage is the People’s Health Movement, including seeking to have a serious debate about the FCGH at the July 2012 People’s Health Assembly, to spread the seeds about the FCGH, with the hopes that people will start to raise the FCGH with their own governments.

10. Another important movement is the international trade union movement. The International Trade Union Confederation has 175 million members. We need to engage movements beyond health.

11. Given the importance of religion in many countries, what role religious entities and leaders in building a social movement behind an FCGH?

12. To get broad support for the Manifesto calling for an FCGH, we will first seek sign-on from various luminaries, then open it up for broad signature. We will also circulate a draft, working set of principles for the 4 JALI key questions based on our discussions. NOTE: This report does not incorporate discussions on these 4 key questions, and may not include all of the points contained in the Manifesto, as those will be available through these separate documents.

13. JALI needs an ambitious vision to mobilize support. A package of minimums won’t mobilize this support.

Political strategy

1. Proposed that we seek another statement of support for an FCGH and its underlying principles in the June 2012 UN Secretary-General report to the UN General Assembly, through UNAIDS.

2. Important organizations to engage include regional organizations (e.g., SADC, ECOWAS in Africa, Mercosur, Unasur in Latin America), media, parliaments (especially relevant parliamentary committees [including finance for budget-setting]), community development organizations, religious leaders.
3. It might be possible to get the FCGH and its principles into regional agreements, preparing the global environment for the FCGH. One opportunity in South America is the South American Institute for Health Governance and the South American Council of Health. The latter is funded by the Brazilian government and composed of 12 ministers of health (http://www.graduateinstitute.ch/webdav/site/globalhealth/shared/Consortium/Cuba2009/Presentations/CUBA%20South%20South%20Coop.Buss.pdf), and is a stable platform that could provide support to an FCGH.

4. Might one strategy be to try to get political parties to include the FCGH in their platforms?

5. We need to engage in power-mapping and connect the dots so that we can understanding the “strategic acupuncture” – where, if we push a needle, will we be able to get something to happen?

6. If we do not have enough people willing to support an FCGH in negotiations, we need to work to create more power, to change the political calculus so that political actors see benefit in supporting the FCGH.

7. A political strategy – champions, etc. – could differ for different aspects of the FCGH (e.g., domestic resources, financial transaction tax, accountability).

8. Issues to consider in forming a political strategy including actor power (agreement within policy community on what an FCGH should entail; leadership within FCGH-supporters and champions in all sectors; guiding institutions, e.g., WHO, Human Rights Council, UNAIDS, Office of the High Commissioner for Human Rights, UNDP, UNICEF; fuel, e.g., civil society mobilization and right to health networks), ideas (will need something simple with broad resonance, and both an internal frame and external frame – how we present to different actors), context (policy windows, evidence, human interest stories, political values that appeal to different actors), and issue characteristics (including making clear the severity of the problem and the effectiveness of the approaches we propose). (See Jeremy Shiffman & Stephanie Smith, “Generation of political priority for global health initiatives: a framework and case study of maternal mortality,” 370 Lancet (October 13, 2007): 1370-1379, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61579-7/fulltext)

9. Be aware that stakeholders and their positions will change over time, and their importance may vary by venue (e.g., World Health Assembly, different UN venues). In part this is because of a lack of coherence within governments, a challenge for international health policymaking, as it is possible to have health ministers on board but foreign ministers who have not been part of the discussions.
This could lead foreign ministries to undermine agreements or understandings from health ministers.

10. The Office of the High Commissioner for Human Rights is very involved in post-MDG discussions and could be an important champion. (Ali volunteered to be JALI ambassador with them.)

11. It is necessary to influence the position of governments at various conferences well before the conferences themselves. We could encourage countries to develop national platforms on global health, as Germany has, which includes trade unions, professional associations, the development community, among others. The Netherlands has its Netherlands Platform of Global Health Policy and Health Systems Research (http://www.globalhealthplatform.nl/).

12. Notably, while JALI itself does not have much power, we are well positioned in relation to power, including proximity to several governments (e.g., Norway, Brazil, South Africa), having the UN Special Rapporteur on the right to health, connections to the Executive Director of UNAIDS, and UN Office of the High Commissioner for Human Rights, among others, as well as certain social movements.

13. Countries with good right to health laws and policies could become FCGH champions.

14. We need to use all political spaces. The effectiveness of different strategies may vary by region – for example, regional organizations are strong in Latin America.

15. WHO reform is another important process to engage, despite questions about where it is going. The Director-General could get behind and champion the FCGH if there is pressure from Member States to do so. Organizations might also take leadership only once a convention is in effect, as was the case with UNICEF and the Convention on the Rights of the Child, which has become the center of UNICEF’s work (effort to make CEDAW more central to the work of UN Women).

16. We must engage the women’s movement.

17. Key upcoming events and processes include the process of developing the post-MDG framework, such as Rio+20 and UN consultations with 50 countries starting in spring 2012, the World Health Assembly, the G20 Summit in Mexico, the UN Secretary-General Report in June 2012, the International AIDS Conference, the People’s Health Assembly 3, the World Economic Forum at Davos, the Lancet-University of Oslo Commission on Global Governance for Health, and a meeting of the Commission on the Status of Women.
18. Need to push Southern governments to contribute more. Southern civil society can hold their governments accountable. Have seen examples, e.g., 15% Now! Campaign. Important role too of media and parliaments, including parliamentary committees. Need buy-in and advocacy from Southern civil society to put pressure on governments.

**Strategic questions**

1. Should the FCGH go through WHO or the UN? The WHO could be easier in terms of primarily requiring support from ministries of health rather than ministry of foreign affairs (though ultimately foreign affairs also required for WHO?), but the Human Rights Council may be more progressive than WHO.

2. Should we seek to develop a full draft of the FCGH, or rather principles that it should incorporate, actions and issues that it should include, possibilities for accountability mechanisms, analysis of how it could address various questions, etc., but not actually a full draft?

3. How can JALI be strengthened to act as an incubator and coordinator of the FCGH process for the next several years?

**Research**

1. What are the most effective ways to enable people to understand and claim their rights (including ensuring education on rights and identifying community champions, who may be health workers)? Are comic books explaining right to health to children a good model?

2. How should the FCGH incorporate building local understanding of the right to health and how to claim it? What are the main organizations/efforts underway to enable people to understand and claim their rights? Can JALI support this in any way (networking, compiling lessons learned, evidence)?

3. Is there any evidence for improvements in health outcomes from right to health education? If so, what?

4. How do legal regimes, including human rights, address the responsibilities of non-state actors?

5. Consider studies in e.g., five countries on what is happening to advance the right to health. (Often only learn about this in international meetings, not otherwise available.) How can these lessons help move countries’ agendas?

6. Where is national capacity for right to health implementation? In national human rights commission, judiciary? How could an FCGH support capacity for these institutions?
7. What can we learn from the Ministerial Leadership Initiative (http://www.ministerial-leadership.org/), which strengthened government ability to develop health systems that are more capable of delivering on the right to health, for an FCGH?

8. What are national laws and policies related to the right to health?

9. Examine work of Norman Daniels for insights on participatory process for setting national health priorities in the context of universal health coverage guarantees.

10. Research possibly on how laws in countries – even where constitution provides for the right to health – may oppose or undermine this right (e.g., budgeting restrictions).

11. JALI might want to develop a paper explaining how a right to health approach will make a difference and lead to better health.

12. JALI should develop a bibliography of relevant resources to our substantive questions that would inform an FCGH.

13. The importance of our understanding technical information (e.g., successful models of universal health coverage, high-performance systems that are efficient/low-cost) is to demonstrate that what we advocate for is achievable, including same or better outcomes at less cost (e.g., little or no evidence that use of ultrasounds during pregnancy contributes to better outcomes, even though protocols may call for one or two ultrasounds per pregnancy). There are solutions.

14. What health system changes would a right to health approach entail?

15. Research might include how human rights principles such as anti-discrimination and dignity are understood in different jurisdictions.

16. What are our opportunities for engaging the post-MDG agenda?

17. We need to research actors (e.g., UN system, governments). Who are the actors that will oppose an FCGH, who could be persuaded to support, and who will be champions? How to mobilize those that do not yet support an FCGH, and change the positions of those opposed? What are ministers’ and diplomats’ true positions (what they say at home versus what they say around the negotiating table)?

18. We should map out various processes – political opportunities, social movements to involve, key events, allies, key people to map – to develop a social and political mobilization strategy for an FCGH. We could develop both an overall map for the
FCGH and with respect to each issue. These could be live documents that we regularly update, including report backs and additions.

19. Research is needed to back up why the problem JALI asserts is indeed a problem. Research is also need to explain how what we are asking for can work and to back up our principles. Similarly, research may be needed to support the Manifesto.

Process

1. We need bottom-up engagement from the beginning. How to get people in villages, communities engaged? Example: Stand Up Poverty (part of the Global Call to Action Against Poverty [GCAP]) involved 173 million people in 2009. We need to translate the right to health into something that really can be used on ground as part of a political struggle.

2. We should delay final draft text of the FCGH until people are on board through broad movements, and have developed a consensus on the need for an alternative health framework. The process of consultations and discussion through which an FCGH will emerge is part of the process of mobilization. The FCGH must incorporate experiential learning, not only abstract reasoning, as conventions are typically based upon.

3. Very tentative timeline before final draft of an FCGH: three to five years.

4. Consider that the process to develop the Convention on the Rights of People with Disabilities took 6 ½ years, and this was considered fast.

5. Need to keep people engaged as we (and they) develop an FCGH, and participate in key events, such as the People’s Health Assembly 3.

6. Ideas for gaining support among and input from people include presenting data and reports, and holding (civil society) hearings and juries.

7. Even where we might not want to define which direction an FCGH should point for a particular area, or details for it to include, it will be useful to have the background research to enable informed debates when the time comes for such discussions and ultimately negotiations.

8. The process towards an FCGH needs to be guided, but it cannot be owned, controlled, by a single group. There will need to be a time when JALI and others are will to cede control of the process to a broader movement.

9. JALI could consider models of other successful civil society-led conventions, where civil society united behind a single, powerful idea with a few key principles, such as a coalition on the International Criminal Court united behind the idea of the need to need to bring those who have committed serious crimes for justice.
JALI is more complex, and needs strong civil society coalitions in both states that want to be champions and that could be the most opposed (the United States?). JALI could include a problem statement (e.g., right to health is not being effectively implemented) and key issues that need to be address (e.g., accountability, funding, trade). This should be relatively spare, and so would have potential for broad support.

10. We might want to avoid drafting a full convention, or else we may end up either negotiating against ourselves, or putting out an ideal convention that states will not engage on. A full convention could also lead to civil society discord around more minor issues. Rather, we need a very clear statement of the problem, clear principles, and explanations of what we require to make the principles work. Also, once our language is public, we cannot ask for more (as it was our language). We may provide proposed language to state champions.

11. Before seeking to begin state negotiations, civil society must establish negotiating power – a movement.

12. Repeating a message over and over and over again can be useful, helping people get used to it and come to accept it. But JALI’s strategy must go much beyond this to build a powerful movement.

13. Even as FCGH itself will not be ready to establish the post-MDG framework, the post-MDG process is an opportunity to get certain very important principles established for post-MDG period.

14. We should generate a support for the right to health, inject into national and regional debates, to create a positive environment for a future FCGH. The Manifesto could be an early part of this process.

15. In order to have FCGH provisions effectively translated into national implementation, it is important to think about implementation ahead of time, and to have very clear definitions and standards (e.g., non-discrimination).

16. Will want to have (at least) tens of thousands of people, organizations, signing onto the Manifesto.

17. An idea offered was an International Labour Organization-type structure where governments, businesses, and labor movements sit together in a collective bargaining process towards an agreed common good (e.g., ending child labor). This type of multi-stakeholder, level playing field is important, but first we need to further define what the FCGH is. It could be more appropriate for further down the road in the FCGH process, once civil society has developed a movement behind the FCGH and established its negotiating power.
Right to health (in general)

1. Shortcomings of right to health include lack of understanding of the right and General Comment 14 among states, communities, and much civil society, and its failure to including binding rules on non-state actors.

2. Participants agreed that countries need universal and comprehensive health systems, otherwise “poor quality for poor people.” Propose reference point of highest best global standards, the best performing health systems (e.g., Norway). There was broad support among participants for this maximalist approach to the right to health, recognizing that priority setting will still be required on the way towards this standard. Even Norway engages in priority setting, and cannot provide everything for everyone. Emphasis from one participant of value of starting with low-cost medical interventions.

3. The “do no harm” principle with respect to health must be claimable.

4. Another way of viewing the right to health: the right to life with dignity (per Indian Supreme Court).

5. Social protection floors that countries define based on their own (insufficient) capacities would be a formula to keep things as they are.

6. The right to health should be seen from the perspective of universality, not only something for the poor. It will be necessary to convince the middle classes to support this collective understanding.

7. Health is presently treated as a commodity. This is today’s “undeclared framework.” This needs to be replaced with the view of health as a common good, which requires a redistribution of resources to achieve. The world is awash in money – enough to provide everyone the highest standard of health.

8. What is the reference level for “the highest attainable standard of health”? Proposed: the best global standard.

9. When consider universality, need to ask who is the population? Migrants must be included.

10. Traditional understanding of “highest attainable standard of health” is based on resource constraints. People don’t know what it means. It requires international cooperation to achieve.

11. Human Rights Council to issue guidelines on a health development issue, which will be technical guidelines focused on maternal health.
12. Right to health issues in Uganda include government failure to investigate where people not receiving access (e.g., to medicine) that they are supposed to receive, limited understanding right to health among civil society organizations, laws from 1940s (e.g., mental health law leading to people being detained), health facilities detentions because people cannot pay, discrimination, unclear mechanisms for redress, lack of funding for civil society leads to competition for few funds from same source. People not using Human Rights Commission to address right to health because people aren’t aware of this possibility.

13. Even if right to health is a collective right, it must be claimable by the individual.

14. In many Latin American countries, people can make claims based on international conventions, but these are hard to use by citizens.

15. Rights language resonates differently in different countries. In Senegal, one Bellagio participant and researcher found that quite unlike South Africa, governments and civil society talked about needs, rather than using rights language.

16. Caution that litigation does not always improve health equity. For example, most litigation in Argentina is for treatment already covered by the existing scheme, and is used primarily by the middle class. In Brazil, while litigation may not have shifted resources away from other health system interventions, courts award almost any treatment irrespective of cost effectiveness or its capacity to benefit people.

17. Potential of litigation – Colombia case where court has required public participation in priority setting, so that ethical judgments about how priorities are set are transparent. In Uganda, much greater civil society access to discuss maternal health with Ministry of Health officials once maternal death case filed than before.

18. Four billion people lack access to justice (specifically, the formal legal system). (http://microjustice.flyers-ic.nl/ -- UN Commission on Legal Empowerment of the Poor) Courts cannot be the only place people can turn to address right to health violations.

19. Should have state responsibility around legal literacy, people knowing their rights?

20. Need to understand equity in the context of equality. Equity can be understood simply as a way of managing scarcity, with scarce resources going to the poorest. Rather, equity should be within the context of achieving equality – universalism – in the end.
21. Who are the duty bearers? What about when companies are harming the environment? Need to make them accountable. And should progressive realization be “confined to the dustbin of history”? Or maintained but clarified and limited in scope?

22. There are sufficient resources to amply realize the right to health – but this requires justice in allocating resources.

23. Ways that the right to health can make a difference include greater accountability, community involvement and engagement in health planning and evaluation, equity and fairness in distribution of resources, and sufficient resources. In the health worker context, a focus on human rights could mean disaggregating data to understand how equitable the distribution of health workers is and how effective policies are at improving that distribution, addressing discrimination and mistreatment of patients by health workers, using all levers to improve the equitable distribution of health workers, ensuring safe working conditions for health workers, educating health workers on human rights including so that they are more likely to be advocates for the health of their patients and communities, ensuring that financial incentives do not undermine the right to health (e.g., a health worker turning away women in urgent need of care in order to avoid having their death attributed to that worker’s health facility) and addressing health workforce-related obstacles to care of marginalized populations, such as ensuring that health workers speak local languages.

24. The right to health is also important for empowerment, enabling people to make their own decisions, to be in charge of their life. Community engagement is often passive, whereas under a right to health approach community engagement means that the community determines how to create a health system that works for them.


Right to health and JALI/FCGH

1. There was as strong view in meeting that cannot have an FCGH related only to providing basics – it needs to look respond to the full right to health. It is possible to shift the debate when do not talk about minimum.

2. Must view right to health in broader ideological and economic context. For example, a country may assert that it cannot pay for greater health because of budgetary constraints, while rules limit states’ capacity to generate greater
revenue through taxes. The overall power structure dominated by economic interests must be challenged. At the end of the day the FCGH is about power. We need to work towards an FCGH is this broader context of the need to redistribute power, as well as the broader context of poverty (what laws contribute to keeping people poor?) and inequality.

3. FCGH is about replacing an undeclared framework around health – that it is a commodity. It should be a campaigning document around the right to health. It is an idea that will not be owned by just a few people.

4. The idea of an FCGH and of a right to health based on universality needs support of labor movements, parliamentarians, political parties. Public Services International is an important labor union ally. We need to gain support for right to health based on universality.

5. How much do people know about the existence of a right to health, and if they do know of it, of its contents and meaning to them? As think about movement building, consider how can we increase understanding of this right and gain buy-in?

6. Finance people uncomfortable with right to health since hard to quantify. Important for them to link to MDGs.

7. Proposed that people should be able to read the FCGH and know what health services they are entitled to free of charge. Article 12 of ICESCR is too vague for this. We need a holistic set of right to health demands enforceable by law.

8. Vision of FCGH mandating right to health-related laws so that the right is situated in countries, and people can enforce it directly in national courts. For example, a law mandating a country to spend a certain percentage of its GDP on health, with a certain portion to an international financing mechanism.

9. Need to have honest, hard conversation about whether view resources for rights as a zero sum game. Never discuss in context of civil and political rights, even though all rights have costs. Do economic and cultural rights cost more? What resources are available?

10. An important part of the project we’re engaged in is to help people claim their rights, including by creating clearer definitions of the right to health and its components, mobilizing people to throw light around the right, and ultimately creating an instrument that will mobilize people and create accountability – creating national conditions to realize this international right.

11. What are the legal definitions that the FCGH will adopt for the right to health and related key concepts?
12. The goods and services people need for health depends on the question. For example, if question is what good and services do people need for good health, education would be included. If the question is of the good and services needed to fulfill the right to health, they would include access to justice.

13. The FCGH should adopt a forward-looking position with respect to health and the right to health.

Global governance for health

1. Newer donors (e.g., China) are more interested in providing assistance bilaterally than through multilateral mechanisms. Do some wealthy countries dislike the Global Fund because it is a powerful new model that involves civil society in decision-making?

2. A view from the ground: It is frustrating to improve local determinants of health only to see progress simultaneously being eroded by global determinants.

3. The Global Fund’s involvement of civil society is an important model of governance, but imperfect. It cuts off funding for countries of certain income level, but many of these countries have high burdens of disease and hidden populations that are being ignored by their governments – so the rest of the world needs to pay attention.

4. FCGH should address global health-related issues that countries need to address together, globally, such as migration, including health worker migration.

5. Need to build capacity of diplomats to understand health implications of other issues that they are working on.

6. Could an FCGH protect countries from having other countries interfere with development loans that are needed to improve health (as the United States blocked loans from the Inter-American Development Bank to Haiti about a decade ago)? At the time, there seemed to be no appropriate forum to take this matter.

7. An FCGH could make aid models more accountable, including with respect to food assistance – which in many cases harms local production. And the FCGH could address accountability of large NGOs.

8. Example of non-state actor impact on health: mining, which is addressed from the perspective of production capacity, but rarely from perspective of impact on health. The state needs to be the defender of the public interest and public goods.

Post-MDG process
1. Need to take advantage of opening over the next two years as the post-MDG development agenda is developed, working with movements such as GCAP. Will need something much more radical than the MDGs. The MDGs came at a very different time, and were designed based on the global South taking certain actions with the North mobilizing funding.

2. Today, 72% of poor people in middle-income countries. We need a truly global post-MDG compact, with fair financing that goes beyond assistance to other mechanisms like a financial transaction tax. JALI’s agenda fits in well with many social movements now organizing around these issues.

3. Current UNDP consultation process is shallow, particularly compared to numerous international conferences involving civil society in the 1990s leading up to the MDGs. Could JALI inject meaningful consultations into the process?

4. Post-MDG agreement likely to set the development agenda for next 25 years. Possibilities include extending timeline for current MDGs, adding several more goals to the MDGs (MDGs plus), simplifying and narrowing the MDGs (MDG minus), having sustainable development goals (proposal from Colombia), incorporating additional elements into the goals such as equity, and no new goals at all. There is some discussion of a public goods framework.

Health financing related points

1. What countries budget for health is often more than they actually spend (funds released).

2. Illicit financial flows out of developing countries annually amount to $850 billion to $1 trillion per year. [http://www.gfintegrity.org/storage/gfip/executive%20-%20final%20version%201-5-09.pdf; this is 2002-2006 estimate. Illicit flows from developing countries are increasing, and were estimated to have reached $1.26 trillion in 2008 (http://iff-update.gfintegrity.org/).]

3. A study of African countries found that countries that rely more on taxation spend more on development needs than countries whose revenue comes more from natural resource royalties.

4. What is the real economic capacity of nations, if they had strong and progressive tax systems?

5. Low out-of-pocket payments may mean that people are poor and unprotected and not getting the health services they need.

6. Reality in South Africa is have “budget-based need” rather than “needs-based budgeting.” Needs must fit the budget allocated, rather than allocating the budget to meet people’s needs. Through JALI, we would like to show models in human
rights law and principles developing other approaches (e.g., needs-based budgeting).

7. IMF loans sometimes give IMF a say in tax policy. We need to oppose countries whose IMF directors allow this to happen. IMF technical agreements are confidential, which highlights the importance of the right to information.

8. Global health care market is at least $5 trillion annually (http://www.ipihd.org/about-ipihd/background-to-world-economic-forum-project). More equitably and efficiently spent this could lead to better global health outcomes.

9. Best health outcomes occur in countries with lowest income and wealth disparities.

10. A global tax system could reduce economic disparities to raise and redistribute resources to meet health (and other development) financing gaps.

11. African countries have not made much progress on increased agricultural spending despite commitments.

12. JALI must be connected to people’s needs, and not be a prisoner of the scarcity model, and escape “the logic of scarcity and mantra of austerity.”

13. A fixation on lack of resources for health ignores distribution of power and lack of political will. Resources can be found.

14. Need to go beyond simple call for, e.g., 15% budgets for funding – too many such declarations, but not implemented. Redrawing rules on taxation could make resources available. OECD has a taskforce on taxation and development.

15. How to address multiple levels of funding for health and education, such as local governments providing much money in these areas? Why can’t local governments seek international funding directly?

16. The “aid world” is in crisis, performing poorly by its own indicators. This contributes to opportunity to reframe discussions from aid to a globally just system.

17. European Union has a target of at least 20% of its aid being for human development, and focusing more on countries in the most need.

18. Study of link between tax revenue and progress in AIDS, TB, and malaria finds no link. Probably this is because of external support for combatting these diseases (such support is significantly link to improvement) – governments may feel that because they are improving, they don’t need to allocate their own funds.
19. With the global economic downturn and recessions, we need to think outside ordinary revenue channels.

20. There are far greater flows of resources from global South to North than assistance from North to South. How can some of these be captured for health?

**FCGH scope and functions**

1. JALI should recognize existing documents such as the People’s Charter for Health. An FCGH must be different, better – a challenge.

2. Need to address social determinants of health – shouldn’t be any less explicit than WHO members about need to tackle inequitable distribution of power, money, and other resources.

3. An FCGH needs to change the chain of decision-making at as many levels as possible. This includes the individual’s ability to claim the right to health (legal accountability), but that alone not enough.

4. The FCGH needs to be as comprehensive and take into as many factors as possible, while keeping the treaty manageable and implementable.

5. We need to be ready for possibility of countries making reservations on provisions of the FCGH. How should the FCGH address this? And how should FCGH address failure to report (major issue with African Charter on Human and Peoples’ Rights)?

6. How far should an FCGH go in detailing requirements? It should not limit states’ ability to develop implementation frameworks that will enable them to address their local needs.

7. We will need to carefully consider what makes sense to include in an FCGH and what, for one reason or another even if it is a good idea that we support, should not be part of an FCGH.

8. Possibly dividing line on food for what an FCGH would and would not cover – might not cover actually producing food, but would regulate food, such as avoiding dangerous pesticides and promoting good nutrition.

**Global and national health facts**

1. There are nearly 20 million excess deaths every year (one-third of all deaths) when compare high-income regions with the rest of the world. One-third of child deaths are not from diarrhea—“they die of injustice.” One determinant, economic disparities, has widened over the past several decades.
2. Sustainable approaches to development that meet world health standards are possible. Seventeen countries have sustainable development approaches (based on an ecological footprint measure) and achieve world health standards at ½ average global GDP per capita.

3. There are some countries that meet global life expectancy and under-5 mortality standards while spending approximately $100 per capita on health. (Though participants raised concerns about this figure; Brazil spends $367 per capita on health care alone, whereas an estimated $1,000 is required, including to correctly pay health workers, cover the whole country, and address issues including transportation and e-health.) What are their arrangements that make this possible? What can we learn from them?

4. By one model, approximately 44 countries lack the economic resources to meet global health standards, with a funding gap of approximately $100 billion.

5. Even though only 20% of the population in South Africa uses the private health system, 80% of health resources are in the private health care system.

6. How is it that Cuba spends about $600 per capita – 1/10 of the United States – on health, but has about the same level of infant mortality? This points to the importance of how health services are organized.

Universal health coverage

1. Recent election in Paraguay successfully placed universal health coverage on the political agenda.

2. It is possible to view universal health coverage from three perspectives: 1) A philosophical strategy: universalism – the need to cover everyone, everywhere; comprehensiveness – the need to meet the needs of each person; equity towards equality – eliminating obstacles and injustices that prevent equality; the state as the duty bearer; a rich form of democracy to produce social justice – not only a formal political process; health superior to private interests, and; a systematic approach to human rights leading to a universal social protection system; 2) the programmatic content of universal health coverage: the technical expression of the philosophical strategy, including the mode of care (responsibility of the system over the needs of the people, going beyond medical needs but including social health care needs), ensuring people the full range of services in a timely fashion, wherever they are, and integrated care), and; 3) the management mode: how to manage universal health coverage, which can be the most difficult area to change; this includes health funding (with a mix of contributive [social security] and progressive non-contributive [general revenue] taxes) and the development of health workers.

4. Areas of the Rockefeller Foundation’s health system involvement (Transforming Health Systems) include universal health coverage (such as support for the WHA universal health coverage resolution and the Joint Learning Network on Universal Health Coverage, where 10 ministries of health are sharing experiences on their universal health coverage efforts), the role of the private factor (agnostic as to its proper role, but recognizing that in many countries, it is an enormous part of the health delivery system, e.g., 80% in India – how to regulate it and make it work better? – including support for HANSHA a coordination group that seeks to harness and align donor efforts towards private sector), and e- and m-health [mobile health], including helping set up an e-health unit in the Ministry of Health in Rwanda and launching the M-Health Alliance). Rockefeller also supports health systems research.

5. Health systems often exacerbate patterns of exclusion in society, especially of poor women.

6. Notable quote from meeting: “We will change the world, but [we/FCGH] are not going to change everything in the world.”

7. Politics and activism are determinants of health.

8. It is important not to lose sight of broader determinants of health, including discriminatory laws, unequal distribution of power between women and men within countries, and other social and structural determinants of health.

9. Individual health care services, like traditional public health functions (e.g., clean water and adequate sanitation) can be viewed from a population-wide, collective perspective. For example, for new neurology services, health authorities can determine what the population-wide needs will be, and plan health services (e.g., health worker training, health facility capacity, referral systems) around these population needs.

10. Civil society can be defined not as particular actors, but a space – like public squares – where struggles for change can take place, where the cultural hegemony can be challenged. Anyone who is part of that struggle (including members of the government) can be part of civil society.

11. Some people may be uncomfortable with our demands. And many may say that what we’re aiming for is impossible, infeasible. We need to be ready to say that not only is it possible and feasible, but these are our rights and we insist upon them. We need to talk outside of the system (e.g., UN system) in order to get the system to get it to respond, and talk back to us on our terms.
12. The Latin American regional organization Mercosur is using the Inter-American human rights system to potentially advance the rights of migrants, having asked the Inter-American Court for an advisory opinion on migrants’ access to rights. The opinion will have implications not only the four countries of the region, but for the whole Americas region.

13. Publicity and the media can get government to act. The Gauteng provincial government in South Africa only responded to a recent health crisis once it made the front pages of the newspaper.

14. We might call on ministers of health to reject private health insurance and systems, and instead use the public system, so that they understand and show confidence in their own systems. The President of Argentina recently went to a public hospital. In Kenya, MPs go to public hospitals – but private wings – because the best consultants are there.

15. Real democracy relates to how much people participate in real decisions (e.g., on policy, budget) that affect power, resources, major questions like the type of taxation system a country has. People need clear mechanisms to participate.

16. The reality of public hospitals is that they are often poor hospitals – where poor people receive poor quality services.