Institutionalizing Solidarity for Health

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Health: a global common good

Talking about *global health* is certainly fashionable! All over the globe politicians, scientists, and also representatives from NGOs have started to refer to these two words – with notions, however, that widely differ. Most likely a German journalist being asked about his concept of *global health* would mention global threats such as AIDS/HIV, avian flu, perhaps also tuberculosis, whereas a WHO official may call for a better coordination in a fragmented global landscape of health actors. But *global health* refers to more than just controlling pandemics or calling for managerial improvements. In the first instance it refers to the need to re-conceptualise health under the premise of the globalized world. Health is an essential condition for human and social development. Thus, from the human-rights perspective *global health* stands for the internationally shared responsibility for the global common good health.

The ambitious goal *Health for All* is not new. It inspired the establishing of the World Health Organisation (WHO) in 1948. Considering the global wealth that has been generated in today's world, the prospect of *Health for All* must not be an illusion any longer. It could have been achieved long ago. *Health for all* is not an issue of creating more wealth, but of the redistribution of existing wealth and income. The world is awash with money. What is missing is the political will for change and the public pressure to make change happen.

In view of the appalling global health crisis, change is urgently needed. Although average life expectancy of the global population has constantly increased over the past 50 years, in Africa and some countries of the former Eastern world, it is declining. Also the second health indicator, the infant mortality rate (IMR), illustrates the inequalities that exist in today’s health. From 1000 live births in Chad, 124 children die before they reach their first birthday. In Sweden, by contrast, the IMR is two (WHO 2011)[1].

In the course of economic globalization the world has progressed, no doubt, but the gap between the rich and the poor has become bigger rather than smaller. The neo-liberal promise that the poor would also benefit from the liberalization of trade in goods and capital has been proven wrong. Instead of a trickle down-effect, we witness an expansion of poverty following a cynical hidden agenda: *Take it from the needy, give it to the greedy*. More than ever it makes a difference whether we are born in one of the prosperous regions of the world, the ‘global north’, or in the zones of social exclusion, poverty, and the denial of future perspectives, the ‘global south’, which in the meantime has also evolved alongside all European and US–cities.

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[1] WHO, *World Health Statistics 2011* (www.who.int/whosis/whostat/EN_WHS2011_Full.pdf), pp 45-48

The good news is that alternatives to the present health inequalities are possible; at least they do not fail because of a lack of resources. However, as alternatives will not appear from nowhere, they can only be realised by dealing with the prevailing power relations that are responsible for the maintenance of the *status quo*. Change for better health requires amendment to, or abolition of, those structural circumstances that fuel the persisting inequalities; it requires social movements guided by a vision of a different world. Academics can be part of this struggle. They can contribute by providing social movements with proper concepts and strategies for creating health justice.

The two areas of change for better health

It is necessary to recognize two areas of struggle that have to be pursued, both at the same time. Getting rid of health inequalities requires both a response to the so-called *Social Determinants of Health* (SDH) and *Universal Coverage* in health care protection. The first refers to the creation of a social environment that allows people to develop and activate their own health potentials. Appropriate living conditions include access to income or land, to adequate nutrition, housing, education, full participation in cultural life, and so on. By emphasizing the importance of the Social Determinants of Health, action for global health has to be connected with the struggle for the protection and recovery of fundamental commons such as land (for nutrition), rivers (for clean water), environmental issues, but also knowledge (for access to medicine). Besides the struggle for the Social Determinants of Health there is the need also to make every effort for effective health care services. Even in a perfect world, in which all the Social Determinants of Health are fully recognised, people will fall ill and will suffer accidents and need medical assistance, for example during pregnancy, in old age, and so on. Thus, Universal Coverage is not contradictory to the SDH-approach. Universal Coverage means that everyone must have access to preventive, curative and rehabilitative health care when needed. Universal Coverage implies equality of access and financial risk protection.

In this chapter I will concentrate on Universal Coverage. I am doing that surely not with the intention of diminishing or denying the importance of the Social Determinants of Health. The world is far from having universally healthy living conditions, *and* there is far from universal access to the highest attainable standard of health care. The statistics are appalling:

- Every year 18 million die of diseases, which would be preventable through sufficient nutrition, safe water, etc., or easy to treat with essential medicines, re-hydration salt, etc. (Pogge 2008)[2]
- Developing countries account for 84% of global population and 90% of the global disease burden, but only 12 percent of global health spending (World Bank 2006).[3]

[2] Thomas Pogge, *Poverty and Human Rights*, (UN-OHCHR 2008) www2.ohchr.org/english/issues/poverty/expert/docs/Thomas_Pogge_Summary.pdf

- 41 low-income countries are too poor to generate sufficient resources required to achieve the MDGs by 2015 (WHO 2010).[4]
- Every year about 100 million people are pushed under the poverty line because they need to pay for health services (WHO 2010).[5]

Due to these scandalous global inequalities, the health of the majority of the world population remains insufficiently protected and promoted. Only a minority enjoys complete financial risk protection. The poorer the country, the larger the private share of health expenditure. In 2007, in 33 mostly low-income countries, more than 50% of health expenses were direct out-of-pocket payments charged when people access doctors or health facilities. Such out-of-pocket payments go along with incalculable financial risks. They are the most inequitable source of health financing.[6]

In 2010, on the occasion of presenting the World Health Report: 'Health Systems Financing' in Berlin WHO Director General Margaret Chan called for the abolition of out-of-pocket payments and particularly 'user fees'. Dr Chan has not had a good word to say for the latter. 'User fees' are punishing the poor, said the DG of the WHO,[7] in the presence of representatives of the World Bank, which in the late 1980s and 1990s, together with the International Monetary Fund, heavily promoted 'user fees' as part of the structural adjustment programmes forced on the developing world. From both a development and a human-rights perspective the past two decades have to be characterized as lost decades.

At least, and this is remarkable too, international politics again recognizes what our ancestors have known for centuries: that poverty fuels sickness, and sickness poverty. Because of the correlation between ill-health and poverty, universal access to health care cannot be achieved by connecting health to individual purchasing power. It is right that health experts again search for ways to break out of the vicious cycle of poverty and sickness. A promising strategy consists of five key actions.

Key actions to enhance Universal Coverage

First and foremost it is necessary to challenge the neoliberal paradigm of self-responsibility and entrepreneurship. Second, as a prerequisite for improving state accountability there is the need for a health governance reform. Third, out-of- pocket payments have to be reduced by enhancing financial risk protection. Fourth, pooled funds have to be created, and - last but not least - the principle of solidarity recalled and implemented.

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[3] Pablo Gottret, George Schieber, *Health Financing Revisited - A Practioner's Guide*, (The World Bank 2006), p 2

[4] WHO, Health Systems Financing – The path to universal coverage, World Health Report (WHO 2010), p xiii

[5] Ibid, p 5

[6] Ibid, p xiv

[7] Thomas Gebauer, *Universal Coverage – A Shift in the International Debate in Global Health* (Equinet Newsletter 119, Jan 2011, Harare), p 1

Challenging the neoliberal ideology

The struggle for Universal Coverage starts with challenging the still dominant neoliberal paradigm. It is well known that globalization has widened health inequalities. However, more emphasis should be given to the fact that the transforming of health services into commodities, the linkage of access to health care to individual purchasing power, the dismantling of public health systems, has only been possible in the context of a specific ideology – an ideology that has widely affected those who are suffering its negative consequences, the global poor.

At the core of the neo-liberal ideology is a concept that has replaced social values and institutions such as solidarity and common goods by self responsibility and individual entrepreneurship. Although there is plenty of evidence that health is primarily determined by the social environment, neo-liberalism has succeeded in pushing the responsibility for health away from public and state institutions to private actors and individuals – individuals seen as business entrepreneurs in a liberalized market. Even those spheres of societies that traditionally do not belong to the field of business, such as health, education, and culture have been increasingly penetrated by market values.

In his contribution to this publication Professor Angus Dawson stresses the need to consider other values than just the value of Liberty.[8] That's true: we should remind ourselves that the French Revolution, which came up with the first comprehensive lists of Human Rights in 1789, called for; Liberty, Equality and Fraternity. 'Fraternity', the revolutionary agenda's third pillar, may be equated with 'solidarity' in today's discourse. It is of tremendous importance in the context of achieving Universal Coverage.

During the last decades the idea of solidarity has been under constant siege. 'There is no such a thing as society', Margret Thatcher said in the early 1980s - paving the way for the cynical credo of neoliberal politics: if everyone takes care of him/herself, then 'all' are taken care of. Millions of people have been excluded from health and social care as a consequence of neglect of the social principles that nurture the cohesion of societies. Only by revitalising solidarity – both as an ethical principle and in its public institutions – can health inequalities be tackled and *Health for All* achieved. Indeed, there is such a thing as society.

The creation of a social environment favourable to health and health protection cannot be settled by market forces alone. Commercial actors might play a role as service providers. However, since their ultimate goal is to make a profit they have to be regulated by institutions that are committed to the public interest of promoting health.

Improving state accountability

While talking about the accountability of governments and public institutions we should not disregard the amazing fragmentation that has taken place in the

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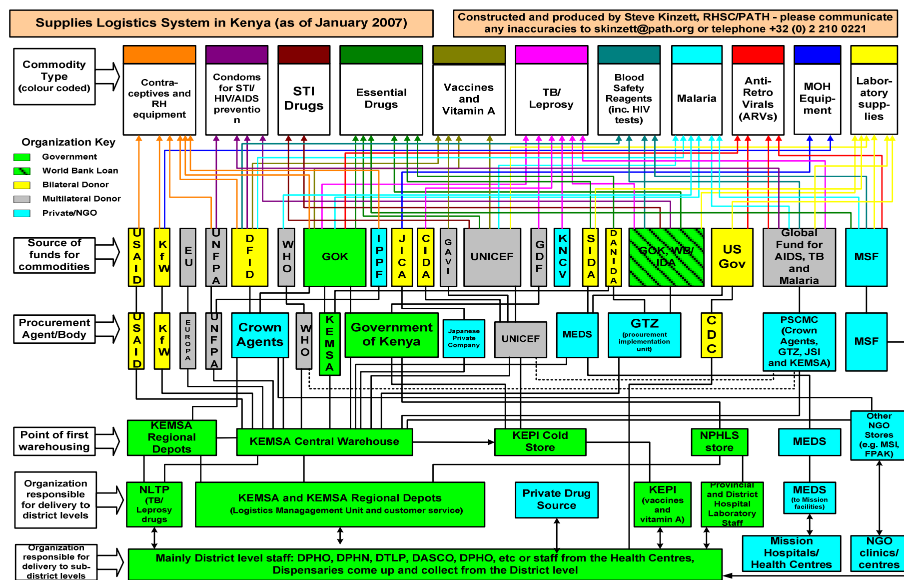
8 See contribution to this book ……

international health landscape during the last two decades. On the one hand the rapid emergence of new actors, such as corporate and private foundations, multinational companies, public-private partnerships, has highlighted health as a priority, but at the same time this has also contributed to the weakening of mandated state institutions at all levels.

Figure 1
Health Supplies Logistics System in Kenya [9]



Particularly the health ministries of many countries in the South have to navigate a verily maze in today's health governance. It is almost impossible to make a national health ministry accountable if it has to deal with dozens of private and international actors all pursuing their own interests. Similar problems afflict the WHO at the international level.

It is obvious that the chaotic situation that has emerged with the fragmentation has to be overcome. In order to stop the wasting of resources, to avoid duplications of activities, to support national ownership, publicly mandated institutions have to be strengthened – a giant task indeed. It is encouraging that the debate on governance reform has commenced. The best solution is to bring health ministries and the WHO back into the 'driver's seat'. Only if mandated institutions again serve as directing and coordinating authorities can we make them accountable: accountable, for example, for introducing financial risk protection schemes – and that is my third point.

Enhance financial risk protection

Financial risk protection means that the major source of health funding needs to come from prepaid and pooled contributions rather than from fees and payments charged once a person falls ill. Universal Coverage will only be

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[9] Steve Kinzett, RHSC/PATH (2007), cit: International Health Partnership IHP+ http://www.internationalhealthpartnership.net

possible if direct payments are progressively replaced by pre-payment plans. The most effective ones are legally binding Social Health Insurance (SHI) schemes that are mandatory for all (partly realised in Germany) and tax-based public health systems (as in the UK). Sometimes health services in tax-based systems are described as being free of charge. That, of course, is not strictly true. State revenues come from tax-payers, and the paying of taxes is – comparable to premiums to social insurance schemes – a kind of pre-payment that protects against financial risks in case of ill-health

There is a long standing debate about the advantages and disadvantages of the two systems. It is obvious that tax-based systems are more adequate for countries with a high part of population that is too poor to pay premiums to SHI. The latter, on the other hand may be better for wealthier countries since the funds collected through SHI schemes are earmarked for health and cannot be misused for other purposes in case of budget constraints.

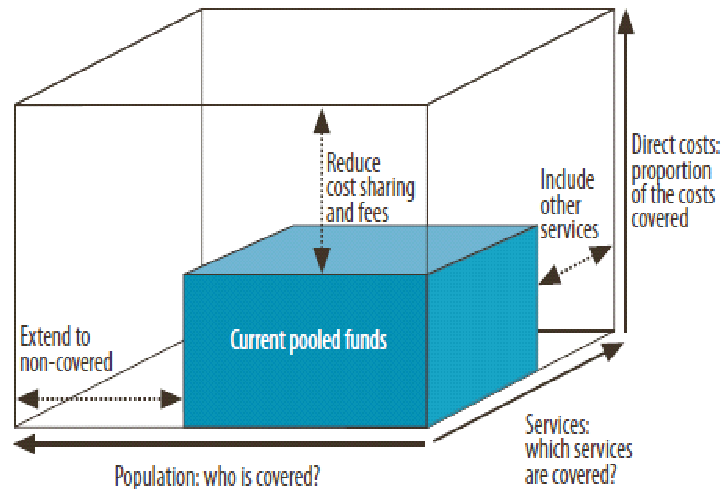
Besides tax-based systems and SHI plans there are other options, such as the idea of Health Saving Accounts (HSA) as promoted in the US. The concept of HSA is to oblige people to build up individual savings to be used when health care is needed. With respect to achieving universal coverage such saving accounts are counterproductive. They are part of a consumer-driven health care system, opposing the idea of health as a common good. They undermine social cohesion: healthy people with higher incomes will prefer HSA while people with health problems will avoid them. Instead of private savings, effective financing for health require pooled funds, and that is my fourth point.

Setting up pooled funds

Both tax-based health systems and social insurance schemes work on the basis of pooled funds. At its best, a pooled fund comprises all citizens of a country and is therefore large enough to cover the risks of all its members. The smaller the group contributing to a pooled fund, the more unlikely it is that all risks can be met. Only if the number of those contributing is great enough can an expensive treatment of a particular person be covered.

Figure 2:
Three dimensions to consider when moving towards universal coverage [10]

[10] WHO, *Health Systems Financing – The path to universal coverage*, p xv



The figure shows the WHO model of pooled funds as presented in the World Health Report 'Health Systems Financing'. It works along three dimensions: expanding the number of people covered; expanding the scope of services; and reducing cost sharing (direct payments such as user fees).

Most remarkably, the WHO model does not speak about just going for some coverage and it also does not advocate for basic protection packages like the ILO does with its concept of a 'Social Protection Floor'[11]. Rather it urges all states to do their utmost to set up pooled funds that provide equal care for everybody. It is a dynamic model that never looses sight of the claim to fully realise the Right to Health. Even if this may not be possible from one day to the next, the duty bearers, the states, are obliged to present strategies and corresponding plans of action describing the way towards the goal to achieve universal coverage. Such an approach opens the space for national adaptations based on democratic decision-making and invites civil society organisations to continuously challenge their governments.

Under ideal conditions all citizens of a country enjoy social health protection, without compromises in the service package and without any extra-payments. Although that sounds utopian it can be achieved – by reiterating solidarity.

The principle of solidarity

Since in every country a part of the population is too poor to contribute to pooled funds, Universal Coverage requires the presence of a permanent and institutionalized system of redistributing wealth. The poor need to be subsidized by those who are in the position to contribute more. Precisely this balancing is established through the principle of solidarity. It is perhaps the most important key to establishing an effective health care system.

In this context it does not matter whether a system is tax-financed or based on SHI schemes. Both are socially agreed funding schemes guaranteeing that even members who are not in a position to contribute a single shilling or cent to

[11] ILO, see: http://www.ilo.org/gimi/gess/ShowTheme.do?tid=1321

national budgets or social insurance will receive the same services as all the others members when they need them. While individual contributions (in terms of taxes or insurance premiums) are dependent on financial capacities, the entitlement to and claiming of services is only determined by need. It is the principle of solidarity that disconnects access to health care from individual purchasing power: those who are wealthier support those who are poorer, younger, or elderly. Those who are economically active, support children and those who are unemployed or retired.

Thus, the principle of solidarity goes far beyond what is usually meant when solidarity refers to empathy and charity. The principle refers rather to an institutionalised solidarity that organises a fair burden sharing. It is fundamental to the 'social infrastructure' of societies. Like the hard infrastructure, like transportation, energy, administration, law enforcement, police, and so on, the social infrastructure also needs to be publicly regulated and funded. The term social infrastructure stands for an ensemble of common goods, such as effective health care services, proper education systems, social protection schemes, food security, and so on. In other words, it covers social institutions that are essential for the social cohesion of societies and should therefore be accessible to everybody, regardless of any individual's purchasing power.

Sooner or later societies will collapse if they lack the social institutions that protect healthy relationships among their citizens. Fair burden sharing, however, needs to be based on mandatory contributions. Otherwise the rich will opt out. It is sad but a fact that all over the globe the rich prefer private assurances or seek tax-dodging and tax avoidance. The corporate sector has done a lot to achieve tax exemption[12]. Sufficient funding to cover the needs of the poor requires compulsory contributions from the rich.

Innovative funding for health

Achieving proper health care depends on the availability of adequate financial resources. The existing health inequalities can only be abolished through increased public spending rather than continuing social cuts. In view of the global poverty that has already affected one third of the world's population, fiscal policy-making has again to focus on the redistribution of wealth. That sounds quite radical, but even the WHO goes along with it. The World Health Report 'Health Systems Financing' (WHO, 2010) invites the WHO Member States to introduce new fiscal measures in order to enhance governmental revenue capacities. Taxation is seen as one of the key policy instruments to widen the fiscal space. As suitable options WHO proposes:

- A special levy on large and profitable companies;
- A levy on currency transactions;

[12] For further reading see e.g. "The Missing Billions – The UK Tax Gap", Trades Union Congress (TUC)

- A financial transaction tax; and
- Taxes on tobacco, unhealthy food, etc.[13]

It is remarkable that the Report does not mention Public-Private-Partnerships as a source of new funding opportunities. Resource innovation goes far beyond the attempt to attract private foundations and the corporate sector. The call for tax justice through progressive taxation is back on the political agenda; it provides civil society organisations with a powerful tool to challenge their governments. Governments should not be allowed to remain inactive just given the assertion that there are no or insufficient resources. In order to properly respond to the social needs of their populations, governments are encouraged to widen their fiscal space. Accountability implies financial capacity, and only adequately funded institutions can be made accountable. If the call for health as a common good in collective responsibility is not just dealing with nice words, health needs to be essentially seen in the context of financing for health.

However, some of the poorest countries will not be able to raise sufficient funds to meet all the health needs even if their governments show the political will for change and try to activate the necessary resources. Maybe because the domestic economy is too weak or the negative impact of the global economy too strong they fail to balance needs with capacities. In these countries governments have limited ability to collect taxes or premiums to SHI schemes because people simply are poor or work in the informal sector.

As mentioned above, only eight of the 49 low-income countries will be able to finance the required level of services from domestic resources in 2015.
In 2001 the WHO Commission on Macroeconomics and Health estimated that even a very basic set of services for prevention and treatment would cost in excess of US$ 34 per person per year. However, 31 countries spend less than US$ 35 per capita on health.[14]

Of course there is every reason to strive for self-reliance and to resist any kind of economic dependency, but change may take time or may fail because of circumstances that cannot be influenced by single governments, such as the effects of climate change and natural disasters. In these cases the gaps between the fiscal needs and fiscal capacity of particular countries can only be bridged by financial support from abroad – support that should be based on global solidarity. And that is where the call for an 'International Fund for Health' comes in.

Globalizing the principle of solidarity

At an international conference on 'Strengthening Local Campaigns for National and International Accountability for Health and Health Services', held in

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[13] WHO, *Health Systems Financing – The path to universal coverage*, p 29

[14] Ke Xu, David B. Evans, Guido Carrin, Ana Mylena Aguilar-Rivera, Philip Musgrove, and Timothy Evans, *Protecting Households From Catastrophic Health Spending - Moving away from out-of-pocket health care payments to prepayment mechanisms is the key to reducing financial catastrophe,* (Health Affairs - Volume 26 , Number 4, July/August 2007), p. 979

Johannesburg, South Africa in March 2011, delegates called for 'the principles of social solidarity that are an accepted part of governance within many nations to be extended to the international level'.[15]

Health care systems based on the principle of solidarity (still) exist in European countries, where they form part of the foundations of societies. Most likely these systems can only be defended by extending them to the international level. In dealing with the neo-liberalism that is persistently posing threats to societies by dismissing solidarity institutions as a proof of 'devilish socialism', it is crucial to again to struggle for solidarity. This struggle needs to be waged at the national level, but it also includes an international dimension. To bridge the gaps, an international financing mechanism is required that obliges rich countries to contribute also to the health budgets of poorer ones.

The Universal Declaration of Human Rights provides the legal foundation for such obligations. Paragraph 28 states that everyone is entitled to a social *and international* order in which the rights and freedoms that are set forth in this Declaration can be fully realized. "The existing international institutional order fails this test, it aggravates extreme poverty", says the Yale philosopher Thomas Pogge: "The rich countries (are) violating human rights when they, in collaboration with Southern elites, impose a global institutional order under which, foreseeably and avoidably, hundreds of millions cannot attain 'a standard of living adequate for the health and well-being of himself and of his family (Paragraph 25 of Universal Declaration of Human Rights)'."[16]

From a human-rights perspective, establishing a global institution that would correct the negative effects of the current global order by redistributing wealth and health-related resources is not a matter of nice-to-have, but an obligation. Such an institution would have to manage two main tasks. It should organize a fair burden sharing between those countries providing the funds. And it should also see to it that these funds are properly used by recipient countries. Such an institution could be seen as "a method to transpose collective entitlements and duties into individual states' entitlements and duties" (Ooms and Hammonds, 2008).[17]

The managing of an International Fund for Health does not necessarily require the creation of a new big bureaucratic body – another Geneva based health actor with thousands of staff members centrally designing programmes and vertically dominating recipient countries. Gorik Ooms and Rachel Hammonds propose to transform the existing Global Fund to Fight AIDS/HIV, Tuberculosis and Malaria (GFATM) into a Global Health Fund by expanding GFATM's mandate from a limited vertical disease approach to a horizontal strengthening of national health systems.[18] It would also be possible to create a small new

[15] Conference Statement, *Strengthen Local Campaigns for National and International Accountability for Health and Health Services*, Section 27 (2011), http://www.section27.org.za/wp-content/uploads/2011/04/Johannesburg-Conference-Consensus-and-Resolutions-final.pdf

[16] Thomas Pogge, *Poverty and Human Rights*, p. 3

[17] Gorik Ooms/Rachel Hammonds, *Correcting Globalisation in Health: Transnational Entitlements versus the Ethical Imperative of Reducing Aid-Dependency*, Public Health Ethics Vol. 1, No 2 (2008), p. 160

[18] Ibid. p 154-170. See also Ooms and Hammonds' chapter in this book.

authority that completely refrains from any operational activity and is just in charge of running a horizontal equalization payment scheme.

Such equalization payments exist at national, regional and even international levels. They exist in countries such as Australia, Belgium, Canada and Germany. The German model is of particular interest here. To balance the economic gaps among the 'Bundesländer' (federal states), those with higher fiscal capacity are legally obliged to transfer funds to those lacking fiscal capacity. The German equalisation payment works horizontally between the federal states. It is based on highly complex calculations taking into account things such as the tax revenues of the states, their population figures, the population density. In 2010 the volume that has been transferred between the states accounted for almost €7 billion; organized by an institution that does not play a big role in the public's mind because it is just raising the right data, feeding computers, and arranging it so that equalisation payments can be made. [19]

Comparable schemes exit at regional levels: the European Social Fund, for example, which was established to balance the needs of the European regions in the context of education, services for unemployed, and so on, is handling €75 billion at present. And even at the international level there is an example for an equalization payment mechanism. It is part of the Universal Postal Union that was founded in 1874. At that time the national postal authorities agreed on a treaty regulating the financial requirements that arise when a letter, sent, for instance, in Germany is to be delivered in India, Malawi or the UK. In other words: when a fee charged in Germany has to also cover the expenses of services provided in other countries. Today, hardly anybody knows of the existence of the Universal Postal Union. But its creation was crucial to allowing global communication, and it still works. The Universal Postal Union shows that the best common goods are those that do their work without causing a fuss. If establishing such an international equalisation payment scheme was possible in the 19th century, why not again today in the context of global governance for health?

International Fund for Health

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

[19] For further reading: Bundesfinanzministerium (Federal Ministry of Finance) The Federal Financial Equalisation System in Germany ,

Therefore an International Fund for Health should be firmly based on a legally binding treaty. Both fair burden sharing among the countries that contribute to the fund as well as the claiming of access should be transparently regulated, based on a human rights approach. An international legal agreement could be arranged either by signing a treaty that just covers the global funding aspect or as an additional protocol to a 'Framework Convention on Global Health' (FCGH), as proposed by Larry Gostin and the 'Joint Action and Learning Initiative' (JALI).[20]

Obviously an International Fund for Health would change the existing paradigm of international co-operation. It would transform Official Development Assistance (ODA) from a donor-recipient interest-driven type of aid to a system of co-operation that is based on entitlements and joint responsibility. Particularly, because an 'International Fund for Health' will not operate as a global body vertically implementing health programmes, the use of transferred funds has to be legally bound by appropriate guidelines and principles. And these guidelines already exist. First and foremost the International Covenant of Economic, Social and Cultural Rights plus the General Comments, the Primary Health Care Declaration of the WHO, the concept of Universal Coverage claiming equal access for all, and other such instruments. Undoubtedly there is sufficient knowledge of how to achieve Health for All. And there are already internationally agreed principles. All that is missing are the institutions to set the knowledge and principles into force.

However, what are the costs? Would it not be much too expensive to run such a fund? Again: it is not the money that is missing. Paying for an International Fund for Health would be feasible. The existing figures provide clarity. The World Health Report mentions an annual amount of US$ 60 per capita to realize access to appropriate health care in today's poor countries. Below the line the total amount required would still be in the range of what is already promised by high-income countries. The costs to significantly improve health care funding in the least developed world would not exceed the 15% margin of health out of the 0.7% goal for ODA. But even if we insist on global health equity – and there is no reason not to go for equity – and calculate US$ 500-700 per capita there would be no need to generate new funds. US$ 500-700 would certainly be a good start to enable all citizen of the world to enjoy health care protection - without exceeding the total of global expenditures for health: in 2007 the world has spent US$ 4.1 trillions for health, which amounts to US$ 639 per person per year. [21]

Taking the principle of solidarity forward internationally is not a matter of finding missing resources. It is rather a matter of the political will to create a new institutional norm ensuring that richer countries with higher fiscal capacity are

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[20] Lawrence O. Gostin, Eric A. Friedman, Gorik Ooms, Thomas Gebauer, Narendra Gupta, Devi Sridhar, Wang Chenguang, John-Arne Røttingen, David Sanders, *The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health,* PLoS Medicine Vol. 8, Issue 5 (May 2011), www.plosmedicine.org . See also Larry Gostin's chapter in this book.

[21] http://www.who.int/mediacentre/factsheets/fs319/en/index.html

obliged to transfer funds to poorer countries, as long as these are lacking adequate fiscal capacity. However, this may raise another concern that has to be taken seriously. How can we avoid internationally supplied resources displacing national efforts? In fact, today's international aid quite often brings with it the effect that recipient countries decrease the allocation of domestic resources. However, having a closer look at the facts it becomes obvious that it is precisely the unreliability of today's international aid that prevents countries from allocating more of their own resources.

Setting up a proper health system in poor countries is certainly quite cost intensive. A government that is trying to do this by using international donations given just for a short period could find itself left behind with unaffordable costs when funding from aboard stops. Under these circumstances countries may prefer not to invest in national health care systems. Thus, it is rather the long-term reliability of international co-financing that allows and motivates national planning based on a steady increase of internal resources (Ooms, 2011).[22]

To summarize: innovative mechanisms for health systems financing need to be based on the redistribution of wealth, a kind of social transfer that goes beyond charity. Funding for health addresses the entitlements of human beings. People in need should not be seen as objects of good will activities. They are human beings enjoying the legal claim to health. To be able to respond to the entitlements of people, mandatory and predictable funding mechanisms have to be created that regulate a fair burden sharing and ensure the proper use of funds. However, international funding mechanisms, even the proposed International Fund for Health, are only the second best option. As their task would be to balance existing financial gaps, everything has to be done to strengthen national capacities on the front line. The global south needs to regain control over its own resources.

Yes, utopian

An International Fund for Health may be considered as utopian. Yes, there is a kind of utopianism, but change will only be possible if we go beyond pragmatism. Looking to all that is happening in today's world in the name of realism, we see that 'realism' has long proven to be wrong-headed. And there is a window of opportunity for change. Margret Thatcher's dictum: 'There Is No Alternative' –known as the TINA principle – is no longer convincing.

Change can be successful if there is the "desire for change", actively expressed by an engaged international public: by social movements, community organisations, civil society creating a 'countervailing power'. Precisely this strong public is needed to gain the 'diplomatic space' that allows the negotiation of new norms and the setting up of new institutions.

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[22] See: Gorik Ooms, Fiscal Space and the Importance of Long Term Reliability of International Co-financing, JALI-Working paper No 1 (2011)

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

References:

Bundesfinanzministerium (Federal Ministry of Finance): *The Federal Financial Equalisation System in Germany* http://www.bundesfinanzministerium.de/nn_4480/DE/BMF__Startseite/Service/Downloads/Abt__V/The_20Federal_20Financial_20Equalisation_20System_20in_20Germany,templateId=raw,property=publicationFile.pdf

Gebauer, Thomas: *Universal Coverage – A Shift in the International Debate in Global Health,* Equinet Newsletter 119, Jan 2011, Harare

Gostin, Laurence, Eric A. Friedman, Gorik Ooms, Thomas Gebauer, Narendra Gupta, Devi Sridhar, Wang Chenguang, John-Arne Røttingen, David Sanders,: *The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health,* PLoS Medicine Vol. 8, Issue 5, May 2011, www.plosmedicine.org

Gottret, Pablo and Schieber, George: *Health Financing Revisited – A Practioner's Guide*, The World Bank 2006

Kinzett, Steve: RHSC/PATH (2007), cit: International Health Partnership IHP+ http://www.internationalhealthpartnership.net

Ooms, Gorik and Hammonds, Rachel: *Correcting Globalisation in Health: Transnational Entitlements versus the Ethical Imperative of Reducing Aid-Dependency*, Public Health Ethics Vol. 1, No 2 (2008)

Ooms, Gorik: *Fiscal Space and the Importance of Long Term Reliability of International Co-financing*, JALI-Working paper No 1 (2011)

Pogge, Thomas: *Poverty and Human Rights*, (UN-OHCHR 2008) www2.ohchr.org/english/issues/poverty/expert/docs/Thomas_Pogge_Summary.pdf

Section 27: *Conference Statement - Strengthen Local Campaigns for National and International Accountability for Health and Health Services*, (2011), http://www.section27.org.za/wp-content/uploads/2011/04/Johannesburg-Conference-Consensus-and-Resolutions-final.pdf

Trades Union Congress (TUC): *The Missing Billions – The UK Tax Gap"*, (2008), http://www.tuc.org.uk/touchstone/Missingbillions/1missingbillions.pdf

WHO: *Health Systems Financing – The path to universal coverage*, World Health Report, WHO 2010

WHO, *World Health Statistics 2011* www.who.int/whosis/whostat/EN_WHS2011_Full.pdf

Xu, Ke / Evans, David B. / Carrin, Guido / Aguilar-Rivera, Ana Mylena / Musgrove, Philip and Evans, Timothy: *Protecting Households From Catastrophic Health Spending - Moving away from out-of-pocket health care payments to prepayment mechanisms is the key to reducing financial catastrophe*, Health Affairs - Volume 26 , Number 4, (July/August 2007)